Proposed Changes to Division 410 Chapter 141 Rules – Effective January 1, 2022

Revised August 26, 2021

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410-141-3500 Definitions (Proposed Changes Effective 1/1/22)

(1) The following definitions apply with respect to OAR chapter 410, division 141. The Authority also incorporates the definitions in OAR 410-120-0000, 309-032-0860 for any terms not defined in this rule.

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

(3) “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, as set forth in OAR 410-120-0000.

(4) “Area Agency on Aging (AAA)” means the designated entity with which the Department contracts in planning and providing services to elderly populations, as set forth in OAR 410-120-0000.

(5) “The Authority” means the Oregon Health Authority.

(6) “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; CMS Section 1557 of the ACA outlines requirements for health plans and providers on alternative formats.

(7) “Auxiliary Aids and Services” means services available to members as defined in 45 CFR Part 92.

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

(9) “Benefit Period” means a period of time shorter than the five-year contract term, for which specific terms and conditions in a contract between a coordinated care organization and the Oregon Health Authority are in effect.

(10) “Business Day” means any day except Saturday, Sunday, or a legal holiday. The word "day" not qualified as business day means calendar day.

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

(12) “Capitation Payment” means monthly prepayment to an MCE for capitated services to MCE members.

(13) "Care Plan" means a documented plan that addresses the supportive, therapeutic, cultural, and linguistic health of a member. The member's care plan shall be developed for in collaboration with the Member and the Member's family or representative, and, if applicable, the Member's caregiver so that it incorporates their preferences and goals to ensure engagement and satisfaction. Care plans include, without limitation:

(a) prioritized goals for a member's health;

(b) identifying interventions and resources that will benefit and support the member's goals such as peer support, non-traditional services, community services, employment and housing support;

(c) medication management; and

(d) monitoring and re-evaluation.

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

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

(16) “Client” means an individual found eligible to receive OHP health services, whether or not the individual is enrolled as an MCE member.

(17) “Community Advisory Council (CAC)” means the CCO-convened council that meets regularly to ensure the CCO is addressing the health care needs of CCO members and the community consistent with ORS 414.625. CCOs shall seek ~~afford~~ an opportunity for tribal participation on CACs by bringing nominee(s) to the attention of the CAC Selection Committee as follows:

(a) In a ~~CCO~~ S~~s~~ervice A~~a~~rea~~s~~ where only one federally recognized tribe exists, the CCO~~tribe~~ shall ~~appoint~~ seek one tribal representative to serve on the CAC;

(b) In ~~CCO~~ S~~s~~ervice A~~a~~reas where multiple federally recognized tribes exist, ~~each tribe~~ the CCO shall ~~appoint~~ seek one ~~a~~ tribal representative from each tribe to serve on the CAC ~~to ensure full representation of all tribes within the service area~~; and

(c) In metropolitan CCO S~~s~~ervice A~~a~~reas where no federally recognized tribe exists, CCOs shall solicit the Urban Indian Health Program for a representative to serve on the CAC.

(18) “Community Benefit Initiatives” (CBI) means community-level interventions focused on improving population health and health care quality.

(19) “Continuous Inpatient Stay“ means an uninterrupted period of time that a patient spends as inpatient, regardless of whether there have been changes in assigned specialty or facility during the stay. This may include discharge transfer to another inpatient facility, in or out of state, including another acute care hospital, acute care psychiatric hospital, skilled nursing facility, psychiatric residential treatment facility (PRTF) or other residential facility for inpatient care and services.

(20~~19~~) “Contract” means an agreement between the State of Oregon acting by and through the Authority and an MCE to provide health services to eligible members.

(21~~0~~) “Coordinated Care Organization (CCO)” means a corporation, governmental agency, public corporation, or other legal entity that is certified as meeting the criteria adopted by the Authority under ORS 414.625 to be accountable for care management and to provide integrated and coordinated health care for each of the organization’s members.

(22~~1~~) “Coordinated Care Services” mean an MCE’s fully integrated physical health, behavioral health services, and oral health services.

(23~~2~~) “Corrective Action” or “Corrective Action Plan” means an Authority-initiated request for an MCE or an MCE-initiated request for a subcontractor to develop and implement a time specific plan for the correction of identified areas of noncompliance.

(24) “Delivery System Network” means the entirety of those Participating Providers who (a) subcontract with, or (b) are employed by, an MCE for purposes of providing services to the Members of such MCE. “Provider Network” has the same meaning.

(25~~3~~) “Dental Care Organization (DCO)” means a prepaid managed care health services organization that contracts, on a capitated basis, with the Authority under ORS 414.654 or with a coordinated care organization, or both with the Authority and a coordinated care organization, to provide dental services to medical assistance recipients. Dental Care Organization also meets the definition of a Prepaid Ambulatory Health Plan as defined under 42 CFR § 438.2.

(26~~4~~) “The Department” means the Department of Human Services.

(27~~5~~) “Department of Consumer and Business Services (DCBS)” means Oregon’s business regulatory and consumer protection department.

(28~~6~~) “Disenrollment” means the act of removing a member from enrollment with an MCE.

(29~~7~~) "Diversity of the Workforce" refers to the ethnic, racial, linguistic, gender, and social variation among members of the health professional workforce. It is generally understood that a more diverse workforce represents a greater opportunity for better quality health care service, due to the array of life experiences and empathy of a mix of providers that can be brought to the delivery of health care.

(30~~28~~) “Enrollment” means the assignment of a member to an MCE for management and coordination of health services.

(~~29~~31) “Family Planning” means services that enable individuals to plan and space the number of their children and avoid unintended pregnancies. The Oregon Health plan covers family planning services for clients of childbearing age, including minors who are considered to be sexually active. Family Planning services include:

(a) Annual exams;

(b) Contraceptive education and counseling to address reproductive health issues;

(c) Prescription contraceptives (such as birth control pills, patches or rings);

(d) IUDs and implantable contraceptives and the procedures requires to insert and remove them;

(e) Injectable hormonal contraceptives (such as Depo-Provera);

(f) Prescribed pharmaceutical supplies and devices (such as male and female condoms, diaphragms, cervical caps, and foams);

(g) Laboratory tests including appropriate infectious disease and cancer screening;

(h) Radiology services;

(i) Medical and surgical procedures, including vasectomies, tubal ligations and abortions.

(32~~0~~) “Flexible Services” means those services that are cost-effective services offered as an adjunct to covered benefits.

(33~~1~~) “Global Budget” means the total amount of payment as established by the Authority to a CCO to deliver and manage health services for its members including providing access to and ensuring the quality of those services.

(34~~2~~) “Grievance System” means the overall system that includes:

(a) Grievances to an MCE on matters other than adverse benefit determinations;

(b) Appeals to an MCE on adverse benefit determinations; and

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

(35~~3~~) “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.

(36~~4~~) “Health-Related Services” means non-covered services under Oregon’s Medicaid State Plan intended to improve care delivery and overall member and community health and well-being, as defined in OAR 410-141-3845. Health-related services include flexible services and community benefit initiatives.

(37~~5~~) “Health System Transformation” means the vision established by the Oregon Health Policy Board for reforming health care in Oregon, including both the Oregon Integrated and Coordinated Health Care Delivery System and reforms that extend beyond the context of OHP.

(38~~6~~) “Holistic Care” means incorporating the care of the entire member in all aspects of well-being including physical, psychological, cultural, linguistic, and social and economic needs of the member. Holistic care utilizes a process whereby providers work with members to guide their care and identify needs. This also involves identifying with principles of holism in a system of therapeutics, such as the practices of naturopathy or chiropractic and often involving nutritional measures.

(39~~7~~) “Home CCO” means the CCO enrollment situation that existed for a member prior to placement, including services received through OHP fee-for-service, based on permanent residency.

(40~~38~~) “Indian” and/or “American Indian/Alaska Native (AI/AN)” means any individual defined at 25 USC 1603(13), 1603(28), or 1679(a), or who has been determined eligible as an Indian, under 42 CFR 136.12; or as defined under 42 CFR 438.14(a).

(41~~39~~) “Indian Health Care Provider (IHCP)” means a health care program operated by the Indian Health Service (IHS) or by an Indian Tribe, Tribal Organization, or Urban Indian Organization (otherwise known as an I/T/U) as those terms are defined in section 4 of the Indian Health Care Improvement Act (25 U.S.C. § 1603).

(42~~0~~) “In Lieu of Service” (ILOS) means a setting or service determined by the Authority to be a medically appropriate and cost-effective substitute for a Covered Services consistent with provisions in OAR 410-141-3820. The utilization and actual cost of an ILOS is included in developing the components of the Capitation Payment. In lieu of services must meet the requirements of 42 CFR 438.3(e)(2).

(43~~1~~) “Individual with Limited English Proficiency” means a person whose primary language for communication is not English and who has a limited ability to read, write, speak, or understand English.

(44~~2~~) "Institution for Mental Diseases (IMD)" means, as defined in 42 CFR § 435.1010, a hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing inpatient psychiatric services such as diagnosis, treatment, or care of individuals with mental diseases, including medical attention, nursing care, and related services. Its primary character is that of a facility established and maintained primarily for the care and treatment of individuals with mental diseases, whether or not it is licensed as such.

(45~~3~~) "Intensive Care Coordination" (ICC) refers to the specialized services described in OAR 410-141-3870. These services have, in other contexts, been labeled Exceptional Needs Care Coordination.

(46~~4~~) "Legal Holiday" means the days described in ORS 187.010 and 187.020.

(47~~5~~) "Licensed Health Entity" means an MCE that has a Certificate of Authority issued by DCBS as a health insurance company or health care service contractor.

(48~~6~~) "Managed Care Entity (MCE)" means, an entity that enters into a contract to provide services in a managed care delivery system, including but not limited to managed care organizations, prepaid health plans, primary care case managers and Coordinated Care Organizations.

(49~~7~~) "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), Dental Care Organization (DCO), or Physician Care Organization (PCO).

(50) "Material Change to Delivery System" means;

(a) Any change to the CCOs Delivery System Network (DSN) that may result in more than five (5) percent of its Members in a given county or Service Area changing the physical location(s) of where services are received; or

(b) Any change to CCO's DSN that would likely affect less than five (5) percent of its Members but involves a Provider or Provider group that is the sole provider specialty type in a given county, Service Area, or area with limited choice to accessible services; or

(c) Any change in CCO's overall operations that affects its ability to meet a required DSN standard including, but not limited to: termination or loss of a Provider or Provider group, or any change likely to affect more than five (5) percent of CCO's total Members or Provider Network or both; or

(d) Any combination of the above changes.

(51~~48~~) "Medicaid-Funded Long-Term Services and Supports (LTSS)" means all Medicaid funded services CMS defines as long-term services and supports, including both:

(a) "Long-term Care," the system through which the Department of Human Services provides a broad range of social and health services to eligible adults who are aged, blind, or have disabilities for extended periods of time. This includes nursing homes and behavioral health care outlined in OAR chapter 410, division 172 Medicaid Payment for Behavioral Health Services, including state psychiatric hospitals;

(b) “Home and Community-Based Services,” the Medicaid services and supports provided under a CMS-approved waiver to avoid institutionalization as defined in OAR chapter 411, division 4 and defined as Home and Community-Based Services (HCBS) and as outlined in OAR chapter 410, division 172 Medicaid Payment for Behavioral Health Services.

(52~~49~~) “Member” means an OHP client enrolled with an MCE.

(53~~0~~) “Member Representative” means an individual who can make OHP-related decisions for a member who is not able to make such decisions themselves.

(54~~1~~) “National Association of Insurance Commissioners (NAIC)” means the U.S. standard-setting and regulatory support organization created and governed by the chief insurance regulators from the 50 states, the District of Columbia, and five U.S. territories.

(55~~2~~) “Non-Participating Provider” means a provider that does not have a contractual relationship with an MCE and is not on their panel of providers.

(56~~3~~) “Ombudsperson Services” means patient advocacy services available through the Authority for clients who are concerned about access to, quality of, or limitations in the health services provided.

(57~~4~~) “Oral Health” means conditions of the mouth, teeth, and gums.

(58~~5~~) “Oregon Health Plan (OHP)” means Oregon’s Medicaid program or related state-funded health programs. Any OHP contract shall identify whether it concerns Oregon’s Medicaid program or a related state-funded health program, or both.

(59~~6~~) “Oregon Integrated and Coordinated Health Care Delivery System” means the set of state policies and actions that promote integrated care delivery by CCOs to OHP clients, pursuant to ORS 414.620.

(60~~57~~) “Participating Provider” means a provider that has a contractual relationship with an MCE. A Participating Provider is not a Subcontractor solely by virtue of a Participating Provider agreement with an MCE. “Network Provider” has the same meaning as Participating Provider. ~~and is on their panel of providers.~~

~~(58) “Participating Provider Organization” means a group practice, facility, or organization that has a contractual relationship with an MCE and is on the MCE’s panel and;~~

~~(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;~~

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

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

(61~~59~~) “Permanent Residency” means the county code-zip code combination of the physical residence in which the member/client lived, as found in the benefit source system, prior to placement and to which the member/client is expected to return to after placement ends.

(62~~0~~) “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 MCE.

(63~~1~~) “Primary Care Provider (PCP)” means an 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 are health professionals who initiate referrals for care outside their scope of practice, consultations, and specialist care, and assure the continuity of medically appropriate client care. PCPs include:

(a) The following provider types: physician, naturopath, nurse practitioner, physician assistant or other health professional licensed or certified in this state, whose clinical practice is in the area of primary care;

(b) A health care team or clinic certified by the Authority as a PCPCH as defined in OAR 409-027-0005 and OAR 410-120-0000.

(64~~2~~) “Provider” means~~, pursuant to OAR 410-120-0000,~~ an individual, facility, institution, corporate entity, or other organization that:

(a) Is engaged in the delivery of services or items or ordering or referring for those services or items; or

(b) ~~supplies health services or items, also termed a rendering provider, or b~~Bills, obligates, and receives reimbursement from the Authority’s Health Services Division on behalf of a Provider, ~~rendering provider of services, (~~also termed a “B~~b~~illing P~~p~~rovider” ~~(BP~~). ~~The term provider refers to both rendering providers and BP unless otherwise specified.~~

(c) Supplies health services or items (also termed a “Rendering Provider”).

~~(63) “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;~~

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

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

(654) "Readily Accessible" means electronic information and services that comply with modern accessibility standards such as section 508 guidelines, section 504 of the Rehabilitation Act, and W3C's Web Content Accessibility Guidelines (WCAG) 2.0 AA and successor versions.

(665) "Service Area" means the geographic area within which the MCE agreed under contract with the Authority to provide health services.

(676) "Serious Emotional Disorder" (SED) means a subpopulation of individuals under age 21 who meet the following criteria:

(a) A child or youth, between the ages of birth to 21 years of age; and

(b) Must meet criteria for diagnosis, functional impairment and duration:

(A) Diagnosis: The child or youth must have an emotional, socio-emotional, behavioral or mental disorder diagnosable under the DSM-5 or its ICD-10-CM equivalents, or subsequent revisions (with the exception of DSM "V" codes, substance use disorders and developmental disorders, unless they co-occur with another diagnosable serious emotional, behavioral, or mental disorder):

(i) For children 3 years of age or younger. The child or youth must have an emotional, socio-emotional, behavioral or mental disorder diagnosable under the Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood-Revised (DC: 0-3R) (or subsequent revisions);

(ii) For children 4 years of age and older. The child or youth must have an emotional, socio-emotional, behavioral or mental disorder diagnosable under the Diagnostic Interview Schedule for Children (DISC) or DSM-5 or its ICD-10-CM equivalents, or subsequent revisions (with the exception of DSM "V" codes, substance use disorders and developmental disorders, unless they co-occur with another diagnosable serious emotional, behavioral, or mental disorder).

(B) Functional impairment: An individual is unable to function in the family, school or community, or in a combination of these settings; or the level of functioning is such that the individual requires multi-agency intervention involving two or more community service agencies providing services in the areas of mental health, education, child welfare, juvenile justice, substance abuse, or primary health care;

(C) Duration: The identified disorder and functional impairment must have been present for at least 1 year or, on the basis of diagnosis, severity or multi-agency intervention, is expected to last more than 1 year.

(687) "Special Health Care Needs" means individuals who have high health care needs, multiple chronic conditions, mental illness or Substance Use Disorders and either:

(a) Have functional disabilities;

(b) Live with health or social conditions that place them at risk of developing functional disabilities (for example, serious chronic illnesses, or certain environmental risk factors such as homelessness or family problems that lead to the need for placement in foster care), or

(c) Are a Member of the Prioritized Populations as defined in 410-141-3870.

(698) "Subcontract" means either:

(a) A contract between an MCE and a subcontractor pursuant to which such subcontractor is obligated to perform certain work that is otherwise required to be performed by the MCE under its contract with the State, or

(b) Is the infinitive form of the verb “to Subcontract”, i.e. the act of delegating or otherwise assigning to a Subcontractor certain work required to be performed by an MCE under its contract with the State.

(70~~69~~) "Subcontractor" means an individual or entity that has a contract with an MCE that relates directly or indirectly to the performance of the MCE's obligations under its contract with the State. A Participating Provider is not a Subcontractor solely by virtue of having entered into a Participating Provider agreement with an MCE.

(71~~0~~) “Trauma Informed Approach” means approach undertaken by providers and healthcare or human services programs, organizations, or systems in providing mental health and substance use disorders treatment wherein there is a recognition and understanding of the signs and symptoms of trauma in, and the intensity of such trauma on, individuals, families, and others involved within a program, organization, or system and then takes into account those signs, symptoms, and their intensity and fully integrating that knowledge when implementing and providing potential paths for recovery from mental health or substance use disorders. The Trauma Informed Approach also means that providers and healthcare or human services programs, organizations, or systems and actively resist re-traumatization of the individuals being served within their respective entities.

(72~~1~~) “Temporary Placement” means, for purposes of this rule, 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.

(73~~2~~) "Trauma-informed services" means those services provided using a Trauma Informed Approach.

(74~~3~~) “Treatment Plan” means a documented plan that describes the patient's condition and procedures that will be needed, detailing the treatment to be provided and expected outcome and expected duration of the treatment prescribed by the health care professional. This therapeutic strategy shall be designed in collaboration with the member, the member’s family, or the member’s representative.

(75~~4~~) “Urban Indian Health Program” (UIHP) means an urban Indian organization as defined in section 1603 of Title 25 that has an IHS Title V contract as described in section 1653 of Title 25.

(76~~5~~) "Workforce diversity capacity" means the organization's ability to foster an environment where diversity is commonplace and enhances execution of the organization's objectives. It means creating a workplace where differences demographics and culture are valued, respected and used to increase organizational capacity.

Statutory/Other Authority: ORS 413.042 & ORS 414.065
Statutes/Other Implemented: ORS 414.065 & 414.727

410-141-3510 Provider Contracting and Credentialing (Proposed Changes Effective 1/1/22)

(1) MCEs shall develop policies and procedures for credentialing providers to include quality standards and a process to remove providers from their provider network if they fail to meet the objective quality standards:

(a) MCEs shall ensure that all participating providers as defined in OAR 410-141-3500 providing coordinated care services to members are credentialed upon initial contract with the MCE and re-credentialed no less frequently than every three years. The credentialing and re-credentialing process shall include review of any information in the National Practitioners Databank. MCEs shall accept both the Oregon Practitioner Credentialing Application and the Oregon Practitioner Recredentialing Application;

(b) MCEs shall screen their participating 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, except in the following circumstances for credentialing COVID-19 vaccine administration providers for the sole purpose of administering COVID-19 vaccines. For the purpose of this rule, COVID-19 vaccination administration provider means a healthcare provider that has successfully enrolled with the Authority's Public Health Division to be a COVID-19 vaccination administration provider, completed all required training, and has agreed to all terms of program participation.

(A) CCOs may rely upon the most recent weekly update of the Authority's active file of vaccine administration providers to meet contractual and regulatory requirements for credentialing COVID-19 vaccine administration providers.

(B) CCOs may enroll COVID-19 vaccine administration providers who are included in the Authority's most recent active file of vaccine administration providers.

(C) CCOs shall monitor changes in the Authority's weekly active file of vaccine administration providers for terminations and changes.

(c) MCEs may elect to contract for or to delegate responsibility for the credentialing and screening processes; however, CCOs shall be solely and ultimately responsible for adhering with all terms and conditions held in its contract with the state. For the following activities including oversight of the following processes regardless of whether the activities are provided directly, contracted, or delegated, MCEs shall:

(A) Ensure 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 shall ensure participating providers are appropriately supervised according to their scope of practice;

(B) Provide training for MCE staff and participating providers and their staff regarding the delivery of coordinated care services, applicable administrative rules, and the MCEs administrative policies.

(d) The MCE shall 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 an MCE 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").

(D) If an MCE removes a provider or fails to renew a provider's contract if the provider fails to meet objective quality standards.

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

(A) Have been terminated from Medicaid;

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

(g) MCEs shall require each atypical provider to be enrolled with the Authority and shall 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. MCEs shall 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), and 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.

(2) An MCE may not discriminate with respect to participation in the MCE 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 an MCE declines to include individual or groups of providers in its

network, it shall give the affected providers written notice of the reason for its decision. This rule may not be construed to:

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

(b) Preclude the MCE 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:

(A) Factors designed to maintain quality of services and control costs and are consistent with its responsibilities to members; or

(B) Factors that add value to the service provided including but not limited to expertise, experience, accessibility, or cultural competence.

(c) The requirements in subsection (b) do not apply to reimbursement rate variations between providers with the same license or certification or between specialists and non-specialty providers.

(3) An MCE shall establish an internal review process for a provider aggrieved by a decision under section (42) 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.

(4) To resolve appeals made to the Authority under sections (23) and (43) of this rule, the Authority shall provide administrative review of the provider's appeal using the administrative review process established in OAR 410-120-1580. The Authority shall invite the aggrieved provider and the MCE to participate in the administrative review. In making a determination of whether there has been discrimination, the Authority shall consider the MCE's:

(a) Network adequacy;

(b) Provider types and qualifications;

(c) Provider disciplines; and

(d) Provider reimbursement rates.

(5) A prevailing party in an appeal under sections (3) through (4) of this rule shall be awarded the costs of the appeal.

(6) MCEs shall not apply any requirement that any entity operated by the IHS, an Indian tribe, tribal organization or urban Indian organization be licensed or recognized under the State or local law where the entity is located to furnish health care services, if the entity meets all the applicable standards for such licensure or recognition. This requirement is pursuant to 25 USC 1621t and 1647a.

(7) MCEs shall not require the licensure of a health professional employed by such an entity under the State or local law where the entity is located, if the professional is licensed in another State.

(8) MCEs shall offer contracts to all Medicaid eligible IHCPs and to provide timely access to specialty and primary care within their networks to MCE enrolled IHS beneficiaries seen and referred by IHCPs, regardless of the IHCPs status as contracted provider within the MCE network.

Statutory/Other Authority: ORS 413.042 & ORS 414.065
Statutes/Other Implemented: ORS 414.065 & 414.727

410-141-3515 Network Adequacy (Proposed Changes Effective 1/1/22)

(1) MCEs shall maintain and monitor a network of participating providers that is sufficient in number, provider type, and geographic distribution to ensure adequate service capacity and availability to provide available and timely access to medically appropriate and culturally responsive covered services to both current members and those the MCE anticipate will become enrolled as members.

(2) The MCE shall develop a provider network that enables members to access services within the standards defined below.

(3) The MCE shall meet access-to-care standards and that allow for appropriate choice for members. Services and supports shall be 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.

(4) MCEs shall meet quantitative network access standards defined in rule and contract.

(5) CCOs shall ensure access to integrated and coordinated care as outlined in OAR 410-141-3860, which includes access to a primary care provider or primary care team that is responsible for coordination of care and transitions.

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

(7) All MCEs shall ensure all members can access providers within acceptable travel time or distance requirements. Specifically;

(a) CCOs shall ensure all members can access providers within acceptable travel time or distance to mental health provider, adult; mental health provider, pediatric; mental health provider, both; oral health provider, adult; oral health provider, pediatric; oral health provider, both (adult and pediatric); specialty practitioner, adult; specialty practitioner, pediatric; specialty practitioner, both (adult and pediatric); substance use disorder provider, adult; substance use disorder provider, pediatric; substance use disorder provider, both (adult and pediatric); patient-centered primary care homes ~~or PCPs~~; primary care provider, adult; primary care provider, pediatric; primary care provider, both (adult and pediatric); Federally Qualified Health Centers; hospital; hospital, acute psychiatric care; Rural Health Centers; pharmacies; post-hospital skilled nursing facilities; Urgent Care Centers; ~~OB/GYN; behavioral health (mental health and substance use disorder), adult and pediatric; specialists, adult and pediatric; hospital; pharmacy; oral care, adult and pediatric~~; and additional provider types when it promotes the objectives of the Authority.

(b) DCOs must ensure all members have access to the following provider types within acceptable travel time and distance: denturist; endodontists; expanded practice dental hygienists; orthodontists and dentofacial orthopedics; oral and maxillofacial pathologists; oral and maxillofacial surgeons; periodontists; primary care dentists, adult; primary care dentists, pediatric; primary care dentist, both (adult and pediatric), prosthodontics; registered dental hygienists; emergency dental services clinics;

federally qualified health centers; Indian Health Services and Tribal Health Services; Public/County Health Departments; Rural Health Centers; and additional provider types when it promotes the objectives of the Authority.

(c) All MCEs a~~A~~cceptable travel time~~s~~ and distance~~s~~ monitoring must assess the geographic distribution of providers relative to members and ~~must be~~ calculated~~d~~ driving time and distance from the member's physical address to the provider's location through the use of geocoding software or other mapping applications.~~,~~ ~~and~~ Time and distance standards may not exceed the following, unless otherwise approved by the Authority:

(a) In urban areas, 30 miles, or 30 minutes;

(b) In rural areas, 60 miles, or 60 minutes.

(8) MCEs shall have an access plan that establishes a protocol for monitoring and ensuring access, outlines how provider capacity is determined, and establishes procedures for monthly monitoring of capacity and access and for improving access and managing access in times of reduced participating provider capacity. The access plan and associated monitoring protocol shall address the following:

(a) Expected utilization of services based on anticipated member enrollment and health care needs of the member population;

(b) The number and types of providers required to furnish the contracted services and the number and types of providers actively providing services within the MCE's current provider network;

(c) How~~include how~~ the ~~CCO~~ MCE will meet the accommodation and language needs of individuals with LEP as defined in 410-141-3500 and people with disabilities in their service area in compliance with state and federal rules including but not limited to ORS 659A, Title VI of the Civil Rights Act of 1964, Section 1557 of the Affordable Care Act, the Americans with Disabilities Act, and Section 504 of the Rehabilitation Act of 1973~~.~~;

(d) The availability of telemedicine within the MCE's contracted provider network.

(9) CCOs shall make the services it provides (including primary care, specialists, pharmacy, hospital, vision, ancillary, and behavioral health services or other services as necessary to achieve compliance with the requirements of 42 CFR 438, subpart K) as accessible to members for timeliness, amount, duration, and scope as those services are to other patients within the same service area. If the MCE is unable to provide those services locally by providers qualified and specialized to treat a member's condition, it must arrange for the member to access care from providers outside the service area.

(10) MCEs 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, or have behavioral health conditions, or who are children receiving Department or OYA services have access to primary care, oral care (when the MCE or DCO is responsible for oral care), behavioral health providers, and referral, and involve those members in accessing and managing appropriate preventive, health, remedial, and supportive care and services. Specifically, MCEs shall monitor and have policies and procedures to ensure:

(a) Access to providers of pharmacy, hospital, vision, ancillary, and behavioral health services;

(b) Priority access for pregnant women and children ages birth through 5 years to health services, developmental services, early intervention, targeted supportive services, oral and behavioral health treatment.

(11) 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 within the following timeframes:

(a) Physical health:

(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 and in accordance with OAR 410-141-3840;

(C) Well care: Within four weeks, or as otherwise required by applicable care coordination rules, including OAR 410-141-3860 through 410-141-3870.

(b) Oral and Dental care for children and non-pregnant individuals:

(A) ~~Emergency oral care~~: Dental Emergency services as defined in 410-120-0000: Seen or treated within 24 hours;

(B) Urgent dental ~~ora~~l care: Within one week or as indicated in the initial screening in accordance with OAR 410-123-1060;

(C) Routine oral care: Within eight weeks, unless there is a documented special clinical reason that makes a period of longer than eight weeks appropriate.

(c) Oral and Dental care for pregnant individuals

(A) Dental Emergency services. Seen or treated within 24 hours;

(B) Urgent dental care, within one week or as indicated in the initial screening in accordance with OAR 410-123-1060;

(C) Routine oral care: Within four weeks, unless there is a documented special clinical reason that would make access longer than four weeks appropriate;

(D) Initial dental screening or examination: within four weeks.

(d~~c~~) Behavioral health:

(A) Urgent behavioral health care for all populations: Within 24 hours;

(B) Specialty behavioral health care for priority populations:

(i) In accordance with the timeframes listed below for assessment and entry, terms are defined in OAR 309-019-1015, with access prioritized per OAR 309-019-0135. If a timeframe cannot be met due to lack of capacity, the member must be placed on a waitlist and provided interim services within 72 hours of

being put on a waitlist. Interim services must be comparable to the original services requested based on the level of care and may include referrals, methadone maintenance, HIV/AIDS testing, outpatient services for substance use disorder, risk reduction, residential services for substance use disorder, withdrawal management, and assessments or other services described in OAR 309-019-0135;

(ii) Pregnant women, veterans and their families, women with children, unpaid caregivers, families, and children ages birth through five years, individuals with HIV/AIDS or tuberculosis, individuals at the risk of first episode psychosis and the I/DD population: Immediate assessment and entry. If interim services are necessary due to capacity restrictions, treatment at appropriate level of care must commence within 120 days from placement on a waitlist;

(iii) IV drug users including heroin: Immediate assessment and entry. Admission for treatment in a residential level of care is required within 14 days of request, or, if interim series are necessary due to capacity restrictions, admission must commence within 120 days from placement on a waitlist;

(iv) Opioid use disorder: Assessment and entry within 72 hours;

(v) Medication assisted treatment: As quickly as possible, not to exceed 72 hours for assessment and entry;

(vi) Children with serious emotional disturbance as defined in 410-141-3500: Any limits that the Authority may specify in the contract or in sub regulatory guidance.

(C) Routine behavioral health care for non-priority populations: assessment within seven days of the request, with a second appointment occurring as clinically appropriate.

(12) MCEs shall implement procedures for communicating with and providing care to members who have difficulty communicating due to a medical condition, who need accommodation due to a disability, or who have limited English proficiency, living in a household where there is no adult available to communicate in English or there is no telephone:

(a) The policies and procedures shall ensure the provision of Oregon certified or Oregon qualified interpreter services by phone or in person if requested anywhere the member is attempting to access care or communicate with the MCE or its representatives;

(b) MCEs shall ensure the provision of certified or qualified interpreter services for all covered services including but not limited to, physical, behavioral health, or oral care (when the MCE or DCO is responsible for oral care) visits, and home health visits to interpret for members with hearing impairment or in the primary language of non-English-speaking members;

(c) All interpreters must be linguistically appropriate and capable of communicating in both English and the member's primary language and be able to translate clinical information effectively. Interpreter services must enable the provider to understand the member's complaint, make a diagnosis, respond to the member's questions and concerns, and communicate instructions to the member;

(d) MCEs shall ensure the provision of services that are culturally appropriate as described in National CLAS Standards, demonstrating both awareness for and sensitivity to cultural differences and similarities and the effect on the member's care. Whenever possible MCES shall ensure the provision of Oregon certified or Oregon qualified interpreters. If that is not possible then interpreters must adhere to

generally accepted interpreter ethics principles, including client confidentiality; demonstrate proficiency in speaking and understand both spoken English and at least one other language and must be able to interpret effectively, accurately, and impartially, both receptively and expressively, using any necessary specialized vocabulary, terminology and phraseology. For an individual with a disability, qualified interpreters can include, sign language interpreters, oral transliterators, and cued language transliterators as defined in 45 CFR 92.4;

(e) MCEs shall comply with requirements of the Americans with Disabilities Act of 1990 in providing access to covered services for all members and shall arrange for services to be provided by non-participating providers when necessary;

(f) MCEs shall collect and actively monitor data on language accessibility to ensure compliance with these language access requirements;

(g) MCEs shall report to the Authority such language access data and other language access related analyses in the form and manner set forth in this rule and as may otherwise be required in the MCE contract. The Authority shall provide supplemental instructions about the use of any required forms:

(A) Using the interpreter services self-assessment reporting template provided by the Authority, MCEs shall conduct an annual language access self-assessment and submit the completed language access self-assessment to the Authority on or before the third Monday of each January;

(B) MCEs shall collect and report ~~complete a quarterly~~ language access and interpreter services to OHA quarterly ~~data report~~ using the report form provided by the Authority. The quarterly due date for each Report is the first day of each calendar quarter, reporting data for the twelve (12) months ending one quarter before the due date. The first such twelve-month Report is due by April 1, 2022, for the twelve-month period from January 1, 2021, through December 31, 2021; ~~language access and interpreter services data report shall be submitted to the Authority on or before the third Monday of each January, April, July, and October. Reporting for Calendar Year 2020 shall commence in April 2020. January reporting requirements shall commence at the beginning of Calendar Year 2021;~~

(C) MCEs shall complete and submit to the Authority any other language access reporting that may be required in the MCE contract.

(13) MCEs shall collect and actively monitor data on provider-to-enrollee ratios, interpretation utilization by the MCE and the MCE's provider network, travel time and distance to providers, percentage of contracted providers accepting new members, wait times to appointment (including specific data for behavioral health wait times), and hours of operation. MCEs shall also collect and actively monitor data on call center performance and accessibility for both member services and NEMT brokerage services call centers.

(14) MCEs must submit a Delivery System Network (DSN) report annually to the Authority that includes access data and other access-related analyses in the form and manner required by the Authority, including but not limited to capacity reports on:

(a) Behavioral health access;

(b) Interpreter utilization by the MCE's provider network;

(c) Behavioral health provider network.

(15) MCEs shall report the methodology for monitoring network adequacy to the Authority and the Authority-contracted External Quality Review Organization (EQRO).

(16) ~~MCEs shall implement and require its providers to adhere to the following appointment and wait time standards:~~

~~(a) Wait times for scheduled appointments shall not exceed 60 minutes. After 30 minutes, members must be given an update on waiting time with an option of waiting or rescheduling the appointment. If the member requests to reschedule, they shall not be penalized for failing to keep the appointment;~~

~~(b)~~ MCEs shall implement written procedures and a monitoring system for timely follow-up with members when a participating provider has notified the MCE that the member failed to keep scheduled appointments. The procedures shall address:

(~~A~~a) Timely rescheduling of missed appointments, as deemed medically appropriate;

(b~~B~~) Documentation in the clinical record or non-clinical record of missed appointments;

(c~~C~~) Recall or notification efforts; and

(d~~D~~) Method of member follow up.

(c) If failure to keep a scheduled appointment is a symptom of the member's diagnosis or disability or is due to lack of transportation to the MCE's participating provider office or clinic, how MCEs will~~shall~~ provide outreach services as medically appropriate;

(d) Recognition of whether NEMT services were the cause of the member's missed appointment.

(17) CCOs must contract with the following specific provider types:

(a) Providers of residential chemical dependency treatment services;

(b) Any oral care organizations necessary to provide adequate access to oral services in the area where members reside.

(18) CCOs shall assess the needs of their membership and make available supported employment and assertive community treatment services when members are referred and eligible:

(a) CCOs shall report the number of individuals who receive supported employment and assertive community treatment services, at a frequency to be determined by OHA. When no appropriate provider is available, the MCE shall consult with the Authority and develop an approved plan to make supported employment and assertive community treatment services available;

(b) If 10 or more members in a CCO region have been referred, are eligible, and are appropriate for assertive community treatment, and have been on a waitlist to receive assertive community treatment for more than 30 days, CCOs shall take action to reduce the waitlist and serve those individuals by:

(A) Increasing team capacity to a size that is still consistent with fidelity standards; or

(B) Adding additional Assertive Community Treatment teams; or

(C) When no appropriate Assertive Community Treatment provider is available, the CCO shall consult with the Authority and develop an approved plan to increase capacity and add additional teams.

Statutory/Other Authority: ORS 413.042, 414.615, 414.625, 414.635 & 414.651
Statutes/Other Implemented: ORS 414.610 - 414.685

NEW RULE: 410-141-3531 Sanctions for Failure to Comply with State or Federal Information Security or Privacy Laws (Proposed Effective Date 1/1/22)

(1) Pursuant to 42 CFR §438.700, the Authority may impose sanctions on an MCE if the Authority makes a determination that an MCE failed to comply with any one or more of the following:

(a) The contractual requirements of accessing or using the Authority's or State Data, Network and Information Systems and Information Assets; or

(b) The Health Insurance Portability and Accountability Act (HIPAA) and the federal regulations implementing the HIPAA Privacy and Security Rules as set forth in 45 CFR Parts 160 and 164; or

(c) The Authority's privacy administrative rules in Chapter 407, Division 014; or

(d) The federal regulations implementing the HIPAA Transaction Rule as set forth in 45 CFR Part 162, and any other federal statutes or regulations relating to health information technology that may come into effect, including, without limitation, the 21st Century Cures Act and the Interoperability and Patient Access regulations; or

(e) The Authority's rules for electronic data transactions in OAR 943-120-0100 through 943-120-0200.

(2) The Authority may impose one or more sanctions under this rule including, but not limited to. the following:

(a) Require the MCE, at its own expense, to engage an independent third-party to conduct one or more security audits and implement any remedies identified or recommended in the audit report(s);

(b) Suspension or termination of one or more MCE employee's access to the Authority's or State's Data, Network Systems, or Information Assets, or termination of access to the Authority's and the State's Data, Network, and Information Assets;

(c) Require the MCE, at its own expense, to engage an independent third-party to conduct penetration testing of its network systems on a monthly or more frequent basis;

(d) Require the MCE, at its own expense, to engage an independent third-party to provide information privacy and security training to the MCE's employees;

(e) Require the MCE to develop and implement a time specific plan for the correction of the identified area(s) of non-compliance under section (1) of this rule; or

(f) Additional sanctions available under OAR 410-141-3530 or any other Oregon Administrative Rule or any Oregon Revised Statute that address areas of noncompliance for an MCE's contractual, statutory, or administrative rule obligations.

(3) The Authority shall have the right to impose one or more sanctions for the same violation depending on the nature of the noncompliance (e.g. number of members impacted, whether an authorized party was provided with or was able to obtain protected health information or other identifiable personal information, or was the result of gross negligence, willful or intentional

misconduct) , whether the violation has occurred before, or if the Authority determines that there has been continued egregious conduct.

(4) In the event the Authority determines an MCE should be subject to sanctions under this rule, the Authority shall comply with, as applicable, sections (5) – (8) of OAR 410-141-3530, relating to written notice, appeal, administrative review, mediation, and termination rights.

Statutory/Other Authority: ORS 413.042

Statutes/Other Implemented: ORS 414.065

410-141-3565 Managed Care Entity Billing (Proposed Change Effective 1/1/22)

(1) Providers shall submit all claims for MCE members in the following timeframes:

(a) Submit initial claims within no more than 120 days of the date of service for all cases, except as provided for in section (1)(b) of this rule. MCEs may negotiate terms within this timeframe agreeable to both parties;

(b) Submit initial claims within 365 days 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 MCE is responsible for the Medicare reimbursement;

(D) Other cases that delay the initial claim to the MCE, not including failure of the provider to verify 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.

(c) For initial claims submitted timely that need correction, have prompted a provider appeal as outlined in OAR ~~141~~410-120-1560, or for a reason not included in (1)(b) of this rule that otherwise require a re-submission, MCEs shall establish a time-frame in their policies and procedures which allow a billing provider to make such re-submissions or appeals for a minimum of 180 days after the initial adjudication date.

(2) Providers shall be enrolled with the Authority 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 before enrollment with the Authority or to be eligible for MCE payment for services. FFS 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 FFS provider or an MCE encounter-only provider prior to submission of encounter claims to ensure the encounter claim is accepted.

(4) Providers shall verify before providing services that the client is:

(a) Eligible for Authority programs and;

(b) Assigned to an MCE on the date of service.

(5) Providers shall use the Authority’s and MCE’s tools 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 prior authorizations from the appropriate payer before providing services. Before providing a non-covered service, the provider shall complete an OHP 3165 “OHP Client

Agreement to Pay for Health Services," or facsimile signed by the client as described in OAR 141-120-1280.

(6) If a member has other insurance coverage available for payment of covered services, the insurance must be exhausted prior to payment for the covered services. Member cost-sharing incurred as part of other coverage shall be paid to the insurer by the MCE.

(7) MCEs shall pay for all covered services. These services shall be billed directly to the MCE, unless the MCE or the Authority specifies otherwise. 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:

(a) A client may not be billed for missed appointments. A missed appointment is not considered to be a distinct Medicaid service by the federal government and as such is not billable to the client or the Division;

(b) A client may not be billed for services or treatments that have been denied due to provider error (e.g., required documentation not submitted, prior authorization not obtained, etc.).

(8) Payment by the MCE to participating providers for capitated or coordinated care services is a matter between the MCE and the participating provider:

(a) MCEs shall have written policies and procedures for processing claims submitted from any source. The policies and procedures shall specify timeframes for:

(A) Date stamping claims when received;

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

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

(D) Sending written notice of the decision with appeal rights to the member when the determination is a denial, in whole or in part, of payment for a service rendered as outlined in OAR 410-141-3875 and 410-141-3885.

(b) MCEs shall pay or deny at least 90 percent of valid claims within 30 days of receipt and at least 99 percent of valid claims within 90 days of receipt. MCEs shall make an initial determination on 99 percent of all claims submitted within 60 days of receipt;

(c) MCEs shall provide written notification of MCE determinations when the determinations result in a denial of payment for services as outlined in OAR 410-141-3885;

(d) MCEs may not require providers to delay claims submission to the MCE;

(e) MCEs 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;

(f) MCEs 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;

(g) MCEs may not delay or deny payments because a co-payment was not collected at the time of service;

(h) MCEs may not delay or deny payments for occupational therapy, physical therapy, speech therapy, nurse services, etc., when a child is receiving such services as school-based health services (SBHS) through either an Individual Educational Plan (IEP) or an Individualized Family Service Plan (IFSP). These services are supplemental to other health plan covered therapy services and are not considered duplicative services. Individuals with Disabilities Education Act (IDEA) mandated school sponsored SBHS will not apply toward the member's therapy allowances. SBHS Medicaid covered IDEA services are provided to eligible children in their education program settings by public education enrolled providers billing MMIS for these services to Medicaid through the Authority for reimbursement under Federal Financial Participation (FFP) as part of cost sharing on a fee-for-service basis;

(i) MCEs may not deny a claim for behavioral health services on the basis that such services were delivered in the member's home unless the MCE would deny a claim for comparable physical health services performed at the same site of service.

(9) MCEs shall pay for Medicare coinsurances and deductibles consistent with Oregon's State Plan methodology up to the Medicare or MCE's allowable for all Medicare Part A and Part B covered services the member receives from a Medicare enrolled provider after adjudication with Medicare or a Medicare Advantage plan:

(a) Providers must be enrolled in Oregon Medicaid to receive cost-sharing payments and non-enrolled providers should be given information on how to enroll to receive cost-sharing. Pursuant to OAR 410-120-1280(i), FFS Medicare providers should be encouraged to submit the Medicaid information necessary to enable electronic crossover to the MCE with their Medicare claims;

(b) MCE and affiliated Medicare Advantage plan shall provide a process for automatic Medicare to Medicaid crossover payments to ensure cost-sharing and reduce duplicate provider submission of claims;

(c) Federal law bars Medicare providers and suppliers from billing an individual enrolled in the Qualified Medicare Beneficiary (QMB) program for Medicare Part A and Part B cost-sharing under any circumstances (see Sections 1902(n)(3)(B), 1902(n)(3)(C), 1905(p)(3), 1866(a)(1)(A), and 1848(g)(3)(A) of the Social Security Act [the Act]). The QMB program is a State Medicaid benefit that assists low-income Medicare beneficiaries with Medicare Part A and Part B premiums and cost-sharing, including deductibles, coinsurance, and copays;

(d) MCE must inform providers of rules that prohibit balance billing and ensure providers serving and accepting plan payment for Qualified Medicare Beneficiaries mean members cannot be balance-billed per Sections 1902(n)(3)(C) and 1905(p)(3) of the Social Security Act.

(10) MCEs shall pay transportation, meals, and lodging costs for the member and any required attendant for services that the MCE has arranged and authorized when those services are not available within the state, unless otherwise approved by the Authority.

(11) MCEs shall pay for ancillary covered services provided by a non-participating provider under the following conditions:

(a) MCEs shall pay for ancillary covered services provided by a non-participating provider that are not prior authorized if all of the following conditions exist:

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

(B) The ancillary covered service was delivered in good faith without the prior authorization;

(C) The ancillary covered service would have been prior authorized with a participating provider if the MCE's referral procedures had been followed.

(b) The MCE shall pay non-participating providers (providers enrolled with the Authority that do not have a contract with the MCE) for ancillary covered services that are subject to reimbursement from the MCE in 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 OAR 410-141-3565 (12-14);

(c) Except as specified in OAR 410-141-3840 Emergency and Urgent Care Services, MCEs shall not be required to pay for covered treatment services provided by a non-participating provider, unless:

(A) The MCE does not have a participating provider that will meet the member's medical need; and

(B) The MCE has authorized care to a non-participating provider.

(d) Notwithstanding OAR 410-120-1280, non-participating providers may not attempt to bill the member for services rendered;

(e) MCEs 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. MCEs shall attest annually to the Authority in a manner to be prescribed to MCE's compliance with these requirements. MCE shall pay hospitals any applicable Qualified Directed Payments pursuant to OAR 410-125-0230.

(12) For Type A or Type B hospitals transitioning from Cost-Based Reimbursement (CBR) to an Alternative Payment Methodology (APM):

(a) Sections (12) and (14) only apply to services provided by Type A or Type B hospitals to members that are enrolled in an MCE;

(b) The Authority may upon evaluation by an actuary retained by the Authority, on a case-by-case basis, require MCEs 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 that transitioned from CBR to an APM, the Authority shall require hospitals and MCEs to enter into good faith negotiations for contracts. Dispute resolution during the contracting process shall be subject to OAR 410-141-3555 and 410-141-3560;

(d) For monitoring purposes, MCEs 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.

(13) Determination of which Type A or Type B hospitals shall stay on CBR or transition from CBR:

(a) No later than June 30 of the odd numbered years, the Authority shall update the algorithm for calculation of the CBR determination methodology with the most recent data available;

(b) After determination 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 of the following (even numbered) year;

(c) Type A and Type B hospitals located in a county that is designated as "Frontier" are not subject to determination via the algorithm and shall remain on CBR.

(14) Non-contracted Type A or Type B hospital rates for those transitioning or transitioned from CBR:

(a) Reimbursement rates under this section shall be based on discounted hospital charges for both inpatient and outpatient services;

(b) Reimbursement rates effective for the initial year of a hospital transitioning from CBR shall be based on that hospital's most recently filed Medicare cost report adjusted to reflect the hospital's Medicaid/OHP mix of services;

(c) Subsequent year reimbursement rates for hospitals transitioned from CBR shall be calculated by the Authority 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) On an annual basis, each Type A or Type B hospital that has transitioned from CBR shall complete a template provided by the Authority that calculates the hospital's change in prices for their MCE population;

(e) Inpatient and outpatient reimbursement rates shall be calculated separately;

(f) Non-contracted Type A or Type B hospital reimbursement rates can be found in the Rate Table on the Authority's website.

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

(a) Certain services shall be authorized by the MCE 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 and MCE assignment as provided for in this rule;

(b) Services authorized by the MCE 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 an MCE has received an MCE 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 an MCE except as provided in Authority administrative rules and supplemental information (e.g., coordinated care and capitated services that are not included in the nursing facility all-inclusive rate);

(g) MCE's 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 MCE would pay for the same service furnished by a provider who is not an FQHC nor RHC, consistent with the requirements of Section 4712(b)(2) of the Balanced Budget Act of 1997.

(16) MCEs shall maintain a Coordination of Benefits Agreement that allows participation in the automated claims crossover process with Medicare for those members dually eligible for Medicaid and Medicare services.

(17) MCEs shall ensure providers under the MCE contract are notified of billing processes for crossover claims processing, as described in OAR 410-120-1280.

(18) Coverage of services through the OHP benefit package of covered services is limited by OAR 410-141-3825 Excluded Services and Limitations for OHP Clients.

(19) MCEs shall engage in collaborative efforts with the Authority to achieve the requirements of the CCO Value-based Purchasing Roadmap.

Statutory/Other Authority: ORS 413.042, 414.065, 414.615, 414.625, 414.635 & 414.651
Statutes/Other Implemented: ORS 414.065 & 414.610 - 414.685

410-141-3566 Telemedicine/Telehealth Service and Reimbursement Requirements

(Proposed Changes Effective 1/1/22)

(1) ~~For the purpose of this rule, the Authority defines telehealth as the use of electronic information and telecommunications technologies~~ The following definitions apply to the Division's administrative rules governing Managed Care Entities (MCEs) as defined in 410-141-3500; ~~to support and promote long-distance clinical health care, patient and professional health-related education, public health and health administration.~~

~~(a) Information related to telehealth services may be transmitted via landlines, and wireless communications, including the Internet and telephone networks;~~

~~(b) Services can be synchronous (using audio and video, video only or audio only) or asynchronous (using audio and video, audio, or text-based media) and may include transmission of data from remote monitoring devices. Communications may be between providers, or be between one or more providers and one or more patients, family members /caregivers /guardians).~~

(a) "Asynchronous" means an interaction between a provider and a member that does not occur at the same time using an interactive telecommunication technology. This may include audio and video, audio, or patient portal and may include transmission of data from remote monitoring devices.

(b) "Audio only" means the use of devices for a telemedicine/telehealth encounter without inclusion of any video component. This may be due to lack of device capacity, Internet access, or member choice.

(c) "Meaningful access" means member-centered access reflecting the following statute / standards:

(A) Pursuant to Title VI of the Civil Rights Act of 1964 and Section 1557 of the Affordable Care Act and the corresponding Code of Federal Regulation (CFR) at 45 CFR Part 92 (Section 1557) and The Americans with Disabilities Act and Amendments Act of 2008 (ADA), providers' telemedicine/telehealth services shall accommodate the needs of individuals who have difficulty communicating due to a medical condition, who need accommodation due to a disability, advanced age or who have limited English proficiency (LEP) and including providing access to auxiliary aids and services as defined in Code of Federal Regulation (CFR) at 45 CFR Part 92 (Section1557);

(B) National Culturally and Linguistically Appropriate Services (CLAS) Standards at https://minorityhealth.hhs.gov/omh/browse.aspx?lvl=2&lvlid=53;

(C) Tribal based practice standards: https://www.oregon.gov/OHA/HSD/AMH/Pages/EBP.aspx.

(d) "Synchronous" means an interaction between a provider and a member that occurs at the same time using an interactive technology. This may include audio only, video only, or audio and video and may include transmission of data from remote monitoring devices.

(e) "Telecommunication technologies" means the use of devices and services for telemedicine/telehealth delivered services. These may include services with information transmitted via landlines and wireless communications, including the Internet and telephone networks.

(f) “Telehealth” may also be used interchangeable with telemedicine. Telehealth also includes the use of electronic information and telecommunications technologies to support and promote remote member and professional health-related education, public health, and health administration.

(g) “Telemedicine” means the mode of delivering health services using information and telecommunication technologies to provide consultation and education or to facilitate diagnosis, treatment, care management or self-management of a member’s health care.

(h) “Trauma informed approach” as defined in OAR 410-141-3500

(i) “Trauma informed services” as defined in OAR 410-141-3500

(2) Telehealth encompasses different types of programs, services and delivery mechanisms for medically appropriate services for covered physical, behavioral and oral health conditions within the patient’s defined benefit package.

(3) Communications may be between providers, or between one or more providers and one or more members, family members /caregivers /guardians.

(4) CCOs shall ensure that Providers do not prohibit, exclude or otherwise limit OHP members from using exclusively telemedicine/telehealth services, except where the Authority issues explicit guidance during a declared state of emergency or if a facility has implemented its facility disaster plan.

(5) CCOs shall ensure that member choice and accommodation for telemedicine/telehealth shall encompass the following standards and services:

(a) CCOs shall ensure that providers offer meaningful access to telemedicine/telehealth services by assessing members’ capacities to use specific approved methods of telemedicine/telehealth delivery that comply with accessibility standards including alternate formats, and provides the optimal quality of care for the member given considerations of member access to necessary devices, access to a private and safe location, adequate internet, digital literacy, cultural appropriateness of telemedicine/telehealth services, and other considerations of member readiness to use telemedicine/telehealth;

(b) CCOs shall ensure that providers offer meaningful access to health care services for LEP and Deaf and hard of hearing members and their families by working with qualified or certified health care interpreters to provide language access services as described in OAR 333-002-0040;. Such services shall not be significantly restricted, delayed, or inferior as compared to programs or activities provided to English proficient individuals.

(c) CCOs shall ensure that providers collaborate with members to identify modalities for delivering health care services which best meets the needs of the member.

(d) CCOs shall ensure that providers offer telemedicine/telehealth services provided are culturally and linguistically appropriate as described in the relevant standards:

(A) National Culturally and Linguistically Appropriate Services (CLAS) Standards;

(B) Tribal based practice standards;

(C) Trauma-informed approach to care as defined in 410-141-3500.

(6~~3~~) CCOs shall provide reimbursement for telehealth services and reimburse Certified and Qualified Health Care Interpreters (HCIs) as defined in OAR 333-002-0010 for interpretation services provided via telemedicine at the same reimbursement rate as if it were provided in person. This requirement does not supersede the CCOs direct agreement(s) with providers, including but not limited to, alternative payment methodologies, quality and performance measures or Value Based Payment methods described in the CCO contract. However, nothing either in this requirement or within CCO direct agreement(s) with providers referenced herein supersedes any federal or state requirements with regard to the provision and coverage of health care interpreter services.

~~(4) Providers are prohibited from excluding or otherwise limiting OHP members to using exclusively telehealth services, except where Authority has implemented section (9) of this rule.~~

~~(5) CCOs shall ensure patient choice and accommodation encompass the following standards and services:~~

~~(a) Consistent with Care Coordination requirements in OAR 410-141- 3865, CCOs shall work with their contracted providers to ensure meaningful access to services by assessing members' capacities to use specific approved methods of telehealth delivery that comply with accessibility standards including alternate formats, and provides the optimal quality of care for the patient given their capacity;~~

~~(b) Pursuant to Title VI of the Civil Rights Act of 1964 and Section 1557 of the Affordable Care Act and the corresponding Code of Federal Regulation (CFR) at 45 CFR Part 92 (Section 1557) and The Americans with Disabilities Act and Amendments Act of 2008 (ADA), CCOs shall provide access to auxiliary aids and services to ensure that telehealth services accommodate the needs of individuals who have difficulty communicating due to a medical condition, who need accommodation due to a disability, advanced age or who have limited English proficiency (LEP);~~

~~(c) CCOs shall ensure access to health care services for LEP and Deaf and hard of hearing patients and their families through the use of qualified and certified health care interpreters, embedded or third-party interpretive services to provide meaningful language access services as described in OAR 333-002-0040;~~

~~(d) CCOs shall ensure that telehealth services provided are culturally and linguistically appropriate as described in the relevant standards:~~

~~(A) National Culturally and Linguistically Appropriate Services (CLAS) Standards, https://minorityhealth.hhs.gov/omh/browse.aspx?lvl=2&lvlid=53;~~

~~(B) Tribal based practice standards, https://www.oregon.gov/OHA/HSD/AMH/Pages/EBP.aspx;~~

~~(C) Trauma-informed approach to care as defined in 410-141-3500.~~

(7~~6~~) Consistent with OAR 410-120-1990 privacy and security standards must be met by satisfying the following:

(a) Prior to the delivery of services via a telemedicine/telehealth modality, a patient oral, recorded, or written consent to receive services using a telehealth delivery method shall be obtained and documented annually. Consent must include an assessment of member readiness to access and participate in telemedicine/telehealth delivered services, including conveying all other options for

receiving the health care service to the member. Consent must be updated at least annually thereafter. For LEP and Deaf and hard of hearing patients and their families, providers must use qualified and certified health care interpreters, when obtaining patient consent.

(b) Consistent with ORS 109.640, provision of birth control information and services shall be provided to any person regardless of age without consent of parent or legal guardian.

(c) Consistent with ORS 109.640, provision of any other medical or dental diagnosis and treatment shall be provided to any person 15 years of age or older without consent of parent or legal guardian.

(d) Services provided using a telemedicine/telehealth platform shall comply with Health Insurance Portability and Accountability Act (HIPAA, https://aspe.hhs.gov/report/health-insurance-portability-and-accountability-act-1996) and with the Authority's Privacy and Confidentiality Rules (Chapter 943 Division 14) except as noted in section (10~~9~~) below.

(e) The ~~patient~~ member may be located in the community or in a health care setting.

(f) Providers may be located in any location where privacy can be ensured.

(g) Persons providing interpretive services and supports shall be in any location where ~~patient~~member privacy and confidentiality can be ensured.

(8~~7~~) CCOs shall ensure their network providers offer telehealth services that meet the following requirements:

(a) Provide services via telehealth that are within their respective certification or licensing board's scope of practice and comply with telemedicine/telehealth requirements including but not limited to:

(A) Documenting patient and provider agreement of consent to receive services;

(B) Allowed physical location of provider and patient;

(C) Establishing or maintaining an appropriate provider-patient relationship.

(b) Complying with HIPAA and the Authority's Privacy and Confidentiality Rules and security protections for the ~~patient~~ member in connection with the telemedicine/telehealth communication and related records requirements (OAR chapter 943 division 14 and 120, OAR 410-120-1360 and 1380, 42 CFR Part 2, if applicable, and ORS 646A.600 to 646A.628 (Oregon Consumer Identity Theft Protection Act)) except as noted in section (9) below;

(c) Obtaining and maintaining technology used in telemedicine/telehealth communication that is compliant with privacy and security standards in HIPAA and the Authority's Privacy and Confidentiality Rules described in subsection (~~A~~b) except as noted in section (9) below;

(d) Ensuring policies and procedures are in place to prevent a breach in privacy or exposure of member~~patient~~ health information or records (whether oral or recorded in any form or medium) to unauthorized persons;

(e) Maintaining clinical and financial documentation related to ~~telehealth~~telemedicine/telehealth services as required in OAR 410-120-1360;

(f) Complying with all federal and state statutes as required in OAR 410-120-1380.

(9~~8~~) CCO reimbursement to network providers offering ~~telehealth~~telemedicine/telehealth services shall meet the following requirements:

(a) Services provided shall be medically and clinically appropriate for covered conditions within the Health Evidence Review Commission's (HERC) prioritized list and in compliance with relevant guideline notes;

(b) Dependent on individual certification or licensing board's scope of practice standards, telehealth delivered services for covered conditions are covered when an established relationship exists between a provider and patient as defined by a patient who has received in person professional services from the physician or other qualified health care professional within the same practice within the past three years, and for establishing a patient-provider relationship;

(c) For all claim types except dental, CCOs shall ensure that encounter submissions for services covered using synchronous audio and video include modifiers GT or 95, and can be billed with either telephone codes (e.g. 99441) or regular in-person codes. For all telehealth services including dental, CCOs shall ensure that encounter submissions include Place of Service code 02;

(d) All physical, behavioral and oral ~~telehealth~~telemedicine/telehealth services except School Based Health Services (SBHS) shall include Place of Service code 02;

(e) When provision of the same service via synchronous audio and video is not available or feasible, e.g. the ~~patient~~ member declines to enable video, or necessary consents cannot reasonably be obtained with appropriate documentation in member~~patient~~'s medical record, then encounter submissions should not include any modifiers but should continue billing Place of Service as 02.

(10~~9~~) In the event of a declared emergency or changes in federal requirements, the Authority may adopt flexibilities to remove administrative barriers and support ~~telehealth~~telemedicine/telehealth delivered services:

(a) The Authority will follow guidance from the US Department of Health and Human Services (HHS) Office for Civil Rights (OCR) which may allow enforcement discretion related to privacy or security requirements;

(b) The Authority may expand network capacity through remote care and telehealth services provided across state lines;

~~(c) The Authority may expand access to telehealth services for new patients;~~

(c~~d~~) Should the Authority exercise options in this section (9), all CCO obligations for Network Adequacy requirements as described in OAR 410-141-3515 remain in full effect.

Statutory/Other Authority: ORS 413.042, 414.572, 414.591, 414.605 & 414.615
Statutes/Other Implemented: ORS 414.572

410-141-3570 Managed Care Entity Encounter Claims Data Reporting (Proposed Changes Effective 1/1/22)

(1) MCEs shall 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 Authority's 837 technical specifications for encounter data, and the Authority's encounter data submission guidelines that are subject to periodic revisions and available on the Authority's web site.

(2) MCEs shall collect service information in standardized formats to the extent feasible and appropriate; if HIPAA standard, the MCE must utilize the HIPAA standards:

(a) MCEs shall submit encounter claims for all covered services, except for health-related services, provided to members as defined in OAR 410-120-0000 and 410-141-3500;

(b) MCEs shall submit encounter claims data including encounters for:

(A) Services where the MCE determined that liability exists; even if the MCE did not make any payment for a claim;

(B) Services where the MCE determined that no liability exists;

(C) Services to members provided by a provider under a subcontract, capitation, or special arrangement with another facility or program;

(D) Paid amounts regardless of whether the servicing provider is paid on a fee for service basis, on a capitated basis by the MCE, or the MCE's subcontractor; and

(E) Services to members who also have Medicare coverage, if a claim has been submitted to the MCE.

(c) MCEs shall obtain a Coordination of Benefits Agreement (COBA) number and coordinate with COBA to receive direct crossover claims for dually eligible members with traditional Medicare pursuant to 42 CFR 438.3(t);

(d) MCEs shall report encounter claims data whether the provider is an in-network participating or out-of-network, non-participating provider.

(3) MCEs shall follow the DCBS standards for electronic data exchange as described in the Oregon Companion Guides available on the DCBS website.

(4) MCEs shall submit all valid unduplicated encounter claims: professional, dental, institutional, and pharmacy within 45 days of the date of adjudication:

(a) MCEs shall 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 or by contacting the National Council for Prescription Drug Programs organization;

(b) Submission Standards and Data Availability:

(A) MCEs shall only use the two types of provider identifiers, as allowed by HIPAA NPI standards 45 CFR 160.103 and as provided to the MCE 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) MCEs shall make an adjustment to any encounter claim within 30 days of discovering 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 MCE must adjust or void the encounter claim within 30 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 MCE must correct the errors within a timeframe specified by the Authority;

(E) If circumstances prevent the MCE from meeting requested timeframes for correction, the MCE may contact the Authority to determine an agreed upon specified date except as required in subsection 4(c)(D) below;

(F) MCEs retain liability for certifying encounter data as complete, truthful, and accurate. MCEs 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.

(G) MCEs shall make all collected and reported data available upon request to the Authority and CMS as described in 42 CFR 438.242.

(c) Encounter Claims Data Corrections for "must correct" Encounter Claims:

(A) The Authority shall notify the MCE 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 MCE each week and for each subsequent week the encounter claim remains in a "must correct" status;

(C) The Authority may not necessarily notify the MCE of other errors; however, this information is available in the MCE's electronic remittance advice supplied by the Authority;

(D) MCEs shall submit corrections to all encounter claims within 63 days from the date the Authority sends the MCE notice that the encounter claim remains in a "must correct" status;

(E) MCEs 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) 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 MCE 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) Respond within the timeframe determined by the Authority to any request for:

(A) Any suspected missing MCE encounter claims, or;

(B) MCE-submitted encounter claims found to be unmatched to an EHR user's meaningful use report.

(6) MCEs shall 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) MCEs 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~~ claims adjudication; or immediately upon notification by the Authority that a qualifying encounter claim has been identified;

(b) The Authority in collaboration and cooperation with the MCE 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 MCE that no further action is needed;

(B) Requesting a corrected informed consent form, or;

(C) Informing the MCE, 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 timeframe set by the Authority.

(7) Upon request by the Authority, MCEs shall furnish information regarding rebates for any covered outpatient drug provided by the MCE 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 MCE, unless the drug is subject to discounts under Section 340B of the Public Health Service Act;

(b) MCEs shall report prescription drug data as specified in section (3)(b).

(8) 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 MCE for review and resolution within 15 days of receipt:

(a) The MCE shall assist in the dispute process as follows:

(A) By notifying the Authority that the MCE agrees an error has been made; and

(B) By correcting and re-submitting the pharmacy encounter data to the Authority within 45 days of receipt of the Invoiced Rebate Dispute.

(b) If the MCE disagrees with the Invoiced Rebate Dispute that an error has been made, the MCE shall send the details of the disagreement to the Authority's encounter data liaison within 45 days of receipt of the Invoiced Rebate Dispute.

Statutory/Other Authority: ORS 413.042, 414.615, 414.625, 414.635 & 414.651
Statutes/Other Implemented: ORS 414.610 - 414.685

410-141-3585 MCE Member Relations: Education and Information

(Proposed Changes Effective 1/1/22)

(1) MCEs may engage in activities for existing members related to outreach, health promotion, and health education. MCE must obtain approval of the Authority prior to distribution of any written communication by the MCE 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.

(2) MCEs may communicate with providers, caseworkers, community agencies, and other interested parties for informational purposes or to enable care coordination and address social determinants of health or community health. The intent of these communications should be informational only for building community linkages to impact social determinants of health or member care coordination 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. MCEs shall address health literacy issues by preparing these documents at a low-literacy reading level, incorporating graphics and utilizing alternate formats.

(3) MCEs shall have a mechanism to help members understand the requirements and benefits of the MCE's integrated and coordinated care plan. The mechanisms developed shall be culturally and linguistically appropriate. Written materials, including provider directories, member handbooks, appeal and grievance notices, and all denial and termination notices are made available in the prevalent non-English languages as defined in OAR 410-141-3575 in its particular service area and be available in formats noted in section (5) of this rule for members with disabilities. MCEs shall accommodate requests made by other sources such as members, family members, or caregivers for language accommodation, translating to the member's language needs as requested.

(4) MCEs shall have written procedures, criteria, and an ongoing process of member education and information sharing that includes member orientation, member handbook, and health education. MCEs 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 how to access intensive care coordination (ICC) Services, and where applicable for full benefit dual eligible (FBDE) members, the process for coordinating Medicaid and Medicare benefits;

(b) Clearly explain how members may receive assistance from certified and qualified health care interpreters and Traditional Health Workers as defined in OAR 410-180-0305 and include information to members that interpreter services in any language required by the member, including American Sign Language, auxiliary aids and alternative format materials at provider offices are free to MCE members as stated in 42 CFR 438.10;

(c) Inform all members of the availability of Ombudsperson services.

(5) Written member materials shall comply with the following language and access requirements:

(a) Materials shall be translated in the prevalent non-English languages as defined in OAR 410-141-3575 in the service area as well as include a tagline in large print (font size 18) explaining the availability of written translation or oral interpretation to understand the information provided, as well as alternate formats, and the toll-free and TTY/TDY telephone number of the MCE's member/customer service unit;

(b) Materials shall be made available in alternative formats upon request of the member at no cost. Auxiliary aids and services must also be made available upon request of the member at no cost. The MCE's process for providing alternative formats and auxiliary aids to members may not in effect deny or limit access to covered services, grievance, appeals, or hearings;

(c) Electronic versions of member materials shall be made available on MCE website, including provider directories, formularies, and handbooks in a form that can be electronically retained and printed, available in a machine-readable file and format, and Readily Accessible, e.g., a PDF document posted on the plan website that meets language requirements of this section. For any required member education materials on the MCE website, the member is informed that the information is available in paper form without charge upon request to Members and Member representatives, and the MCE shall provide it upon request within five business days.

(6) MCE provider directories shall be a single, comprehensive resource that encompasses MCE's entire Provider Network, including any Providers contracted by Subcontractors that serve the MCE's Members. MCEs may not utilize a Subcontractor's separate or standalone provider directory to meet the Provider Directory requirement and shall include:

(a) The provider's name as well as any group affiliation;

(b) Street address(es);

(c) Telephone number(s);

(d) Website URL, as appropriate;

(e) Provider Specialty, as appropriate;

(f) Whether the provider will accept new members;

(g) Whether the provider offers both telehealth and in-person appointments;

(h) Information about the provider's race and ethnicity, cultural and linguistic capabilities, including languages (including American Sign Language) offered by the provider or an OHA-approved qualified and, as applicable, certified health care interpreter(s) at no cost to members at the provider's office;

(i) Availability of auxiliary aids and services for all members with disabilities upon request and at no cost;

(j) Whether the provider has completed cultural competence training as required by ORS 413.450 and in accordance to CCO Health Equity Plan Training and Education plan described in OAR 410-141-3735 whether providers have verifiable language fluency in non-English (i.e., such as clinical training in a foreign country or clinical language testing);

(k) Whether the provider's office or facility is accessible and has accommodations for people with physical disabilities, including but not limited to information on accessibility of providers' offices, exam rooms, restrooms, and equipment.

(L) The information for each of the following provider types covered under the contract, as applicable to the MCE contract:

(A) Physicians, including specialists;

(B) Hospitals;

(C) Pharmacies;

(D) Behavioral health providers; including specifying substance use treatment providers;

(E) Dental providers.

(m) Information included in the provider directory must be updated at least monthly, and electronic provider directories must be updated no later than 30 days after the MCE receives updated provider information. Updated materials shall be available on the MCE website in a readily accessible and machine-readable file, e.g., a PDF document posted on the plan website, per form upon request and another alternative format.

(7) Each MCE shall make available in electronic or paper form the following information about its formulary:

(a) Which medications are covered both generic and name brand;

(b) What tier each medication is on.

(8) Within 14 days of an MCE's receiving notice of a member's enrollment, MCEs shall mail a welcome packet to new members and to members returning to the MCE 12 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, including a list of any in-network retail and mail-order pharmacies.

(9) For existing MCE members, an MCE shall notify members annually of the availability of a member handbook and provider directory and how to access those materials. MCEs shall send hard copies upon request within five days.

(10) MCEs must notify enrollees:

(a) That oral interpretation is available free of charge for any language, including American Sign Language, and written information is available in prevalent non-English languages as defined in OAR 410-141-3575 and alternate formats that include but are not limited to audio recording, close-captioned videos, large type (18 font), and braille; and

(b) The process for requesting and accessing interpreters or auxiliary aids and alternative formats, including where appropriate how to contact specific providers responsible through sub-contracts to ensure provision of language and disability access;

(c) Language access services also applies to member representatives, family members and caregivers with hearing impairments or limited English proficiency who need to understand the member's condition and care.

(11) An MCE shall electronically provide to the Authority 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.

(12) The CCO member handbook shall be written in plain language using a font size no smaller than 12 point. At a minimum, the member handbook shall contain the following:

(a) Revision date including month, day, and year;

(b) Tag lines in English and other prevalent non-English languages, as defined in OAR 410-141-3575, spoken by populations of members. The tag lines shall be in large type (18 point font). The tag lines shall be located at the beginning of the document for the ease of the member and describe the following:

(A) How members may, at no cost to them, access sign language and oral interpreters, translations and materials in alternate formats, and auxiliary aids and services;

(B) The toll-free and TTY/TDY telephone numbers of the MCE's customer service unit.

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

(d) Explanation of access and care standards consistent with the requirements set forth in 42 CFR §438.206 and OARs 410-141-3515 and 410-141-3860;

(e) 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, and;

(f) Explanation of the health risk screening process;

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

(h) Explanation that American Indian and Alaskan Native members of the CCO may receive care from a tribal wellness center, Indian Health Services clinic, or the Native American Rehabilitation Association of the Northwest (NARA);

(i) Explanation of which participating or non-participating provider services the member may self-refer;

(j) Policies on referrals for specialty care, including prior authorization requirements and how to request a referral;

(k) Information on how to obtain a second opinion;

(L) Explanation of ICC services, including persons eligible as priority populations served and requirements for Intensive Care Coordination care planning, and how eligible members may access those services;

(m) Information about the coordinated care approach, how to navigate the coordinated care health care system as applicable to dual-eligible individuals, the process for coordinating Medicaid and Medicare benefits;

(n) Explanation of care coordination services and how the member can request and access a care coordinator.

(o) Information about the benefits and availability of traditional health worker (THW) services as defined in OAR 410-180-0305, and how to contact the CCO's THW liaison.

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

(q) How and when members are to use emergency services, both locally and when away from home, including examples of emergencies and use of 911;

(r) Information on how to contact the CCO's in-house or subcontracted after-hours call-in system to triage Urgent Care and Emergency service calls from members or a member's long term care provider or facility.

(s) Information on contracted hospitals in the member's service area including hospital name, physical address, toll-free phone number, TTY, and webpage;

(t) Information on mobile crisis services and crisis hotline for members, including information that crisis response services are available 24 hours a day for members receiving Intensive In-Home Behavioral Health Treatment.

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

(v) Explanation of available telehealth services as described in OAR 410-141-3566 including, but not limited to, the information contained in sections (4) and (5) of 410-141-3566, how to access telehealth services, and information on supports available to the member to assist them in accessing telehealth services.

(w) A statement or narrative that articulates the CCO's commitment to preventing fraud, waste, and abuse and complying with all applicable laws including, but not limited to, the State's False Claims Act and the federal False Claims Act;

(x) Information on where and how to report fraud, waste, or abuse by a provider or a member and a member's right to report fraud, waste, and abuse anonymously and be protected under applicable Whistleblower laws;

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

(A) Information about assistance in filling out forms and completing the grievance process available from the CCO to the member as outlined in OAR 410-141-3875;

(B) Information about the member's rights in the grievance, appeals, and hearings process, including the right to continued benefits as provided in OAR 410-141-3885;

(C) The requirements and timeframes related to the processes for grievances, appeals, and hearings.

(z) Information on the member's rights and responsibilities, including the rights of minors, and availability of the OHP Ombudsperson;

(z) Information on charges for non-covered services, and the member's possible responsibility for charges if they go outside of the CCO network for non-emergent care; including information specific to deductibles, copays and coinsurance for dually-enrolled qualified Medicare beneficiaries;

(aa) 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;

(bb) Information on coverage and billing for out of state services, including information how to access additional assistance from the CCO with a bill from an out of state provider and any appeal rights available to the member, if applicable;

(cc) Explanation of 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 how to access such services and specific communications for members who are becoming new Medicare enrollees;

(dd) 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;

(C) Avenues for filing complaints concerning noncompliance with the Advance Directive requirements, including the grievance and hearings process or directly with OHA, and information on how to file such a complaint with OHA;

(ee) Whether or not the CCO uses provider contracts, including alternative payment methodologies or incentives, and how this will impact the member;

(ff) 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;

(gg) How and when members are to obtain ambulance services;

(hh) Resources for help with transportation to appointments with providers and scheduling process for use of non-emergency medical transportation (NEMT) services;

(ii) All NEMT policies and procedures as outlined in OAR 410-141-3920 through 410-141-3965 and the CCO Contract, unless the member is provided with a stand-alone document, referred to as a "NEMT Rider Guide";

(jj) Explanation of the covered and non-covered services in sufficient detail to ensure that members understand the benefits to which they are entitled, including but not limited to;

(A) A delineation of the non-covered services the CCO coordinates from the non-covered services the CCO does not coordinate;

(B) Contact information for the Authority contractor responsible for coordination of non-covered services the CCO is not obligated to coordinate;

(C) Explanation that the CCO is responsible to arrange transportation for non-covered services that are coordinated by the CCO.

(kk) Information regarding any service not covered, in accordance with law, due to the religious or moral objections of the CCO and how to contact Oregon Health Authority for information regarding accessing the service;

(LL) How to access in-network retail and mail-order pharmacies;

(mm) How members are to obtain prescriptions including information on the process for obtaining non-formulary and over-the-counter drugs;

(nn) The CCO's confidentiality policy;

(oo) Explanation of the CCO's nondiscrimination policy and how and where to file a grievance if a member feels they were treated unfairly;

(pp) How and where members may access any benefits that are available under OHP but are not covered under the CCO's contract, including any cost sharing;

(qq) When and how members may voluntarily and involuntarily disenroll from CCOs and change CCOs;

(rr) Explanation of care and services available to members during a transition of care as defined in OAR 410-141-3850 and 42 CFR § 438.62, including CCO contact information to request more information regarding continued access to care and services during a transition of care and instructions on accessing the CCO's written transition of care policy;

(ss) 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;

(tt) The "Oregon Health Plan Client Handbook" is in addition to the CCO's member handbook, and an CCO may not use it to substitute for any component of the CCO's member handbook.

(13) The DCO member handbook shall be written in plain language using a font size no smaller than 12 point. The DCO member handbook is required for DCOs directly contracted by OHA. At a minimum, the member handbook shall contain the following:

(a) The revision date, including month, day, and year;

(b) Tag lines in English and other prevalent non-English languages, as defined in as defined in OAR 410-141-3575, spoken by populations of members. The tag lines shall be in large type (18-point font). The tag lines shall be located at the beginning of the document for the ease of the member and describe the following:

(A) How members may access free sign and oral interpreters, translations and materials in alternate formats, and auxiliary aids and services;

(B) The toll-free and TTY/TDY telephone numbers of the DCO's customer service unit.

(c) DCO's office location, mailing address, web address, office hours, and telephone numbers including TTY;

(d) The toll-free number for any partners providing services directly to members, including non-emergency medical transportation providers;

(e) The DCO's confidentiality policy;

(f) Information about the structure and operations of the DCO, including whether or not the DCO uses provider contracts, including alternative payment methodologies or incentives, and how this will impact the member;

(g) Explanation of oral health benefits and covered services available to members without charge in sufficient detail to ensure that members understand the benefits to which they are entitled;

(h) Explanation of care and services available to members during a transition of care as defined in OAR 410-141-3850 and 42 CFR § 438.62, including DCO contact information to request more information regarding continued access to care and services during a transition of care and instructions on accessing the DCO's written transition of care policy;

(i) Explanation of 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 Primary Care Dentist (PCD), other prescribing provider, or obtain new orders during that period;

(j) Explanation of how to choose a PCD, how to make an appointment, how to change PCDs, and the DCO's policy on changing PCDs;

(k) Explanation that American Indian/Native Alaskan members may choose an Indian Health Care Provider (IHCP) as the member's PCD if:

(A) The IHCP is participating as a PCD within the provider network; and

(B) The member is otherwise eligible to receive services from such Indian Health Care Provider; and

(C) The IHCP has the capacity to provide the services to such members.

(L) Explanation that American Indian members may obtain covered services from non-participating providers and can be referred by an IHCP to a participating provider for covered services in accordance with 42 CFR §438.14;

(m) Explanation of access and care standards consistent with the requirements set forth in 42 CFR §438.206 and OARs 410-141-3515 and 410-141-3860;

(n) Explanation of available telehealth services as described in OAR 410-141-3566 including, but not limited to, the information contained in sections (4) and (5) of 410-141-3566, how to access telehealth services, and information on supports available to the member to assist them in accessing telehealth services.

(o) Explanation of the health risk screening process;

(p) Information about tobacco dependency and cessation services and how to access such services through the DCO;

(q) Explanation of non-emergency medical transportation (NEMT) services, including how the DCO coordinates NEMT services for members and how a member accesses NEMT services.

(r) Explanation of care coordination services and how the member can request and access a care coordinator, including information that the DCO must coordinate dental services furnished to the member with the services the member receives from other plans and/or from community and social support providers.

(s) Policies on referrals, prior authorization and pre-approval requirements and how to request a referral, including but not limited to the following:

(A) No prior authorization or referral is necessary for urgent or emergency dental services including dental post-stabilization services;

(B) Information on how to access specialty dental care furnished by the DCO;

(C) Information on how to access specialty care and other benefits that are not furnished by the DCO;

(t) Information on how to obtain a second opinion;

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

(v) Information regarding any service not covered, in accordance with law, due to the religious or moral objections of the DCO and how to contact Oregon Health Authority for information regarding accessing the service;

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

(x) How and when members are to use emergency services, both locally and when away from home, including examples of dental emergencies and use of 911;

(y) Information on how to contact the DCO's after-hours call-in system to triage Urgent Care and Emergency service calls from members or a member's long-term care provider or facility;

(z) Explanation that members can access dental services while out of state in an urgent or emergency situation, including information on how to access additional assistance from the DCO with a bill from an out of state provider and any appeal rights available to the member, if applicable;

(aa) Information on when and how members may voluntarily and involuntarily disenroll from DCOs or change DCOs;

(bb) A statement or narrative that articulates the DCO's commitment to preventing fraud, waste, and abuse and complying with all applicable laws including, but not limited to, the State's False Claims Act and the federal False Claims Act;

(cc) Information on where and how to report fraud, waste, or abuse by a provider or a member and a member's right to report fraud, waste, and abuse anonymously and be protected under applicable Whistleblower laws;

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

(A) Information about assistance in filling out forms and completing the grievance process available from the DCO to the member as outlined in OAR 410-141-3875;

(B) Information about the member's rights in the grievance, appeals, and hearings process, including the right to continued benefits as provided in OAR 410-141-3885.

(C) The requirements and timeframes related to the processes for grievances, appeals, and hearings.

(ee) Information on the member's rights and responsibilities, including the rights of minors, and availability of the OHP Ombudsperson;

(ff) 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;

(gg) Explanation of the DCO's nondiscrimination policy and how and where to file a grievance if a member feels they were treated unfairly, including contact information for the DCO's Non-discrimination coordinator;

(hh) Information about the requirement to provide providers and subcontractors with third-party liability information;

(ii) Explanation that the DCO will provide written notice to affected members of any significant changes in provider, program, or service sites that affect the member's ability to access care or services from the DCO's participating providers. Such notice shall be translated as appropriate and provided to the member at least 30 days before the effective date of the change, or as soon as possible if the participating provider has not given the DCO sufficient notification to meet the 30-day notice requirement;

(jj) 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 DCO's policies for implementation of those rights, including a statement of any limitation regarding the implementation of advanced directives as a matter of conscience;

(C) Avenues for filing complaints concerning noncompliance with the Advance Directive requirements, including the grievance and hearings process or directly with OHA, and information on how to file such a complaint with OHA;

(kk) DCOs 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 DCO's internal changes. If changes affect the member's ability to use services or benefits, the DCO shall offer the updated member handbook to all members;

(LL) The "Oregon Health Plan Client Handbook" is in addition to the DCO's member handbook, and an DCO may not use it to substitute for any component of the DCO'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. MCE providers or other individuals or programs approved by the MCE may provide health education. MCEs shall make every effort 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) Information specifying that MCEs may not prohibit or otherwise restrict a provider acting within the lawful scope of practice from advising or advocating on behalf of a member who is their patient for the following:

(A) The member's health status, medical care, or treatment options, including any alternative treatment that may be self-administered;

(B) Any information the member needs to decide among all relevant treatment options;

(C) The risks, benefits, and consequences of treatment or non-treatment.

(c) MCEs shall ensure development and maintenance of an individualized health educational plan for members whom their provider has identified as requiring specific educational intervention. The Authority may assist in developing materials that address specifically identified health education problems to the population in need;

(d) An explanation of ICC services and how eligible members may access those services. MCEs should ensure that ICC-related education reaches potentially eligible members, including those with special health care needs including those who are aged, blind, or disabled, or who have complex medical needs or high health care needs, multiple chronic conditions, mental illness, chemical dependency, or who receive additional Medicaid-funded LTSS;

(e) 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;

(f) MCEs shall provide written notice to affected members of any Material Changes to Delivery System as defined in 410-141-3500 or any other significant changes in provider(s), program, or service sites that affect the member's ability to access care or services from MCE's participating providers. The MCE shall provide, translated as appropriate, the notice at least 30 days before the effective date of that change, or as soon as possible if the participating provider has not given the MCE sufficient notification to meet the 30-day notice requirement. The Authority shall review and approve the materials within two working days.

(15) MCEs shall provide an identification card to members, unless waived by the Authority, 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 MCE, members, and providers.

Statutory/Other Authority: ORS 413.042 & ORS 414.065
Statutes/Other Implemented: ORS 414.065 & 414.727

410-141-3591 MCE Interoperability Requirements (Proposed Changes Effective 1/1/22)

(1) Interoperability and Access to Health Information

(a) MCEs shall comply with all federal regulations set forth in the CMS Interoperability and Patient Access Final Rule.

(b) All MCEs shall review the Office of National Coordinator for Health Information Technology (ONC) 21st Century Cures Act Final Rule relating to determine the applicably of the rule to their organizations' s obligation to comply with the final rule. This includes the organization's status as an Actor and the applicability of information blocking.

(2) For the purpose of this rule, the following definitions shall apply:

(a) "Application Programming Interface" (API) – means a technological interface defining the kinds of programming calls or requests that may be performed against an underlying data source;

(b) "Publicly Accessible'' means that any person using commonly available technology to browse the internet could access the information without any preconditions or additional steps, such as a fee for access to the documentation; a requirement to receive a copy of the material via email; a requirement to register or create an account to receive the documentation; or a requirement to read promotional material or agree to receive future communications from the organization making the documentation available;

(c) "Third-Party Application" means a computer program that is developed and distributed by an organization or individual other than that which owns, administers, or manufactures the data being accessed;

(d) "Data Sharing agreement" means a formal contract detailing what data are being shared and the appropriate use of those data;

(e) "Information blocking" means a practice by a health care provider, health IT developer, health information exchange, or health information network that, except as required by law or specified by the Secretary of Health & Human Services (HHS) as a reasonable and necessary activity, is likely to interfere with access, exchange, or use of electronic health information.

(3) MCEs must implement and maintain standards-based APIs that permits Third-Party Applications to retrieve data, with the approval and at the direction of the current individual member or the member's personal representative through the use of common technologies, without special effort from the member or Data Sharing Agreement with the Third-Party Application. APIs must meet the following requirements:

(a) Interoperability requirements at 45 CFR 170.215 and technical requirements found at § 422.119(c) including identity proofing and authentication processes that must be met by third-party application developers in order to connect to the API and access the specific member's data through the API;

(b) MCEs must comply with content and vocabulary standard requirements as applicable to the data type or data element found at 45 CFR 170.213 and 45 CFR part 162 and 42 CFR Part 406 § 423.160 unless alternate standards are required by other applicable law;

(c) For each API implemented, MCEs shall make publicly accessible, by posting directly on its website or via publicly accessible hyperlink(s), complete accompanying documentation that contains, at a minimum the following information:

(i) API syntax, function names, required and optional parameters supported and their data types, return variables and their types/structures, exceptions and exception handling methods and their returns;

(ii) The software components and configurations that an application must use in order to successfully interact with the API and process its response(s); and

(iii) All applicable technical requirements and attributes necessary for an application to be registered with any authorization server(s) deployed in conjunction with the API.

(4) MCEs must conduct routine monitoring and testing and update as appropriate to ensure the API functions properly, including assessments to verify that the API is fully and successfully implementing privacy and security features to ensure compliance with all state and federal laws to protect the privacy and security of individually identifiable data.

(5) MCEs shall deny or discontinue any third-party application's connection to the API if it:

(a) Reasonably determines, consistent with its security risk analysis under 45 CFR part 164 subpart C, that allowing an application to connect or remain connected to the API would present an unacceptable level of risk to the security of protected health information on the MCE's systems; and

(b) Makes this determination using objective, verifiable criteria that are applied fairly and consistently across all applications and developers through which members seek to access their electronic health information as defined at 45 CFR 171.102, including but not limited to criteria that may rely on automated monitoring and risk mitigation tools.

(6) MCEs must provide in an easily accessible location on their public website and through other appropriate mechanisms through which it ordinarily communicates with current and former members seeking to access their health information held by the MCE, educational resources in non-technical, simple and easy-to-understand language explaining at a minimum:

(a) General information on steps the member may consider taking to help protect the privacy and security of their health information, including factors to consider in selecting an application including secondary uses of data, and the importance of understanding the security and privacy practices of any application to which they will entrust their health information; and

(b) An overview of which types of organizations or individuals are and are not likely to be HIPAA covered entities, the oversight responsibilities of the US Department of Health and Human Services, Office of Civil Rights (OCR) and the Federal Trade Commission (FTC), and how to submit a complaint to both agencies.

(7) MCEs must implement and maintain a standards-based API that permits third-party applications to retrieve, with the approval and at the direction of a member or the member's personal representative, data specified in this section through the use of common technologies and without special effort from the member:

(a) Data concerning adjudicated claims, including claims data for payment decisions that may be appealed, were appealed, or are in the process of appeal, and provider remittances no later than one (1) business day after a claim is adjudicated;

(b) Data concerning adjudicated claims for prescription drug utilization including those carved out from MCE contracts, including remittances, no later than one (1) business day after a claim is adjudicated or carve-out utilization is reported to the MCE;

(c) All encounter data, including encounter data from any network providers the MCE is compensating on the basis of capitation payments, adjudicated claims and encounter data from any subcontractors must be available no later than one (1) business day after data concerning the encounter is received by the MCE;

(d) Clinical data, including laboratory results, if the MCE maintains any such data, no later than one (1) business day after the data is received by the MCE; and

(e) Formulary data that includes covered outpatient drugs, and any tiered formulary structure or utilization management procedure which pertains to those drugs.

(8) MCEs shall make provider directory information available publicly through a standards-based API. Information shall include provider names, addresses, phone numbers, and specialty. APIs shall be implemented consistent with §422.119. Information shall be updated no later than 30 calendar days after the MCE receives provider directory information or updates to provider directory information.

(9) MCEs must provide a process for the electronic exchange of, at a minimum, the data classes and elements included in the content standard adopted at 45 CFR 170.213 and identified in the United States Core Data for Interoperability (USCDI)

(a) Such information received by the MCE must be incorporated into the MCE's records about the current member.

(b) Upon approval and at the direction of a current or former member or their personal representative, the MCE must:

(A) Receive all such data for a current member from any other payer obligated to provide it under federal regulations, that has provided coverage to the enrollee within the preceding 5 years;

(B) At any time the member is currently enrolled in the MCE and up to 5 years after disenrollment, send all such data to any other payer that currently covers the enrollee or a payer the enrollee or the enrollee's personal representative specifically requests receive the data; and

(C) Send data received from another payer obligated to provide it under federal regulations, in the electronic form and format it was received.

(c) MCEs must comply with the requirements of this section with regard to data they maintain with a date of service on or after January 1, 2016.

Statutory/Other Authority: ORS 413.042 & ORS 414.065
Statutes/Other Implemented: ORS 414.065 & 414.727

410-141-3710 Contract Termination and Close-Out Requirements (Proposed Changes Effective 1/1/22)

(1) This rule applies to any termination of an MCE contract, including but not limited to non-renewal under OAR 410-141-3725, expiration of the contract at the end of its term, or termination during the term of the contract initiated by either party. Consistent with OAR 410-141-3725, MCEs shall abide by all requirements in this rule regardless of whether termination notice is provided by the Authority or the MCE.

(2) The party initiating the termination shall render written notice of termination to the other party by certified mail, return receipt requested, or in person with proof of delivery and a contemporaneous copy emailed to the other party's contract administrator.

(3) The notice of termination shall specify the circumstances giving rise to termination and the date on which such termination shall become effective.

(4) After receipt of an MCE's notification of intent not to renew or notice of termination, the Authority shall issue written notice to the MCE specifying:

(a) The effective date of termination;

(b) The MCE's operational and reporting requirements; and

(c) Timelines for submission of deliverables.

(5) Upon notification of termination or non-renewal, an MCE shall submit to the Authority a transition plan detailing how it fulfills its continuing obligations for the duration of the contract. The transition plan shall include:

(a) How each of the MCE's members and contracted providers are notified of the termination of the contract;

(b) A plan to transition its members to other MCEs; and

(c) A plan for closing out its MCE business, including but not limited to the operational and reporting requirements and timelines for submission of deliverables, as specified by the Authority, and the requirements specified in this rule.

(6) Transition plans are subject to approval by the Authority:

(a) The MCE must revise the transition plan as necessary to obtain approval by the Authority;

(b) Failure to submit a transition plan and obtain written approval of the termination plan by the Authority may result in the Authority's withholding of 20 percent of the MCE's monthly capitation payment until the Authority has approved the transition plan;

(c) If the Authority's approval of the transition plan occurs less than 90 days before the effective date of termination, then the Authority may require the MCE to extend the contract to a later effective date of termination, including as necessary the MCE's acceptance of amendments to the contract generally applicable to MCE contracts through the extended effective date.

(7) The MCE shall designate an individual as the contract transition coordinator.

(8) The contract transition coordinator shall be the Authority's contact for ensuring the MCE's completion of the MCE's contractual obligations, performance, operations, and member transitions including the transition plan.

(9) MCEs must submit reports to the Authority every 30 calendar days detailing the MCE's progress in executing its transition plan. In the event of the MCE's substantial failure to execute timely its transition plan, the Authority may withhold 20 percent of any payments due to the MCE from the Authority until such failure is corrected.

(10) MCEs shall submit a final report to the Authority describing how it fulfilled all transition and close-out activities described in the transition plan. The final report is subject to the Authority approval before issuance of any final payment.

(11) MCEs shall continue to perform all financial, management, and administrative services obligations identified in contract throughout the closeout period, including at minimum:

(a) Restricted reserves and insurance coverage for a period of 18 months following the notice of termination, or until the state provides the MCE with written release agreeing that all continuing obligations are fulfilled, whichever is earlier;

(b) Maintaining adequate staffing to perform all required functions as specified in contract;

(c) Supplying all information necessary to the Authority or its designee upon request for reimbursement of any outstanding claims at the time of termination;

(d) Assisting the Authority to ensure an orderly transition of member services after notice of termination consistent with the Authority's Transition of Care Policy; and

(e) To make available all signed provider agreements or subcontracts to the Authority upon request.

(12) The MCE must arrange for the orderly transfer of all OHP members assigned to the MCE to coverage under any new arrangement authorized by the Authority, including any actions required by the Authority to complete the transition of members and the termination of the MCE contract. These actions include:

(a) Forwarding of all medical or financial records related to the contractually obligated activities;

(b) High needs care coordination;

(c) Facilitation and scheduling of medically necessary appointments for care and services;

(d) Identification of chronically ill high risk, hospitalized, and pregnant members in their last four weeks of pregnancy.

(13) If a change of providers may be harmful to the member, the MCE must continue to provide services until that treatment is concluded or appropriate transfer of care is arranged.

(14) The MCE shall make available and require its providers and subcontractors to make available to the Authority copies of medical, behavioral, oral and managed long-term services and supports records, patient files, and any other pertinent information necessary for efficient care management of enrollees, as determined by the Director of the Authority:

(a) Records shall be in a usable form and shall be provided at no expense to the Authority, using a file format and dates for transfer specified by the Authority;

(b) Under no circumstances shall a Medicaid member be billed for this service;

(c) Information that shall be required includes:

(A) Numbers and status of grievances in process;

(B) Numbers and status of hospital authorizations in process, listed by hospital;

(C) Daily hospital logs;

(D) Prior authorizations approved, pending, or denied;

(E) Program exceptions approved;

(F) Medical cost ratio data;

(G) Information on outstanding payments for medical care rendered to members;

(H) All encounter data required under the terminated agreement;

(I) Identification of members whose treatment or treatment plans require continuity of care consideration;

(J) Any other information or records deemed necessary by the Authority to facilitate the transition of care.

(15) Following expiration of the contract and the completion of closeout period obligations, the MCE shall:

(a) Maintain claims processing functions as necessary for a minimum of 18 months after the date of termination. If additional claims are outstanding, the MCE shall maintain the claims processing system as long as necessary to complete final adjudication of all claims;

(b) Remain liable and retain financial responsibility for all claims with dates of service prior to the date of termination;

(c) Maintain financial responsibility for patients who ~~are hospitalized~~ were admitted to an inpatient stay prior to the termination date through the date of discharge ~~or for patients receiving post hospital extended care benefits after termination~~ from their continuous inpatient stay in accordance with OAR 410-141-3805 and to the extent the MCE is responsible under the contract;

(d) Maintain financial responsibility for services rendered prior to the termination date, for which payment is denied by the MCE and subsequently approved upon appeal by the provider; and

(e) Assist the Authority with grievances and appeals for dates of service prior to the termination date.

(16) Runout activities shall consist of the processing, payment, and reconciliations necessary regarding all enrollees, claims for payment from providers, appeals by both providers and members, and financial reporting deemed necessary by the Authority, including:

(a) Monthly claims aging report including IBNR amounts;

(b) Quarterly financial statements and annual audited financial statements in conformity with the specification in the contract up to the date specified by the Authority;

(c) Certified encounter reporting until all services rendered prior to contract expiration or termination have reached adjudicated status and the Authority data validation of the information is complete;

(d) Arranging for the retention, preservation, and availability of all records, including those records related to member grievance and appeals, litigation, base data, Medical Loss Ratio (MLR) reports, claims settlement, and those records covered under HIPAA as required by contract and state and federal law;

(e) Details of any existing third-party liability (TPL) or personal injury lien (PIL) cases and making any necessary arrangements to transfer the cases to the Authority's TPL and PIL units; and

(f) Final reports that identify all expenditures for any period in which the MCE continued to pay claims for services provided during the contract period.

(17) The Authority may require status reports or updates to the data reporting requirements in section (16) upon request.

(18) MCEs shall submit to the Authority a written request for release certifying that all obligations have been satisfied. The Authority shall provide an official written release upon satisfaction of activities associated with the contract expiration or termination plan. The request must be signed, expressly under penalty of False Claims Act liability, by the president and the chief financial officer of the MCE and must attest that, except as expressly described in a writing attached to the attestation:

(a) All payments are received by the MCE under the contract, and all the MCE's liabilities under the contract are extinguished;

(b) All reports, reconciliations, member matters, and provider matters are resolved and finalized; and

(c) The MCE complied with all contractual and legal requirements, including completion of the activities described in the transition plan.

(19) To the extent that the request for release under section (18) attaches any exception, the request for release must include a plan describing how each exception is resolved. Any payments due under the terms of the contract for services between the Authority and the MCE, including the distribution of restricted reserve funds or any withheld capitation amount, may be withheld until the Authority receives all written and properly executed documents from the MCE. The MCE is subject to all obligations under the contract, associated rules, and the transition plan until a final written release is issued by the Director of the Authority. Such release:

(a) Shall apply only to the extent of the MCE's responsibilities under the MCE contract, associated rules, and the transition plan;

(b) Shall apply only to the extent the MCE's submissions to the Authority are true, complete, and accurate;

(c) Shall apply only between the Authority and the MCE;

(d) May not bind third parties;

(e) May not preclude the Authority’s assertion of indemnity, contribution, or other obligations based on third-party claims;

(f) May not preclude the Authority’s assertion of false claims liability, Medicaid fraud, common-law fraud, or other claims, false statements, or fraud; and

(g) May not affect any post-termination obligations of the MCE under the contract for preservation of records or for auditors’ access.

Statutory/Other Authority: ORS 413.042
Statutes/Other Implemented: ORS 414.065

410-141-3735 Social Determinants of Health and Equity; Health Equity

(Proposed Changes Effective 1/1/21)

(1) This rule defines health disparities and the social determinants of health and equity (SDOH-E), establishes requirements for the Supporting Health for All through Reinvestment Initiative (SHARE Initiative), establishes the role of the Community Advisory Councils in supporting SDOH-E, establishes requirements for collecting data on race, ethnicity, and primary language, and establishes requirements for developing health equity infrastructure within a Coordinated Care Organization (CCO). This rule provides structure and guidance to CCOs to support long-term, community-specific investment and partnership in SDOH-E.

(2) The following definitions apply for purposes of this rule:

(a) "Adjusted Net Income" is the pre-tax net income reported by a CCO for a calendar year (or a partial year, if relevant) pursuant to OAR 410-141-5015, adjusted by the Authority pursuant to section 3(a)(E) for items such as the following:

(A) Excessive administrative expenses, including management bonuses

(B) Improper allocation of expenses across lines of businesses

(C) Non-operating revenues and expenses

(D) Adjustments to base data made as part of the capitation rate development

(E) Expenses not supported by legitimate business purposes

(F) Payments or transfers to subcontractors, parent companies, affiliates, or subsidiaries

(b) "Affiliate" has the meaning defined in OAR 410-141-5285

(~~a~~c) "Health Disparities" are the structural health differences that adversely affect groups of people who systematically experience greater economic, social, or environmental obstacles to health based on their racial or ethnic group, religion, socioeconomic status, gender, age, or mental health; cognitive, sensory, or physical disability; sexual orientation or gender identity; geographic location; or other characteristics historically linked to discrimination or exclusion. Health disparities are the indicators used to track progress toward achieving health equity.

(~~b~~d) "Social Determinants of Health and Equity" (SDOH-E):

(A) SDOH-E encompasses three terms:

(i) The social determinants of health refer to the social, economic, and environmental conditions in which people are born, grow, work, live, and age, and are shaped by the social determinants of equity. These conditions significantly impact length and quality of life and contribute to health inequities;

(ii) The social determinants of equity refer to systemic or structural factors that shape the distribution of the social determinants of health in communities;

(iii) Health-related social needs refer to an individual's social and economic barriers to health, such as housing instability or food insecurity.

(B) SDOH-E initiatives may involve interventions that occur outside a clinical setting, and may pursue mechanisms of change including:

(i) Community-level interventions that directly address social determinants of health or social determinants of equity;

(ii) Interventions to address individual health-related social needs.

(~~c~~e) "SDOH-E Partner" is a single organization, local government, one or more of the Federally-recognized Oregon tribal governments, the Urban Indian Health Program, or a collaborative, that delivers SDOH-E related services or programs, or supports policy and systems change, or both within a CCO's service area.

(3) The following requirements are specific to the Supporting Health for All through Reinvestment Initiative (SHARE Initiative):

(a) For each calendar year starting on or after January 1, 202~~1~~3, CCOs shall dedicate a portion of their previous calendar year's adjusted net income or reserves to SDOH-E spending, pursuant to ORS 414.625(1)(b)(C) ~~(as such statute was amended by 2018 HB 4018)~~ and as set forth in the contract;

(A) The portion of adjusted net income or reserves spent shall equal or exceed the greater of:

(i) A percentage of average adjusted net income for the prior three calendar years on a sliding scale based on Contractor's Risk Based Capital (RBC) percentage as of the end of the most recent calendar year (but prior to the SHARE portion calculation); or

(ii) A proportion of the amount recorded in dividends or similar payments or both to shareholders, affiliates, or other owners in that prior year. For purposes of this section, these payments include adjusted net income earned by subcapitated entities who are owners or affiliates of Contractor. Subcapitated owners' or affiliates' adjusted net income is calculated as defined in section 2(a), but with respect to the subcapitated entities' lines of business under the Contractor. For purposes of this section, dividends or similar payments solely designated to satisfy tax obligations of affiliates that arise on account of serving the CCO's Medicaid members shall be excluded, provided that the CCO provides documentation which is approved by the Authority.

(B) The Authority will provide the specifications for (i) and (ii), including the sliding scale to CCOs in the SHARE Initiative Guidance, which is located here: https://www.oregon.gov/oha/HPA/dsi-tc/Documents/SHARE-Initiative-Guidance-Document.pdf.

(C) The value of the RBC% floor, for the purposes of the sliding scale, will be the greater of:

(i) 250% RBC, or

(ii) The percentage referenced in OAR 410-141-5180(2) in relation to dividend payment restrictions.

(D) Notwithstanding the preceding clauses, for the 2023 and 2024 calendar year, the minimum SHARE obligation shall not be less than the amounts calculated applying the above provisions for those individual calendar years, plus 60% of the difference between:

(i) The SHARE Initiative obligation calculated using a two-year average of 2020 and 2021 adjusted net income, a two-year average of RBC% at the end of 2020 and 2021, and the 2022 specifications published under 3(a)(B) above; and

(ii) A two-year average of actual provisions for SHARE Initiative designations for calendar years 2021 and 2022, as reported by Contractor. In the event that average actual provisions exceed average amounts under clause (i) above, the effect will be to reduce the 2023 and 2024 calendar year obligations under this subparagraph (D).

(E) The Authority may adjust net income under section 2(a) for the purpose of ensuring that CCOs do not calculate or distribute net income to avoid or reduce SHARE Initiative spending. The Authority will present any adjustments made under this section via administrative notice to an affected CCO within 45 days of the due date for filing the financial reporting in which the SHARE obligation is determined. The notice will indicate the reasons for the adjustment and the amount of adjustment arising from each reason. The Authority will provide the CCO 30 days to reply in writing with objections or comments.

(F) The Authority may extend relief from minimum SHARE Initiative spending requirements in the event of net losses that would otherwise place the CCO's capital, surplus or reserves below 200% RBC.

(b) CCOs shall select SDOH-E spending priorities that fall into at least one of four domains of SDOH-E: Neighborhood and Built Environment, Economic Stability, Education, and Social and Community Health, and are consistent with:

(A) The CCO's most recent Community Health Improvement Plan (CHP) that is a shared plan with the Collaborative Partners, as defined in 410-141-3730, including local public health authorities and local hospitals. If the CCO has not yet developed a shared CHP, the CCO shall align its priorities with those identified in CHPs developed by other stakeholders in the service area, such as local public health authorities, hospitals, and other CCOs; and

(B) Any SDOH-E priority areas identified by the Authority.

(c) A portion of SHARE Initiative dollars must go directly to SDOH-E Partner(s) for the delivery of services or programs, policy, or systems change, or any of these, to address the social determinants of health and equity as agreed by the CCO. CCOs shall enter into a contract, a Memorandum of Understanding, or other form of agreement including a grant agreement, with each SDOH-E Partner that defines the services to be provided and the CCO's data collection methods as provided in the contract between the Authority and the CCO.

(d) SHARE Initiative expenses need not meet the requirements of 45 CFR 158.150(b), and are paid for with funding separate from premium revenue. Therefore, SHARE Initiative expenses do not meet the requirements of health-related services or "activities that improve health care quality" under CMS regulations.

(~~d~~e) CCOs shall report completed and anticipated SDOH-E expenditures using the format specified by the Authority. These reports will be posted publicly.

(4) Community Advisory Councils (CAC):

(a) CCOs shall designate a role for the CAC in ~~directing, tracking, and reviewing spending on the~~ SHARE Initiative spending decisions;

~~(b) CCOs shall designate a role for the CAC in health-related services community benefit initiative spending decisions, as defined in OAR 410-141-3845.~~

(b~~c~~) CCOs shall have a conflict of interest policy that applies to its CAC members and accounts for financial interests related to ~~potential health-related services,~~ the Share Initiative, and~~or~~ other SDOH-E spending;

(c~~d~~) CCOs shall submit reports to the Authority no less than annually that describes the CAC's role in making decisions on these issues. These reports will be posted publicly with appropriate redactions.

(5) CCOs shall collect and maintain data on race, ethnicity, and primary language for all members on an ongoing basis in accordance with standards established by the Authority, including REAL-D. CCOs shall track and report on any quality measure by these demographic factors. The CCOs shall make this information available by posting on the web.

(6) Health Equity Infrastructure:

(a) The term "Health equity infrastructure" refers to the adoption and use of culturally and linguistically responsive models, policies and practices including and not limited to community and member engagement; provision of quality language access; workforce diversity; ADA compliance and accessibility of CCO and provider network; ACA 1557 compliance; CCO and provider network organizational training and development; implementation of the CLAS Standards; non-discrimination policies;

(b) The "Health Equity Plan" is part of the "Health Equity Infrastructure;"

(c) CCOs shall develop and implement the "Health Equity Plan" to embed health equity as a value and business practice into organizational policies, procedures, and processes; meet state and federal laws and contractual obligations regarding accessibility and culturally and linguistically responsive health care and services; inform using an equity framework in all policy, operational, and budget decisions; provide a structure to ensure oversight and management of programs and services with the goal to advance health equity and provide culturally and linguistically appropriate services. The health equity plan shall include the following:

(A) Narrative of the health equity plan development process, including description of meaningful community engagement;

(B) Health equity focus areas, including strategies, goals, objectives, activities and metrics;

(C) Organizational and Provider Network Cultural Responsiveness and Implicit Bias training plan:

(i) CCO shall incorporate Cultural Responsiveness and implicit bias continuing education and training into its existing organization-wide training plan and programs;

(ii) CCO shall align cultural responsiveness and implicit bias trainings with the "Cultural Competence Continuing Education" criteria developed by the Authority's Cultural Competence Continuing Education Advisory Committee referenced in OAR 943-090-0020;

(iii) CCO shall adopt the definition of Cultural Competence set forth in OAR 943-090-0010;

(iv) CCO shall provide and require all its employees, including directors, executives, and CAC members to participate in all such trainings;

(v) CCO's shall require all of the CCO's Provider Network to comply with Cultural Competency Continuing Education requirements set forth in ORS 676.850.

(d) The health equity plan and the language access self-assessment report are required to be submitted under OAR 410-141-3515 and shall be submitted every year to the Authority for review and approval;

(e) CCOs shall designate a Single Point of Accountability. The single point of accountability can also be called the Health Equity Administrator:

(A) The Single Point of Accountability ("Health Equity Administrator") shall be responsible and accountable for all matters relating to Health Equity within the CCO, CCO Provider Network and CCO service area;

(B) The Single Point of Accountability ("Health Equity Administrator") shall have budgetary decision-making authority and health equity expertise;

(C) The Single Point of Accountability ("Health Equity Administrator") shall be a high-level employee (e.g., director level or above) and can have more than one area of responsibility and job title;

(D) The CCO shall inform and describe to the authority any changes related to the "Health Equity Administrator" role or scope using the Health Equity Plan;

(E) The Single Point of Accountability ("Health Equity Administrator") shall have the authority to communicate directly with CCO executives and governing board.

Statutory/Other Authority: ORS 414.615, 414.625, 413.042, 414.635 & 414.651
Statutes/Other Implemented: ORS 414.610 - 414.685

410-141-3805 Mandatory MCE Enrollment Exceptions (Proposed Changes Effective 1/1/22)

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

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

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

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

(3) MCE enrollment is mandatory in service areas with adequate access and capacity to provide health care services through an MCE. If upon application or redetermination a client does not select an MCE, the Authority shall auto-assign the client and the client's household to an MCE that has adequate access and capacity. Enrollment may vary depending on which options are available in the member's service area at the time of enrollment:

(a) The member shall be enrolled with a CCO that offers bundled physical health, behavioral health, and oral health services; or

(b) The member shall be enrolled with a CCO for physical health and behavioral health services and with a DCO for oral health services; or

(c) The member shall be enrolled with a CCO for behavioral health and oral health services and shall remain FFS for physical health services; or

(d) The member shall be enrolled with a CCO for behavioral health services and with a DCO for oral health services and shall remain FFS for physical health services; or

(e) The member shall be enrolled with a DCO for oral health services and with an MHO for behavioral health services and shall remain FFS for physical health services; or

(f) The member shall be enrolled with a DCO for oral health services and remain FFS for physical health and behavioral health services; or

(g) The member shall remain FFS for health care services if no MCE is available.

(4) MCE enrollment is voluntary in service areas without adequate access and capacity to provide health care services through an MCE.

(5) If a service area changes from mandatory enrollment to voluntary enrollment while a member is enrolled with an MCE, the member shall remain enrolled with the MCE for the remainder of their eligibility period or until the Authority or Department redetermines their eligibility, whichever comes first, unless the member is otherwise eligible to disenroll pursuant to OAR 410-141-3810.

(6) Members who are exempt from physical health services shall receive behavioral health services and oral health services through an MCE:

(a) The member shall be enrolled with a CCO that offers behavioral health and oral health services; or

(b) The member shall be enrolled with a DCO for oral health services and with an MHO for behavioral health services; or

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

(d) The member shall remain FFS for both behavioral health and oral health services if neither a DCO nor an MHO is available.

(7) The following pertains to the effective date of the enrollment. If the member qualifies for enrollment into an MCE, the effective date of 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.

(8) Coordinated care services shall begin as of the effective date of enrollment with the MCE except for:

(a) A newborn's services shall begin on the date of birth if the mother was a member of a CCO at the time of birth;

~~(b) For individuals 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 60 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;~~

(b~~d~~) For adopted children or children placed in an adoptive placement, the date of enrollment shall be the date specified by the Authority.

(9) Pursuant to ORS 414.631, the following populations may not be enrolled into an MCE for any type of health care coverage:

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

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

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

(10) ~~In addition~~ If enrollment action coincides with an individual's Continuous Inpatient Stay as defined in 410-141-3500, the following enrollment rules apply:

(a) A newly eligible OHP client who became eligible while admitted as an inpatient ~~in a hospital, or while receiving post-hospital extended care (PHEC),~~ is exempt from enrollment with a CCO for physical health and behavioral health services but not exempt from MCE enrollment oral health services with a DCO. The client shall receive health care services on a fee-for-service (FFS) basis ~~only~~ until the ~~hospital~~ individual is discharged~~s~~ from the continuous inpatient stay~~the client, or until the member completes PHEC or the PHEC benefit is exhausted~~;

(b) In settings where the CCO is fully responsible for covered services, such as an acute care hospital, acute care psychiatric hospital, skilled nursing facility specific to the post-hospital extended care (PHEC) benefit, psychiatric residential treatment facility (PRTF), or a residential Behavioral Health or Substance Use Disorder treatment facility that is not considered a Home and Community-Based Services (HCBS) setting as described in OAR 410-173-0035:

(A) The CCO is responsible for covered services if the individual is enrolled as of the date they are admitted to the inpatient setting. No enrollment changes shall be made (CCO-to-FFS, CCO-to-CCO, or FFS-to-CCO) until the member is discharged from their continuous inpatient stay to ensure continuity of care and care coordination, and to mitigate billing confusion.

(B) If the individual is enrolled after the first day of admission to the inpatient setting, the individual will be disenrolled, and the date of enrollment shall be the next available enrollment date following discharge from the continuous inpatient stay to ensure continuity of care and care coordination, and to mitigate billing confusion.

(C) When a justice-involved individual, meeting the definition for Inmate stated within 410-200-0015, is admitted to an inpatient setting with an expected stay of at least 24 hours, the individual temporarily resumes OHP eligibility and the inpatient stay is covered by Fee-for-Service; CCO enrollment shall be the next available enrollment date following release from the penal facility as consistent with OAR 410-200-0140, OAR 461-135-0950, and OAR 410-141-3810, and based on the service area of the member's current permanent residence.

(c) In settings where the CCO is responsible for care coordination but not health services, including, but not limited to Medicaid-Funded Long Term Services and Supports (LTSS) or Behavioral Health Carve-Out Services:

(A) Contractor is responsible for care coordination if the individual is enrolled as of the date they are admitted to the inpatient setting. No enrollment changes shall be made (CCO-to-FFS, CCO-to-CCO, or FFS-to-CCO) until the member is discharged from their continuous inpatient stay to ensure continuity of care coordination.

(B) If the individual is enrolled after the first day of admission to the inpatient setting, the individual will be disenrolled, and the date of enrollment shall be the next available enrollment date following discharge from the continuous inpatient stay to ensure continuity of care coordination.

(C) When a resident of a public institution, as defined in 461-135-0950, is voluntarily or involuntarily admitted to the Oregon State Hospital, OHP eligibility is suspended and any associated CCO enrollment is ended with an effective date of the inpatient admission; however, the CCO is responsible for care coordination.

(d) If an individual is currently experiencing an extended but temporary hold within an Emergency Department due to unavailability of inpatient placement or delay in secure transportation to a facility that can evaluate appropriate psychiatric referrals, no enrollment changes shall be made (CCO-to-FFS or CCO-to-CCO) until the individual is no longer in the Emergency Department or, if subsequent action is admission to an inpatient setting, until the individual is discharged from their continuous inpatient stay.

(~~b~~11) A client may not be enrolled with a CCO if the client is covered under a major medical insurance policy, third party liability (TPL), or other third-party resource (TPR) that covers the cost of services to be provided by a CCO as specified in ORS 414.631 and except as provided for children in Child Welfare through the Behavior Rehabilitation Services (BRS) and Psychiatric Residential Treatment Services (PRTS) programs outlined in OAR 410-141-3800.

(a~~A~~) A client shall be enrolled with a DCO for oral health services even if they have a dental TPR.

(b~~B~~) At the Authority's discretion, a client shall be enrolled with the highest level of CCO coverage, including physical health, behavioral health, and oral health services, if coverage through the TPR poses a safety risk to the member, specific to Good Cause determination as described in OAR 461-120-0350(1) and OAR 410-200-0220(6). In these situations:

(A~~i~~) Recovery of third-party insurance should not be pursued; and

(B~~ii~~) Explanation of Benefits (EOB) should be suppressed.

(12~~1~~) Individuals who are documented American Indian and Alaskan Native (AI/AN) beneficiaries are exempt from mandatory enrollment into an MCE, as specified in 42 USC 1932, 2 (C), but may elect to be manually enrolled.

(13~~2~~) A child 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 is exempt from mandatory enrollment for physical health services from a CCO but is subject to mandatory enrollment into both behavioral and oral health services as available in the member's service area unless:

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

(b) Enrollment preserves continuity of care. In these cases, the member may be manually enrolled into a physical health plan or remain enrolled as deemed appropriate by the Authority.

(14~~3~~) Clients who are dually eligible for Medicare and full Medicaid but not enrolled in a program of all-inclusive care for the elderly (PACE) may be automatically enrolled into an MCE. The following apply to automated duals enrollment:

(a) The dually eligible Medicare and Medicaid client shall receive choice counseling on Medicare-Medicaid options at their request from a local APD/AAA office or other Department or Authority designated entity, as well as information on the benefits for clients in aligning Medicare and Medicaid;

(b) If a client is already enrolled in a Medicare Advantage or Dual Special Needs Plan (D-SNP), the member shall be enrolled into an affiliated CCO if one exists. Otherwise the client shall be enrolled in a CCO available to the member based on the member's residential address or home geographic region;

(c) A Full Medicare and Medicaid ~~full~~ dually eligible members may request to opt out of enrollment for physical health services from a CCO but is subject to mandatory enrollment into both behavioral and oral health services as available in the member's service area. Disenrollment requests are subject to review or delay as deemed appropriate by the Authority when:

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

(B) Enrollment preserves continuity of care. In these cases, the member has a condition, treatment, or specialized consideration that requires individual care transition, members may not be disenrolled without review and approval by the Authority. The Authority will consider the following in its review;

(i) The development of a prior-authorized treatment plan;

(ii) Care management requirements based on the beneficiary's medical condition;

(iii) Transitional care planning including but not limited to hospital admissions/discharges, palliative and hospice care, long-term care and services; and

(iv) Need for individual case conferences to ensure a "warm hand-off."

(d) The following choices of plans shall be extended to dually eligible Medicare-Medicaid clients or members with full Medicaid as follows:

(A) The option to enroll in a CCO regardless of whether they are enrolled in an affiliated Medicare Advantage, enrolled in Medicare Advantage with another entity, or if the member remains in FFS Medicare;

(B) The option to enroll in a CCO when enrolled in Medicare Advantage, whether or not they pay their own premium, even if the MCE does not have a corresponding Medicare Advantage plan;

(C) The option to enroll with a CCO even if the client withdrew from the CCO's Medicare Advantage plan.

(e) The CCO shall accept the client's enrollment if the CCO has adequate health access and capacity;

(f) CCO care coordination and communication requirements to reduce duplication of care planning activities in OAR 410-141-3860 and 410-141-3870 are required regardless of the member's choices in Medicare and Medicaid enrollments.

(15~~4~~) 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) 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 are not exempt from enrollment unless the Authority determines there are other just causes to preserve the continuity of care.

(16~~5~~) MCE enrollment standards:

(a) MCEs shall remain open for enrollment unless the Authority has closed enrollment. Reasons for closing enrollment may include:

(A) The MCE has exceeded its enrollment limit or does not have sufficient capacity to provide access to services, as mutually agreed upon by the Authority and the MCE;

(B) Closed enrollment as a sanction for MCE misconduct.

(b) MCEs shall accept all eligible potential members, regardless of health status at the time of enrollment, subject to the stipulations in contracts/agreements with the Authority to provide covered services;

(c) MCEs may confirm the enrollment status of a client by one of the following:

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

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

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

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

(d) MCEs shall have open enrollment for 30 continuous calendar days during each 12-month period of January through December, regardless of the MCE's enrollment limit. The open enrollment periods for consecutive years may not be more than 14 months apart.

(17~~6~~) If the Authority permits an MCE to assign its contract to another MCE, members shall be automatically enrolled in the MCE that has assumed the contract:

(a) Each member will have 30 calendar days from the date of notice of enrollment to request disenrollment from the MCE that has assumed the contract;

(b) If the MCE that has assumed the contract is a Medicare Advantage plan, those members who are Medicare beneficiaries shall not be automatically enrolled but shall be offered enrollment in the succeeding MCE.

(18~~7~~) If an MCE engages in an activity such as the termination of a participating provider or participating provider group that has significant impact on access in that service area such that the MCE cannot meet the access to care requirements set forth in OAR 410-141-3515 and which necessitates either transferring members to other providers or the MCE withdrawing from part or all of a service area, the MCE shall provide the Authority at least 90 calendar days written notice prior to the planned effective date of such activity:

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

(b) The MCE shall provide members with at least a 30-calendar-day notice of such changes. In the event the MCE is not available to provide members with notice of a change in participating providers or MCE, the Authority shall instead notify members of a change in participating providers or MCEs. In such instances the MCE shall provide the Authority with the name, prime number, and address label of the members affected by such changes at least 30 calendar days prior to the planned effective date of such activity.

Statutory/Other Authority: ORS 413.042 & ORS 414.065
Statutes/Other Implemented: ORS 414.065 & 414.727

410-141-3810 Disenrollment from MCEs (Proposed Changes Effective 1/1/22)

(1) Member-initiated requests for disenrollment.

(a) All member-initiated requests for disenrollment from an MCE shall be initiated orally or in writing by the primary person in the benefit group enrolled with an MCE 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. Some disenrollment requests may not be applicable to all MCEs. In instances where that is the case, the type of MCE is specified within the applicable section or subsection of this rule.

(b) The Authority or MCE shall honor a member or representative request for disenrollment for the following reasons:

(A) Without cause:

(i) Members may request to change their MCE enrollment within 30 calendar days of the Authority's automatic or manual enrollment error. If approved, the change would occur during the next weekly enrollment cycle.

(ii) Members may request to change their MCE enrollment within 90 calendar days of the initial MCE enrollment. If approved, the change would occur during the next weekly enrollment cycle.

(iii) Members may request to change their MCE enrollment after they have been enrolled with a plan for at least six months. If approved, the change would occur at the end of the month.

(iv) Members may request to change their MCE enrollment at their OHP eligibility renewal. If approved, the change would occur at the end of the month.

(v) Members have one additional opportunity to request a plan change during the eligibility period if none of the above options can be applied. If a request for disenrollment is approved under this section, the change would occur at the end of the month.

(B) With cause, at any time as follows:

(i) The member moves out of the MCE service area; or

(ii) Due to moral or religious objections the CCO does not cover the service the member seeks.

(iii) When the member needs related services (for example a Caesarean 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.

(C) Medicare and Medicaid fully dual eligible members may change plans or disenroll to fee-for-service at any time subject to the provisions set forth in OAR 410-1413805(13)(c) based on enrollment options in the member's service area and to ensure continuity of care during a transition.

(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 specific member's health care needs. Examples of sufficient cause include but are not limited to:

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

(ii) The member is at risk of experiencing a lack of continuity of care. Continuity of care for the purpose of this rule means the ability to sustain services necessary for a person's treatment. A request for disenrollment based on continuity of care shall be denied if the basis for this request is primarily for the convenience or preference of a member for a provider of a treatment, service, or supply.

(I) A request for disenrollment based on continuity of care shall be deemed by the Authority a request for an open card for continuity of care and a temporary CCO exemption.

(II) Authority decisions to approve or deny the member's request shall be communicated in a written notice to the member. A Copy of the notice shall be sent, if applicable, to the providers that participated in the member's request. The notice to the member shall include the regulatory or clinical criteria, or both, relied upon to make the decision cited in the notice. If the Authority's decision is a denial of a request for disenrollment, the notice shall include information about the member's right to, and how to, file a grievance and other information related to the member's administrative hearing rights; and

(E) If 30 calendar days pass without a decision from the Authority on a member's disenrollment request, the request becomes effective on the first calendar day of the following calendar month (unless the Authority takes action before that date).

(c) A member may request a temporary enrollment exception during pregnancy as follows:

(A) A temporary enrollment request will be granted if a member is at any point in the third trimester of pregnancy and:

(i) The member is newly determined eligible for OHP; or

(ii) The member is newly re-determined eligible for OHP and not enrolled in a CCO within the past three months; or

(iii) The member is enrolled with a new CCO MCE that does not contract with the member's current OB provider and the member wishes to continue obtaining maternity services from that non-participating OB provider.

(B) The enrollment exemption shall remain in place until 60 calendar days postdate of either the delivery of the member's child or the pregnancy otherwise ends, at which time the member shall be enrolled in the appropriate CCO in their service area. Where there is a choice among multiple CCOs in the member's service area they may choose an open plan; however, if the member does not express a preference to OHP, OHP will auto assign on a next weekly basis.

(d) Upon approval of a member's disenrollment from a CCO, the Member shall join another CCO unless:

(A) The member resides in a service area where enrollment is voluntary; or

(B) The member meets the exemptions to enrollment set forth in OAR 410-141-3805; or

(C) The member meets disenrollment criteria stated in this rule; or

(D) There is not another CCO available and open to new enrollment in the service area.

(2) MCE-initiated disenrollment requests.

(a) MCEs may request disenrollment for any of the reasons set forth below in this subsection (a). Such requests shall be submitted to the Authority's Client Enrollment Services (CES) unit unless otherwise specified in this subsection (a) below. After review of all necessary documentation submitted with an MCE's request, the Authority will grant such requests, except the Authority may deny requests based on the reason set forth in subparagraph (G) below.

(A) ~~If the member is enrolled in the CCO on the same day the member is admitted to the hospital, the CCO shall be responsible for the hospitalization and the post-hospital extended care (PHEC) benefit.~~ If the ~~member~~ individual is enrolled after the first ~~calendar~~ day of admission to an ~~the~~ inpatient ~~stay~~ setting, the member shall be disenrolled and enrolled on the next available enrollment date following discharge from ~~inpatient hospital services~~ the continuous inpatient stay, unless the member is a newborn child born to an OHP eligible mother enrolled with a CCO in accordance with OAR 410-141-3805;

(B) If the CCO determines the member has Third Party Liability (TPL), the CCO shall report the TPL to the Authority's Health Insurance Group (HIG) on the webform located at https://www.oregon.gov/dhs/business-services/opar/pages/tpl-hig.aspx. The CCO shall receive an emailed tracking number following the online report. The CCO may use this number, should they choose to follow up on their referral submission via the provider portal. If the member is determined to have active TPL, HIG shall disenroll the member from the CCO effective at the end of the month the TPL is reported, with the exception of:

(i) When Good Cause determination is active or concurrently documented, in which case the member will retain the highest level of CCO coverage as set forth in OAR 410-141-3805(10)(b);

(ii) Some situations in which the Authority may approve retroactive disenrollment.

(C) If a member has been residing outside the MCE's service area for more than three months unless previously arranged with the MCE. The MCE shall provide written documentation that the member has been residing outside its service area for more than three months. The proof shall be provided along with the initial request for disenrollment to the CCO account representative (CCO AR) for validation and a decision. The CCO AR will notify the MCE of the approval or denial and rational for the decision. If approved, the effective date of disenrollment shall be the date specified by the Authority, and if a partial month remains, the Authority shall recoup the balance of that month's capitation payment from the MCE;

(D) If 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~~ facility. This does not include members on probation, house arrest, living voluntarily in a facility before or after their case has been adjudicated, infants living with an inmate, or inmates who become inpatients. The MCE shall identify the members and provide sufficient written proof of incarceration to the Authority for review of the disenrollment request. The Authority shall retroactively disenroll or suspend enrollment when the member has been taken into custody. The effective date of any disenrollment approved by the Authority shall be the date the member was incarcerated;

(E) If, prior to January 1, 2022 (or later if specified by the Authority), the member is in a state psychiatric institution. After December 31, 2021 (or later if specified by the Authority) the Authority shall not automatically grant requests for disenrollment based solely on a member's admission to a state psychiatric institution; or

(F) The Medicare member is enrolled in a Medicare Advantage plan and was receiving hospice services at the time of enrollment in the MCE.

(G) The member had End Stage Renal Disease at the time of enrollment in the MCE.

(3) MCE Disenrollment Requests: Fraudulent or Illegal Acts.

(a) MCEs have the right to request the Authority disenroll members when they commit fraudulent or illegal acts related to participation in the OHP such as: Permitting the use of their medical ID card by others, altering a prescription, theft, or other criminal acts.

(b) The MCE shall report any illegal acts to law enforcement authorities and, if appropriate, to the DHS Fraud Investigations Unit.

(c) When requesting disenrollment based on a member's fraudulent or illegal act(s), the MCE shall submit a written disenrollment request to its CCO AR at the Authority. In the disenrollment request, the MCE shall document the reasons for the request, provide written evidence to support the basis for the request, including any verification of reports submitted to law enforcement and, if applicable, the DHS Fraud Investigations Unit.

(d) Based on the evidence presented, the CCO AR will review the disenrollment request and all submitted evidence with Authority staff. The review process will be documented and a recommendation for disenrollment will be submitted to the Authority's management to make a final decision on the appropriateness of disenrolling a member and whether any recommended disenrollment decision must be made immediately or wait until after the completion of any fraud investigation.

(4) MCE Disenrollment Requests: Uncooperative or Disruptive Behavior.

(a) Subject to applicable disability discrimination laws and this subsection (4), the Authority may, upon request of an MCE, disenroll members for cause when a member is uncooperative or disruptive, except when such behavior is the result of the member's special health care needs or disability. A member's refusal to accept a provider's treatment plan does not constitute uncooperative or disruptive behavior for purposes of this rule.

(b) For purposes of this rule, a "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 MCE shall make an individualized assessment based on reasonable judgment that relies on current medical knowledge or the 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.

(c) MCEs shall not have the right to request a member be disenrolled based solely on any of the following reasons:

(A) Physical, intellectual, developmental, or mental disability; or

(B) An adverse change in the member's health; or

(C) Under or over-utilization of services; or

(D) Filing a grievance or exercising any appeal or contested case hearing rights; or

(E) The member exercises their option to make decisions regarding their medical care with which the MCE disagrees; or

(F) Uncooperative or disruptive behavior resulting from the member's special needs.

(d) MCEs shall require their providers to provide the MCE with prompt written notification of a member's uncooperative or disruptive behavior. The provider's notification shall describe the uncooperative or disruptive behavior and, except as provided for in section (5) of this rule, allow time for appropriate resolution by the MCE before refusing to provide services to the member. The provider shall document the written notification to the MCE in the member's medical record.

(e) In response to notification of a member's uncooperative or disruptive behavior, the MCE shall do all of the following prior to submitting a request for disenrollment:

(A) Furnish education and training to the notifying provider about the need for early intervention, disability accommodation, and the resources or services available to the provider. The MCE shall document the education, training, and the resources or services furnished to the reporting provider.

(B) Contact the member either in person, by telephone, or in writing. All contacts made in person or by telephone shall be followed by written confirmation and sent to the member with a copy to the provider that notified the MCE of the member's uncooperative or disruptive behavior. When contacting the member, the MCE shall:

(i) Inform the member of the uncooperative or disruptive behavior that has been identified and attempt to develop an agreement with the member regarding the behavior;

(ii) Advise the member that the MCE will provide, and the member shall be required to participate in individual education, disability accommodation, counseling, or other interventions in an effort to resolve the behavior; and

(iii) Inform the member that their continued behavior may result in disenrollment from the MCE.

(C) In the event the interventions undertaken in accordance with Subsections (e)(B) of this rule do not ameliorate the member's uncooperative or disruptive behavior, the MCE shall Contact the member's care team, or develop a member focused care team if one does not already exist, to support the member in remediating their behavior. If needed, and with the consent of the member, the care team shall involve other appropriate individuals working with the member in the resolution within the laws governing confidentiality. The MCE shall facilitate cross functional care conferences that include the member, member focused care team, and other individuals chosen by the member with appropriate releases documented.

(D) In the event the member's uncooperative or disruptive behavior continues after undertaking the efforts identified in subsections (e)(C) of this rule, the MCE shall convene an interdisciplinary team that

includes a mental health professional or behavioral specialist and other health care professionals who have the clinical expertise necessary for reviewing and assessing the member's behavior, their behavioral history, and previous efforts undertaken to manage the member's behavior, including those developed through the members care team and care conferences, in order to determine whether the member may be able to remediate their uncooperative or disruptive behavior through other reasonable clinical or social interventions.

(f) All efforts undertaken in connection with this section (4) of the rule, including, without limitation, all interventions, written and oral communications, training and education provided to the member and the member's provider(s), as well as those persons who participated in any and all interventions, care teams, assessments and the like, shall be documented in the member's MCE case file and as applicable, the provider shall document all efforts undertaken in the member's medical record.

(g) If, after undertaking all efforts identified in subsection (e) of this rule, the member's disruptive or uncooperative behavior cannot be managed sufficiently in order for a provider to provide the services the member requires, the MCE may submit to its CCO AR on MCE letterhead a written request for disenrollment that complies with all of the following:

(A) Sets forth the reasons for the request for disenrollment, details the attempts at intervention and accommodations that were made, why those interventions and accommodations were not effective, and includes all written documentation required under subsection (f) of section (4) of this rule.

(B) Identifies, and provides documentation in support of the identification of, any special health care needs or disability the disruptive or uncooperative member may have and describes:

(i) The relationship the uncooperative or disruptive behavior may have, if any, to the member's special health care needs or disability, which must be substantiated by a provider with the appropriate credentials and expertise in the member's special health care needs or disability; and

(ii) Why the MCE has concluded the member's disruptive or uncooperative behavior is not a consequence of the member's special health care needs or disability.

(C) States whether the member's uncooperative or disruptive behavior poses a direct threat to the health or safety of others.

(D) Identifies the documentation that supports the MCE's rationale for concluding that the member's continued enrollment in the MCE seriously impairs the MCE's ability to furnish services to either the member who has engaged in the uncooperative or disruptive behavior or the MCE's other members.

(E) Provide written documentation of CMS' approval for disenrollment of the member when the member is also enrolled in the CCO's Medicare Advantage plan.

(F) Furnish all other information and documentation requested by the MCE's CCO AR.

(h) If a Primary Care Provider (PCP) terminates the provider/patient relationship during the period of time the CCO is undertaking the efforts described in this section (4), the CCO shall, prior to submitting a request for disenrollment, attempt to locate another participating PCP who will accept the member as their patient. If needed, the CCO shall obtain an authorization for release of information from the member in order to share the information necessary for a new PCP to evaluate whether they can treat

the member. All terminations of provider/patient relationships shall be consistent with the CCO's OHP policies, the CCO or PCP's policies for commercial members, and applicable disability discrimination laws.

(5) MCE Disenrollment Requests: Credible Threats of Violence.

(a) MCEs have the right to request an exception to the MCE initiated disenrollment requirements outlined in section (4) of this rule when a member has 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 MCE staff, so that it seriously impairs the MCE's ability to furnish services to either this particular member or other members.

(b) For purposes of this rule, a credible threat means that there is a significant risk that the member may cause grievous physical injury (including but not limited to death) in the near future, and that risk cannot be eliminated by a modification of policies, practices, or procedures.

(c) MCEs shall require their providers to notify both the MCE and law enforcement immediately when a member has acted violently or makes a credible threat of physical violence.

(A) The notification may be made to the MCE by telephone provided that such notice is followed by written notice to the MCE.

(B) Notice under this subsection (c) shall describe the circumstances surrounding the act or credible threat of violence and the actions taken by the provider as a result.

(C) MCEs shall require their providers to document the incident in the member's medical record and the MCE shall document the provider's notice in the member's case file.

(d) The MCE shall notify the member's care team of the act or credible threat of violence. The MCE shall involve the member's care team and, within the laws governing confidentiality, other appropriate individuals which may include, without limitation, a mental health professional or behavioral specialist and other health care professionals who have the clinical expertise necessary for reviewing and assessing the member's behavior to develop a plan to contact and provide support to the member in remediating the member's violent behavior.

(e) The MCE and the care team shall make, and document all attempts at contacting and actual contacts with the member regarding the act or credible threat of violence.

(f) If the MCE determines the member does not pose an imminent and credible threat to others, the MCE shall undertake the efforts and processes set forth in section (4) of this rule prior to making any request for disenrollment.

(g) If the MCE determines the member does pose an imminent and credible threat to others and cannot be remediated, as determined by the persons identified in subsection (d) of this section (5), by following the process set forth in section (4) of this rule, the MCE shall have the right to request the member's disenrollment. The MCE's disenrollment request shall comply with all of the requirements set forth in section (4)(g) of this rule and shall also comply with all additional requirements as follows:

(A) Include an explanation of why the MCE believes the exception to following the process set forth in section (4) of this rule is necessary as it relates to an act of, or credible threat of, physical violence; and

(B) In addition to all other documentation required to be submitted under section (4) of this rule, the request must also include a copy of the police report or case number. If a police report or case number is not available, the MCE shall submit a copy of the provider's entry in the member's medical record, which must be signed by the provider, or a copy of the MCE's entry into the member's case file signed by the applicable MCE personnel, or both, that documents the report to law enforcement or any other reasonable evidence.

(6) Approval or Denials of MCE Requests for Disenrollment Due to Uncooperative or Disruptive Behavior, Acts of Violence, or Credible Threats of Violence.

(a) MCE requests made without all documentation, including CCO AR requests for additional or clarifying information, required under sections (4) and (5) of this rule shall be denied.

(A) When there is insufficient documentation submitted with a request for disenrollment, the CCO AR shall notify the MCE of the denial within two business days of the initial request.

(B) MCEs may submit a new request for disenrollment once all required documentation is completed and available to be provided to the CCO AR.

(b) After receipt of a complete MCE request for disenrollment, the request will be evaluated by the MCE's CCO AR and relevant subject matter experts, including those with licensure or certification, as well as expertise appropriate to the circumstances identified in the request for disenrollment (disenrollment review team).

(c) The CCO AR will document the review, recommendations, and rational with relevant regulatory or clinical criteria made by the disenrollment review team.

(A) The CCO AR shall provide the documentation and recommendations made by the disenrollment review team to Authority's management for a decision regarding disenrollment of the affected member.

(B) The documentation provided to Authority management by the CCO AR shall also include the name of all disenrollment review team members, their respective areas of expertise, licensure or certification, or both.

(C) The decision, and all individuals involved in making the decision to approve or deny an MCE request for disenrollment under this section (6) of this rule shall be documented in the affected member's case file maintained by OHA.

(d) The CCO AR shall provide written notice on Authority letterhead to the MCE of the Authority's decision to approve or deny the MCE's request for disenrollment. The CCO AR shall provide copies of the notice to the MCE CEO, MCE COO, and OHA Medicaid Director.

(A) All notices of disenrollment approvals and denials shall include the reason for the decision along with applicable, supporting regulatory or clinical criteria, or both, and identify the subject matter expertise and credentials of the disenrollment review team. However, the names of the individuals on the disenrollment review team shall not be included in the notice.

(B) When there is sufficient documentation for the CCO AR to convene a disenrollment review team, the notice of approval or disapproval of the request for disenrollment shall be made by the Authority within 15 business days of receipt of the request for disenrollment.

(e) The CCO AR shall provide the affected member with written notice of their disenrollment within five business days after the Authority has approved the MCE's request for disenrollment. A copy of the member notice shall be sent to the MCE, which the MCE shall distribute to the member's care team. A copy of the member notice shall be placed in the member's case file maintained by the Authority. The notice of disenrollment provided to the member shall include all of the following information:

(A) The disenrollment date;

(B) The reason for disenrollment;

(C) Information regarding the member's right to file a grievance and their administrative hearing rights; and

(D) All applicable statutory and regulatory support for the decisions made and the member's rights. A copy of the member's notice shall be included in OHA's record of the request and provided to the MCE for distribution the member's care team.

(f) The date of disenrollment shall be effective ten calendar days after the date of the member's disenrollment notice, unless:

(A) The member files a grievance or otherwise requests a hearing, in which case disenrollment is tolled pending the outcome of any and all final administrative processes. Upon final decision by an administrative law judge to uphold the Authority's decision to grant disenrollment, or if the member chooses not to appeal any grievance that results in upholding the approval of disenrollment, the member's disenrollment shall become effective immediately upon such decisions; or

(B) In cases where the member had a CCO aligned Medicare Advantage plan the date of disenrollment from the MCE will be the same date as the disenrollment from the MCE aligned Medicare Advantage Plan approved by CMS.

(7) Enrollment for Authority Approved Disenrollment.

(a) When circumstance permit, the CCO AR shall enroll a member disenrolled under sections (4) or (5) of this rule into another MCE that is contracted for a service area that includes the member's residence; or

(b) When circumstances permit, when there are multiple MCE's contracted for the service area that includes the member's residence, the CCO AR shall coordinate with the member's care team to identify an appropriate MCE; or

(c) When no alternative MCE is available in service area that includes the member's residence, the CCO AR will place an enrollment exemption for the appropriate MCE CCO-A, CCO-B, CCO-E, and CCO-G plans and place the member on Open Card for a twelve month period, after which the CCO AR will reevaluate enrollment options for the member.

(8) Unless specified otherwise in these rules, or in the Authority notification of disenrollment to the MCE, all disenrollments are effective the end of the month the Authority approves the disenrollment.

(a) If the member is no longer eligible for OHP, the effective date of disenrollment shall be the date specified by the Authority.

(b) If the member dies, the last date of enrollment shall be the date of the member's death.

(9) Transfers of 500 or more members.

(a) As specified in ORS 414.647, the Authority may approve the transfer of 500 or more members from one MCE to another MCE if:

(A) The member's provider has contracted with the receiving MCE and the provider has stopped accepting patients from the MCE from which the member is being transferred, or has terminated providing services to members who are enrolled with the MCE from which the member is being transferred;

(B) Members are offered the choice of remaining enrolled in the transferring MCE; and

(C) The member and all family (case) members shall be transferred to the provider's new MCE.

(b) The transfer shall become effective the date on which the provider's contract with their current MCE terminates or otherwise expires, or on another date approved by the Authority.

(c) Members shall not be transferred under this section (9) unless the following conditions have been satisfied:

(A) The Authority has evaluated the receiving MCE and determined that the receiving MCE meets criteria established by the Authority as stated in OAR 410-141-3705 including, but not limited to, ensuring that the MCE 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

(B) The Authority has provided notice of a transfer to members affected by the transfer at least 90 calendar days before the scheduled date of the transfer.

Statutory/Other Authority: ORS 413.042 & 414.065
Statutes/Other Implemented: 414.065 & ORS 414.727

410-141-3815 CCO Enrollment for Temporary Out-of-Area Behavioral Health Treatment Services (Proposed Changes Effective 1/1/22)

(1) 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 410-141-3805 and OAR 410-141-3810 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 410-141-3800 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.

(2) Specific to residential settings specializing in the treatment of Substance Use Disorders (SUD), if the individual is enrolled in a CCO or FFS on the same day the individual is admitted to the residential treatment services, the CCO or FFS 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. Upon discharge, FFS members will, upon the next weekly enrollment period, enroll with the CCO that is contracted for their residential service area.

(3) Home CCO assignment is based on the member's residence. Home CCO enrollment for temporary out-of-area placement shall:

(a) Meet Oregon residency requirements defined in OAR 410-200-0200;

(b) Comply with the CCO enrollment rules specified in OAR 410-141-3805;

(c) Be based on most recent permanent residency and related CCO enrollment history prior to temporary 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 410-141-3810 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.

(4) Home CCO enrollment policy for State Hospital discharges shall be implemented as follows:

(a) Upon State Hospital discharge, the State Hospital Benefit Coordination Unit shall consult and coordinate with the Home CCO for client placement;

(b) Beginning in Contract year 202~~2~~3 (or later if specified by the Authority), if the client is enrolled in a CCO at the time of the acute care admission to the State Hospital when a bed becomes available, 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 CCO's responsibility shall be in accordance with a risk sharing agreement to be entered into between the CCO and the State Hospital, in a form required by the Authority. The individual is presumed to continue to be enrolled in the CCO with which the individual was most recently enrolled.

(5) 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, oral, 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.

(6) 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; or

(b) Home CCO enrollment may create a continuity of care concern, as specified in OAR 410-141-3810. If a continuity interruption to a client's care is indicated, the Authority shall align enrollment with the care and claims history.

(7) Pursuant to OAR 410-141-3810, 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 410-141-3805.

(8) For consideration of disenrollment decisions other than specified in this rule, OAR 410-141-3810 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 410-141-3860. This shall provide for an adequate transition to the next responsible coordinated care organization.

Statutory/Other Authority: ORS 413.042 & ORS 414.610 - 414.685
Statutes/Other Implemented: ORS 413.042 & ORS 414.610 - 414.685

410-141-3835 MCE Service Authorization (Proposed Changes Effective 1/1/22)

(1) Coverage of services is outlined by MCE contract and OHP benefits coverage in OAR 410-120-1210 and 410-120-1160.

(2) A member may access urgent and emergency services 24 hours a day, seven days a week without prior authorization.

(3) The MCE may not require a member to obtain the approval of a primary care physician to gain access to behavioral assessment and evaluation services. A member may self-refer to assessment, evaluation, and behavioral health ~~and~~ services ~~available~~ from the provider network. Members may obtain primary care services in a behavioral health setting, and behavioral health services in a primary care setting without authorization.

(4) A member may access the following behavioral health services without Prior Authorization:

(a) Outpatient behavioral health services including but not limited to;

(A) Specialty programs which promote resiliency and rehabilitative functioning for individual and family outcomes; and

(B) Assertive Community Treatment as defined in OAR 309-019-0105, Enhanced Care Services as defined in OAR 309-019-0105, Enhanced Care Outreach Services as defined in OAR 309-019-015, Wraparound as defined in OAR 309-019-0105, behavior supports, crisis care as defined in OAR 309-019-0105, Respite Care as defined in OAR 309-019-0105, and Intensive Outpatient Services and Supports as defined in OAR 309-019-0165, and Intensive In-Home Behavioral Health Treatment as defined in OAR 309-019-0167.

(b) Behavioral Health Peer Delivered Services as defined in OAR 309-019-0125 from within the MCE's provider network

(c) Medication-Assisted Treatment for Substance Use Disorders as defined in OAR 309-019-0105, including opioid and opiate use disorders, within the MCE's Provider Network without Prior Authorization of payment during the first thirty (30) days of treatment.

(5~~4~~) Contractors must permit out-of-network IHCPs to refer an MCE-enrolled American Indian/Alaska Native to a network provider for covered services as required by 42 CFR 438.14(b)(6).

(6~~5~~) The MCE shall ensure the services are furnished in an amount, duration, and scope that is no less than the amount, duration, and scope for the same services furnished to beneficiaries under FFS Medicaid and as described in ORS chapter 414 and applicable administrative rules, based on the Prioritized List of Health Services and OAR 410-120-1160, 410-120-1210, and 410-141-3830.

(7~~6~~) MCEs may not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of diagnosis, type of illness, or condition of the beneficiary.

(8~~7~~) MCEs shall observe required timelines for standard authorizations, expedited authorizations, and specific OHP rule requirements for authorizations for services, including but not limited to residential treatment or substance use disorder treatment services and requirements for advance notice set forth in OAR 410-141-3885. MCEs shall observe required timely access to service timelines as indicated in OAR 410-141-3515.

(98) MCEs may place appropriate limits on a service authorization based on medical necessity and medical appropriateness as defined in OAR 410-120-0000 or for utilization control provided that the MCE:

(a) Ensures the services are sufficient in amount, duration, or scope to reasonably achieve the purpose for which the services are furnished;

(b) Authorizes the services supporting individuals with ongoing or chronic conditions or those conditions requiring long-term services and supports in a manner that reflects the member's ongoing need for the services and supports;

(c) Provides family planning services in a manner that protects and enables the member's freedom to choose the method of family planning to be used consistent with 42 CFR §441.20 and the member's free choice of provider consistent with 42 USC §1396a(a)(23)(B) and 42 CFR §431.51; and

(d) Ensures compensation to individuals or entities that conduct utilization management activities is not structured to provide incentives for the individual or entity to deny, limit, delay, or discontinue medically necessary services to any member.

(109) For authorization of services:

(a) Each MCE shall follow the following timeframes for authorization requests other than for drug services:

(A) For standard authorization requests for services not previously authorized, provide notice as expeditiously as the member's condition requires and no later than 14 days following receipt of the request for service with a possible extension of up to 14 additional days if the following applies:

(i) The member, the member's representative, or provider requests an extension; or

(ii) The MCE justifies to the Authority upon request a need for additional information and how the extension is in the member's interest.

(B) For notices of adverse benefit determinations that affect services previously authorized, the MCE shall mail the notice at least 10 days before the date the adverse benefit determination takes effect:

(i) The MCE shall make an expedited authorization decision and provide notice as expeditiously as the member's health condition requires and no later than 72 hours after receipt of the request for service, which period of time shall be determined by the time and date stamp on the receipt of the request;

(ii) The MCE may extend the 72-hour period up to 14 days if the member requests an extension or if the MCE justifies to the Authority upon request a need for additional information and how the extension is in the member's interest.

(b) Prior authorization requests for outpatient drugs, including a practitioner administered drug (PAD), shall be addressed by the MCEs as follows:

(A) Respond to requests for prior authorizations for outpatient drugs within 24 hours as described in 42 CFR 438.210(d)(3) and section 1927(d)(5)(A) of the Social Security Act. An initial response shall include:

(i) A written, telephonic or electronic communication of approval of the drug as requested to the member, and prescribing practitioner, and when known to the MCE, the pharmacy; or

(ii) A written notice of adverse benefit determination of the drug to the member, and telephonic or electronic notice to the prescribing practitioner, and when known to the MCE, the pharmacy if the drug is denied or partially approved; or

(iii) A written, telephonic, or electronic request for additional documentation to the prescribing practitioner when the prior authorization request lacks the MCE's standard information collection tools such as prior authorization forms or other documentation necessary to render a decision; or

(iv) A written, telephonic, or electronic acknowledgment of receipt of the prior authorization request that gives an expected timeframe for a decision. An initial response indicating only acceptance of a request shall not delay a decision to approve or deny the drug within 72 hours.

(B) The 72-hour window for a coverage decision begins with the initial date and time stamp of a prior authorization request for a drug;

(C) If the response is a request for additional documentation, the MCE shall identify and notify the prescribing practitioner of the documentation required to make a coverage decision and comply within the following timeframes:

(i) Upon receiving the MCE's completed prior authorization forms and required documentation, the MCE shall issue a decision as expeditiously as the member's health requires, but no later than 72 hours from the date and time stamp of the initial request for prior authorization as follows:

(I) If the drug is approved as requested, the MCE shall notify the member in writing and prescribing practitioner, and when known to the MCE, the pharmacy, telephonically, or electronically; or

(II) If the drug is denied or partially approved, the MCE shall issue a written notice of adverse benefit determination to the member, and telephonic or electronic notice to the prescribing practitioner, and when known to the MCE, the pharmacy.

(ii) If the requested additional documentation is not received within 72 hours from the date and time stamp of the initial request for prior authorization, the MCE shall issue a written notice of adverse benefit determination to the member, and telephonic or electronic notice to the prescribing practitioner, and when known to the MCE, the pharmacy.

(D) The MCE shall provide approved services as expeditiously as the member's health condition requires;

(E) If an emergency situation justifies the immediate medical need for the drug during this review process, an emergency supply of 72 hours or longer shall be made available until the MCE makes a coverage decision.

(c) For members with special health care needs as determined through an assessment requiring a course of treatment or regular care monitoring, each MCE shall have a mechanism in place to allow members to directly access a specialist (for example, through a standing referral or an approved number of visits) as appropriate for the member's condition and identified needs;

(d) Any service authorization decision not reached within the timeframes specified in this rule shall constitute a denial and becomes an adverse benefit determination. A notice of adverse benefit determination shall be issued on the date the timeframe expires;

(e) MCEs shall give the member written notice of any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested or when reducing a

previously authorized service authorization. The notice shall meet the requirements of CFR §438.404 and OAR 410-141-3885;

(f) The MCE and its subcontractors shall have and follow written policies and procedures to ensure consistent application of review criteria for service authorization requests including the following:

(A) MCEs shall consult with the requesting provider for medical services when necessary:

(i) Requesting all the appropriate information to support decision making as early in the review process as possible; and

(ii) Adding documentation in the authorization file on outreach methods and dates when additional information was requested from the requesting provider.

(B) Decisions shall be made by an individual who has clinical expertise in addressing the member's medical, behavioral, or oral health needs or in consultation with a health care professional with clinical expertise in treating the member's condition or disease. This applies to decisions to:

(i) Deny a service authorization request;

(ii) Reduce a previously authorized service request; or

(iii) Authorize a service in an amount, duration, or scope that is less than requested.

(C) MCEs shall have written policies and procedures for processing prior authorization requests received from any provider. The policies and procedures shall specify timeframes for the following:

(i) Date and time stamping prior authorization requests when received;

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

(iii) The specific number of days allowed for follow-up on pended prior authorization requests to obtain additional information;

(iv) The specific number of days following receipt of the additional information that an approval or denial shall be issued;

(v) Providing services after office hours and on weekends that require prior authorization.

(D) An MCE shall make a determination on at least 95 percent of valid prior authorization requests within two working days of receipt of a prior authorization or reauthorization request related to:

(i) Drugs;

(ii) Alcohol;

(iii) Drug services; or

(iv) Care required while in a skilled nursing facility.

(g) MCEs shall notify providers of an approval, a denial, or the need for further information for all other prior authorization requests within 14 days of receipt of the request as set forth in OAR 410-141-3885 unless otherwise specified in OHP program rules:

(A) MCEs shall make three reasonable attempts using two methods to obtain the necessary information during the 14-day period;

(B) If the MCE needs to extend the timeframe, the MCE shall give the member written notice of the reason for the extension;

(C) The MCE shall make a determination as the member's health or mental health condition requires, but no later than the expiration of the extension.

(11) Report to the Authority annually requests for prior authorization. The report shall include:

(a) The number of requests received;

(b) The number of requests that were initially denied and the reasons for the denials, including, but not limited to, lack of medical necessity or failure to provide additional clinical information requested by the insurer;

(c) The number of requests that were initially approved; and

(d) The number of denials that were reversed by internal appeals or external reviews.

Statutory/Other Authority: ORS 413.042, ORS 414.065, 414.651, 414.615, 414.625 & 414.635
Statutes/Other Implemented: ORS 414.065 & ORS 414.610-414.685
History:
DMAP 56-2019, adopt filed 12/17/2019, effective 01/01/2020

410-141-3845 Health-Related Services (Proposed Changes Effective 1/1/22)

(1) The goals of health-related services (HRS) are to promote the efficient use of resources and address members' social determinants of health to improve health outcomes, alleviate health disparities, and improve overall community well-being. Health-related services are provided as a supplement to covered health care services:

(a) HRS may be provided as flexible services or as community benefit initiatives, as those terms are defined below;

(b) CCOs have the flexibility to identify and provide health-related services beyond the list of examples in 45 CFR §§ 158.150, 158.151, as long as the HRS satisfy the requirements of this rule;

(c) As allowed under 42 CFR 438.6(e), MCEs may offer additional services that are separate from HRS and delivered at the complete discretion of the CCO;

(d) HRS may be used to pay for non-covered health care services including physical health, mental health, behavioral health, oral health, and tribal-based services.

(2) To qualify as an HRS within the meaning of this rule, a service must meet the following requirements, consistent with 45 C.F.R. § 158.150:

(a) The service must be designed to:

(A) Improve health quality;

(B) Increase the likelihood of desired health outcomes in a manner that is capable of being objectively measured and produce verifiable results and achievements;

(C) Be directed toward either individuals or segments of members, or provide health improvements to the population beyond those enrolled without additional costs for the non-members; and

(D) Be based on any of the following:

(i) Evidence-based medicine; or

(ii) Widely accepted best clinical practice; or

(iii) Criteria issued by accreditation bodies, recognized professional medical associations, government agencies, or other national health care quality organizations.

(b) The service must be primarily designed to achieve at least one of the following goals:

(A) Improve health outcomes compared to a baseline and reduce health disparities among specified populations;

(B) Prevent avoidable hospital readmissions through a comprehensive program for hospital discharge;

(C) Improve patient safety, reduce medical errors, and lower infection and mortality rates;

(D) Implement, promote, and increase wellness and health activities;

(E) Support expenditures related to health information technology and meaningful use requirements necessary to accomplish the activities above that are set forth in 45 CFR 158.151 that promote clinic community linkage and referral processes or support other activities as defined in 45 CFR 158.150.

(c) The following types of expenditures and activities are not considered HRS:

(A) Those that are designed primarily to control or contain costs;

(B) Those that otherwise meet the definitions for quality improvement activities but that were paid for with grant money or other funding separate from revenue received through a CCO's contract;

(C) Those activities that may be billed or allocated by a provider for care delivery and that are, therefore, reimbursed as clinical services;

(D) Establishing or maintaining a claims adjudication system, including costs directly related to upgrades in health information technology that are designed primarily or solely to improve claims payment capabilities or to meet regulatory requirements for processing claims, including maintenance of ICD-10 codes sets adopted pursuant to the Health Insurance Portability and Accountability Act (HIPAA), 42 U.S.C. § 1320d-2, as amended;

(E) That portion of the activities of health care professional hotlines that do not meet the definition of activities that improve health quality;

(F) All retrospective and concurrent utilization review;

(G) Fraud prevention activities;

(H) The cost of developing and executing provider contracts and fees associated with establishing or managing a provider network, including fees paid to a vendor for the same reason;

(I) Provider credentialing;

(J) Costs associated with calculating and administering individual member incentives; and

(K) That portion of prospective utilization that does not meet the definition of activities that improve health quality.

(3) CCOs shall implement policies and procedures (P&Ps) for HRS. These P&Ps shall be submitted to the Authority for approval:

(a) HRS P&Ps shall encourage transparency and provider and member engagement, reflect streamlined administrative processes that do not create unnecessary barriers, and provide for accountability;

(b) A CCO's HRS spending on community benefit initiatives shall promote alignment with the priorities identified in the CCO's community health improvement plan, and with any HRS community benefit initiative spending priorities identified by the Authority;

(c) The P&P shall describe how HRS spending decisions are made, including the role of the CAC and tribes in community benefit initiatives spending decisions;

(d) CCOs shall not limit the range of permissible health-related services by any means other than by enforcing the limits defined in this rule.

(4) Flexible services are cost-effective services offered to an individual member as an adjunct to covered benefits. Flexible services shall be consistent with the member's treatment plan as developed by the member's care team and agreed to by the CCO. The care team and the CCO shall work with the member and, as appropriate, the family of the member in determining the HRS needed to supplement the member's care.~~ These services shall be documented in the member's treatment plan and clinical record~~:

(a) CCOs shall provide members with a written notification of a refusal of individual flexible services request and shall copy any representative of the member and any provider who made or participated in the request on the member's behalf. The written notification shall inform the member and provider of the member's right to file a grievance in response to the outcome;

(b) A CCO's refusal to permit an individual flexible service request is not an "adverse benefit determination" within the meaning of OAR 410-141-3875. CCOs shall have written procedures to acknowledge the receipt, disposition, and documentation of each grievance from members, which shall be modelled on the procedures specified in 42 CFR 438.402-408 and OAR 410-141-3835 through 3915.

(5) Community benefit initiatives are community-level interventions that include, but are not necessarily limited to, members and are focused on improving population health and health care quality. CCOs shall designate a role for the community advisory council in health-related services community benefit initiative spending decisions as provided in OAR 410-141-3735.

(6) CCOs shall submit their financial reporting for health-related services as directed through the CCO contract and in compliance with 42 CFR 438.8 Medical Loss Ratio (MLR).

(7) Except as provided in section (4), members have no appeal or hearing rights in regard to a refusal of a request for HRS.

Statutory/Other Authority: ORS 413.042
Statutes/Other Implemented: ORS 413.042

410-141-3850 Transition of Care (Proposed Changes Effective 1/1/22)

(1) This rule applies to care of a Medicaid member who is enrolled in a CCO (the "receiving CCO") immediately after disenrollment from a "predecessor plan," which may be another CCO (including disenrollment resulting from termination of the predecessor CCO's contract) or Medicaid fee-for-service (FFS). This rule does not apply to a member who is ineligible for Medicaid or who has a gap in coverage following disenrollment from the predecessor plan.

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

(a) "Continued Access to ~~Care~~Services" means making available to the member services and prescription drug coverage consistent with the access they previously had including permitting the member to retain their current provider, even if that provider is not in the CCO network., ~~during a member's transition of care from the predecessor plan to the receiving CCO, providing access without delay to:~~

~~(A) Medically necessary covered services;~~

~~(B) Prior authorized care;~~

~~(C) Prescription drugs; and~~

~~(D) Care coordination, as defined in OAR 410-141-3860 and 410-141-3870.~~

(b) "Medically Fragile Children" as defined by OAR 411-350-0020 means children that have a health impairment that requires long-term, intensive, specialized services on a daily basis, who have been found eligible for MFC services by the Department of Human Services (DHS);

~~(c) "Prior Authorized Care" means covered services that were authorized by the predecessor plan. This term does not, however, include health-related services approved by the predecessor plan;~~

(~~d~~c) "Transition of Care Period" means the period of time after the effective date of enrollment with the receiving CCO, during which the receiving CCO must provide continued access to services. The transition of care period lasts for:

(A) Ninety days for members who are dually eligible for Medicaid and Medicare; or

(B) For other members, the shorter of:

(i) Thirty days for physical and oral health and 60 days for behavioral health; or

(ii) Until the enrollee's new PCP (oral or behavioral health provider, as applicable to medical care or behavioral health care services) reviews the member's treatment plan; or the minimum or authorized prescribed course of treatment has been completed.

(3) CCOs must implement and maintain a transition of care policy that, at a minimum, meets the requirements defined in this rule and 42 CFR § 438.62(b). A receiving CCO must provide continued access to services to, at minimum, the following members:

(a) Medically Fragile Children;

(b) Breast and Cervical Cancer Treatment program members;

(c) Members receiving CareAssist assistance due to HIV/AIDS;

(d) Members receiving services for end stage renal disease, prenatal or postpartum care, transplant services, radiation, or chemotherapy services; and

(e) Any members who, in the absence of continued access to services, may suffer serious detriment to their health or be at risk of hospitalization or institutionalization.

(4) ~~Receiving CCO obligations d~~During the ~~t~~Transition of ~~c~~Care ~~p~~Period the receiving CCO shalI~~s~~ ensure that any member identified in section (3):

(a)~~ The receiving CCO shall ensure that any member identified in section (3) has ~~Is provided with ~~c~~Continued ~~a~~Access to ~~care ~~Services and has support necessary to access those services such as~~and~~ Non-Emergency Medical Transportation (NEMT);

(b) ~~The receiving CCO shall permit the member to ~~Is permitted to continue receiving services from the member's previous provider, regardless of whether the provider participates in the receiving CCO's network

(c) Is referred to appropriate providers of services that are in the network at the duration of the Transition of Care period.

~~, until one of the following occurs:~~

~~(A) The minimum or authorized prescribed course of treatment has been completed; or~~

~~(B) The reviewing provider concludes the treatment is no longer medically necessary. For specialty care, treatment plans must be reviewed by a qualified provider.~~

(~~c~~d) Notwithstanding section (4)(b), the receiving CCO is responsible for continuing the entire course of treatment with the recipient's previous provider as described in the following service-specific transition of care period situations:

(A) Prenatal and postpartum care;

(B) Transplant services through the first-year post-transplant;

(C) Radiation or chemotherapy services for the current course of treatment; or

(D) Prescriptions with a defined minimum course of treatment that exceeds the transition of care period.

(~~d~~e) Where this section (4) allows the member to continue using the member's previous provider, the receiving CCO shall reimburse non-participating providers consistent with OAR 410-120-1295 at no less then Medicaid fee-for-service rates;

(f~~e~~) The receiving CCO is not financially responsible for ~~paying for~~ a continuous inpatient hospitalization ~~or post hospital extended care~~ for which a predecessor CCO was responsible under its contract, in accordance with OAR 410-141-3805.

(5) After the ~~t~~Transition of ~~c~~Care ~~p~~Period ends, the receiving CCO remains responsible for care coordination and discharge planning activities as described in OAR 410-141-3860 and OAR 410-141-3870.

~~(6) A receiving CCO shall obtain written documentation as necessary for continued access to care from the following:~~

~~(a) The Authority's clinical services for members transferring from FFS;~~

~~(b) Other CCOs; and~~

~~(c) Previous providers, with member consent when necessary.~~

(6) The Predecessor Plan shall fully and timely comply with request for historical utilization data and clinical records from the receiving CCO.

~~(7) During the transition of care period, a receiving CCO shall honor any written documentation of prior authorization of ongoing covered services:~~

(a) CCOs shall not delay the provision of services ~~authorization for the covered service~~ if ~~written documentation of prior authorization~~ historical utilization data and clinical records is not available in a timely manner;

(b) In such instances, the CCO is required to approve claims for which it has received no ~~written documentation~~ historical utilization data and clinical records during the transition of care time period, as if the covered services were prior authorized~~.~~

(7~~8~~) ~~The predecessor plan~~CCOs shall have a process ~~comply with~~ for the electronic exchange~~requests from the receiving CCO for complete historical utilization data within seven calendar days of the request from the receiving CCO.~~

of, at a minimum, the data classes and elements included in the content standard adopted at 45 CFR 170.213. Such information must be incorporated into the CCO's records about the current member. With the approval and at the direction of a current or former enrollee or the enrollee's personal representative, the CCO must:

(A) Receive all such data for a current member from any other payer that has provided coverage to the enrollee within the preceding 5 years;

(B) At any time the member is currently enrolled in CCO and up to 5 years after disenrollment, send all such data to any other payer that currently covers the enrollee or a payer the enrollee or the enrollee's personal representative specifically requests receive the data; and

(C) Send data received from another payer under this paragraph in the electronic form and format it was received. ~~(a) Data shall be provided in a secure method of file transfer;~~

~~(b) The minimum elements provided are:~~

~~(A) Current prior authorizations and pre-existing orders;~~

~~(B) Prior authorizations for any services rendered in the last 24 months;~~

~~(C) Current behavioral health services provided;~~

~~(D) List of all active prescriptions; and~~

~~(E) Current ICD-10 diagnoses.~~

(7~~9~~) The receiving CCO shall follow all service authorization protocols outlined in OAR 410-141-3835 and give the member written notice of any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested or when reducing a previously authorized service authorization. The notice shall meet the requirements of 42 CFR §438.404 and OAR 410-141-3885.

Statutory/Other Authority: ORS 413.042

Statutes/Other Implemented: ORS 414.065

410-141-3865 Care Coordination Requirements (Proposed Changes Effective 1/1/22)

(1) CCOs will ensure continuous care management for all members.

(2) For the purpose of OARs 410-141-3860 – 410-141-3870, the following meanings apply:

(a) “Health Risk Screening” means:

(A) A systematic collaborative approach by the CCO and provider to collecting information from a Member about key areas of their health for the purpose of:

(i) Assessing the Member’s health,

(ii) Evaluating the Member’s level of health risk, and

(iii) Providing the Member with individualized feedback about the results of the screening and evaluation with the goal of motivating behavioral changes to reduce health risks, maintain health, and prevent disease.

(B) Results of the Health Risk Screening shall be documented in the member’s care plan.

(C) Health Risk Screenings are usually administered through a survey or questionnaire. Suggested areas of information to collect include questions, depending on the Member’s age, regarding:

(i) Demographics, such as age, gender, relationship status;

(ii) Lifestyle behaviors, such as exercise, eating habits, alcohol and tobacco use, activities of daily living;

(iii) Living Conditions such as access to food, housing and related living conditions;

(iv) Behavioral/emotional health, such as stress, mood, life events, abuse;

(v) Physical health, such as weight, height, blood pressure; and

(vi) Personal and family health history.

(b) “Intensive Care Coordination (ICC) Assessment” means the utilization of standardized tools, instruments, or processes for the purpose of identifying, and creating individual, personalized treatment and service plans to address the specific physical, behavioral, oral, and social needs of Priority Population Members, as well as other Members who have been identified, as a result of their Health Risk Screenings, as potentially in need of ICC Services, or having experienced a triggering event as set forth in OAR 410-141-3870(9).

(3) CCOs shall conduct a health risk screening, which shall include a screening for behavior health issues, for each new member in accordance with OAR 410-141-3870. This screening is distinct from the assessment of special health care needs:

(a) CCOs must use a screening process to evaluate all members for critical risk factors that trigger the need for intensive care coordination for members with special health care needs;

(b) Members shall be screened upon initial enrollment with their CCO. This screening shall be completed as follows:

(A) Within 90 days of the effective date of initial enrollment;

(B) Within 30 days of the effective date of initial enrollment when the member is:

(i) Referred; or

(ii) Receiving Medicaid-funded long-term care, services and supports (LTSS); or

(iii) Is a member of a priority population as such term is defined in OAR 410-141-3870(2); or

(C) Sooner than required under (A) or (B) if required by the member's health condition.

(c) CCOs shall rescreen members annually or sooner if there is a change in health status indicating need for an updated assessment. Members shall be rescreened in accordance with this section (c) even if they have previously declined care coordination or ICC services;

(d) If a member's health risk screening indicates that they meet criteria for ICC services, the CCO shall conduct, in accordance with OAR 410-141-3870, an ICC assessment within 30 days of completing the health risk screening;

(e) All Screenings and assessments shall be trauma-informed, culturally responsive and linguistically appropriate and person-centered.

(4) CCOs shall document all screenings and assessments in the member's case file:

(a) If a CCO requires additional information from the member to complete a screening or assessment, the CCO shall document all attempts to reach the member by telephone and mail;

(b) CCOs shall maintain all screening and assessment documentation in accordance with OAR 410-141-3520;

(c) CCOs shall share the results of member assessments and screenings consistent with ORS 414.679 and all other applicable state and federal privacy laws with the following:

(A) Participating medical providers serving the member, who are encouraged to integrate the resulting care plan into the individual's medical record;

(B) The state or other MCEs serving the member;

(C) Members receiving LTSS and, if approved by the member, their case manager and their LTSS provider, if approved by the member; and

(D) With Medicare Advantage or DSNP plans serving dual eligible members.

(5) CCOs shall have processes to ensure review of a member's potential need for long-term services and supports (LTSS) and for identifying those members requiring referral to the Department for LTSS.

(6) CCOs shall require their care coordinators to develop, and CCOs shall require their provider network to use, individualized care plans to the extent feasible to address the supportive and therapeutic needs of each member, particularly those with ICC needs, including those with serious and persistent mental illness receiving home and community-based services covered under the state's 1915(i) State Plan Amendment and those receiving LTSS.

(7) A member's care plan must at a minimum:

(a) Incorporate information from treatment plans from providers involved in the member's care, and, if appropriate and with consent of the member, information provided by community partners;

(b) Contain a list of care team members, including contact information and role, compiled in cooperation with the member;

(c) Make provision for authorization of services in accordance with OAR 410-141-3835;

(d) For members enrolled in ICC or a condition-specific program, intensive care coordination plans (ICCP) must be developed within 10 days of enrollment in the ICC program and updated every 90 days, or sooner if health care needs change.

(8) Care plans must reflect the member's preferences and goals, and if appropriate, family or caregiver preferences and goals:

(a) Care plans shall be trauma-informed, culturally responsive and linguistically appropriate and person-centered;

(b) To ensure engagement and satisfaction with care plans, care coordinators shall:

(A) Actively engage members in the creation of care plans;

(B) Ensure members understand their care plans; and

(C) Ensure members understand their role and responsibilities outlined in their care plans.

(c) Care coordinators shall actively engage caregivers in the creation of member care plans and shall ensure that they understand their role as outlined in the care plan and that they feel equipped to fulfill their responsibilities;

(d) If participation in creating a member's care plan would be significantly detrimental to the member's care or health, the member, the member's caregiver, or the member's family may be excluded from the development of a care plan. The CCO must document the reasons for the exclusion, including a specific description of the risk or potential harm to the member, and describe what attempts were made to ameliorate the risk(s). This decision must be reviewed prior to each plan update, and the decision to continue the exclusion shall be documented as above;

(e) Members shall be provided a copy of their care plan at the time it is created, and after any updates or changes to the plan. However, if providing the member with a copy of their care plan would be significantly detrimental to their care or health, the care plan may be withheld from the member. CCOs must document the reasons for withholding the care plan, including a specific description of the risk or potential harm to the member, and describe what attempts were made to ameliorate the risk(s). This decision must be reviewed prior to each plan update, and the decision to continue withholding the care plan shall be documented as above.

(9) A member may decline care coordination and ICC. CCOs shall explicitly notify members that participation in care coordination or ICC is voluntary, and that treatment or services cannot be denied as a result of declining care coordination.

(10) Care coordinators shall perform their care coordination tasks in accordance with the following principles:

(a) Use trauma informed, culturally responsive and linguistically appropriate care, motivational interviewing, and other patient-centered tools to actively engage members in managing their health and well-being;

(b) Work with members to set agreed-upon goals with continued CCO network support for self-management goals;

(c) Promote utilization of preventive, early identification and intervention, and chronic disease management services;

(d) Focus on prevention, and when prevention is not possible, manage exacerbations and unanticipated events impacting progress toward the desired outcomes of treatment;

(e) Provide evidence-based condition management and a whole person approach to single or multiple chronic conditions based on goals and needs identified by the individual;

(f) Promote medication management, intensive community-based services and supports and, for ICC members, peer-delivered services and supports; and

(g) Have contact with, if the member is participating in a condition-specific program, the active condition-specific care team at least twice per month, or sooner if clinically necessary for the member's care.

(11) Care coordinators shall promote continuity of care and recovery management through:

(a) Episodes of care, regardless of the member's location;

(b) Monitoring of conditions and ongoing recovery and stabilization;

(c) Adoption of condition management and a whole person approach to single or multiple chronic conditions based on the goals and needs identified by the individual, including avoidance and minimization of acute events and chronic condition exacerbations; and

(d) Engaging members, and their family and caregivers as appropriate.

(e) For FBDE members, engagement of member Medicare providers and, when applicable, member Medicare Advantage or DSNP care coordination team, in order to reduce duplication, share assessments, coordinate NEMT, address member language or disability access needs, coordinate referrals, and ensure effective transitions of care.

(12) CCOs must facilitate transition planning for members. In addition to the requirements of 410-141-3860, care coordinators shall facilitate transitions and ensure applicable services and appropriate settings continue after discharge by taking the steps set forth below.

(a) Taking an active role in discharge planning from a condition-specific facility including, without limitation, acute care or behavior rehabilitation services facilities.

(b) For discharges from the State Hospital and residential care, the care coordinator shall do all of the following:

(A) Have contact with the member no less than two times per month prior to discharge and two times within the week of discharge;

(B) Assist in the facilitation of a warm handoff to relevant care providers during transition of care and discharge planning; and

(C) Engage with the member, face to face, within two days post discharge.

(c) For discharges from an acute care admission, the care coordinator shall have contact with the member on a face-to-face basis whenever possible, as follows:

(A) Within one business day of admission;

(B) Two times per week while the member is in acute care; and

(C) No less than two times per week within the week of discharge.

(d) Prior to discharge from any residential, inpatient, long-term care, or other similarly licensed care facility, care coordinators shall conduct a transition meeting to facilitate development of a transition plan for both applicable services and appropriate settings. This meeting must be held 30 days prior to the member's return to the CCO's service area or, if applicable, to another facility or program or as soon as possible if the CCO is notified of impending discharge or transition with less than 30 days' advance notice. The discharge plan must include a description of how treatment and supports for the member will continue;

(e) In the event a member has a lapse in Medicaid coverage while admitted to a hospital, residential, inpatient, long-term care, or other similarly licensed in-patient facility, CCOs must also, in addition to providing the services set forth in subsections (a)-(d) of this section (12) of this rule, oversee management of the member's care, work to establish services that may be needed but currently are not available in their service areas, and if eligible, assist in the reinstatement of Medicaid coverage. The CCO's obligation to provide such services shall continue for the period of 60 days from the date the member lost Medicaid coverage or until the member's discharge, whichever occurs sooner.

(13) CCOs shall ensure care coordinators are providing the required and appropriate behavioral, oral, and physical health care services and supports to members. The individual(s) tasked with responsibility for supervising care coordinators, whether employed by a CCO or employed by a Subcontractor providing care coordination services, shall be;

(a) A~~a~~ licensed master's-level mental health professional, or;

(b) A licensed nurse by the State of Oregon, holding a Bachelor's degree or higher in nursing.

(14) CCOs shall not subcontract or otherwise delegate the responsibility for ensuring any subcontracted care coordination services and activities meet the requirements set forth in this rule, OARs 410-141-3860, 410-141-3870, and any other applicable care coordination requirements.

Statutory/Other Authority: 414.615, 414.625, 414.635, 414.651 & ORS 413.042
Statutes/Other Implemented: ORS 414.610–414.685

410-141-3870 Intensive Care Coordination (Proposed Changes Effective 1/1/22)

(1) CCOs are responsible for Intensive Care Coordination (ICC) services. The requirements described in this rule are in addition to the general care coordination requirements and health risk screenings described in OAR 410-141-3860 and 410-141-3865.

(2) “Prioritized Populations” means individuals who:

(a) Are older adults, individuals who are hard of hearing, deaf, blind, or have other disabilities;

(b) Have complex or high health care needs, or multiple or chronic conditions, or SPMI, or are receiving Medicaid-funded long-term care services and supports (LTSS);

(c) Are children ages 0-5:

(A) Showing early signs of social/emotional or behavioral problems, or

(B) Have a Serious Emotional Disorder (SED) diagnosis;

(d) Are in medication assisted treatment for SUD;

(e) Are women who have been diagnosed with a high-risk pregnancy;

(f) Are children with neonatal abstinence syndrome;

(g) Children in Child Welfare;

(h) Are IV drug users;

(i) People with SUD in need of withdrawal management;

(j) Have HIV/AIDS or have tuberculosis;

(k) Are veterans and their families; and

(L) Are at risk of first episode psychosis, and individuals within the Intellectual and developmental disability (IDD) populations.

(3) “Intensive Care Coordinator” (ICC Care Coordinator) means a person coordinating ICC services as defined in this rule.

(4) “Intensive Care Coordination Plan” (ICC Plan) means a collaborative, comprehensive, integrated and interdisciplinary-focused written document that includes details of the supports, desired outcomes, activities, and resources required for an individual receiving ICC Services to achieve and maintain personal goals, health, and safety. It identifies explicit assignments for the functions of specific care

team members, and addresses interrelated medical, social, cultural, developmental, behavioral, educational, spiritual and financial needs in order to achieve optimal health and wellness outcomes.

(5) All members of prioritized populations shall be automatically assessed for ICC services within 10 calendar days of completion of the health risk screening, or sooner if required by their health condition. Children who are members of a prioritized population shall be provided behavioral health services according to presenting needs.

(6) CCOs shall also conduct an ICC assessment of other members, including children age 18 and under, upon referral or after an initial-health risk screening as set forth below in this section (6). All referrals for ICC assessments shall be responded to by the CCO within one business day of receipt of the referral and the ICC assessment shall be completed within 30 days after receipt of referral or completion of an initial health-risk screening. ICC assessments shall be conducted when:

(a) A health risk screening conducted under, and in accordance with, OAR 410-141-3865 indicates a member has special health care needs or other needs or conditions that may indicate a need for ICC services;

(b) A member refers themselves;

(c) A member's representative or provider, including a home and community- based services provider, refers the member; or

(d) Upon referral of any medical personnel serving as a member's LTCSS case manager.

(7) CCOs shall have policies and procedures in place that enable early identification of members who may have ICC needs. CCOs shall have established process for responding to all requests for ICC assessments or services, which shall include, without limitation, the requirement to respond to all requests or referrals for ICC assessments or services within one business day.

(8) ICC assessments shall identify the physical, behavioral, oral and social needs of a member.

(9) For those members not receiving ICC services, and upon the occurrence of any of the reassessment triggering events listed below in subsections (c)(A) through (S) of this section (9), CCOs shall conduct new health risk screenings, and, as applicable, reassess members for ICC eligibility revise care plans, and ensure care coordination efforts are undertaken in accordance with OAR 410-141-3865. Contact shall be made with the member by the care coordinator within seven calendar days of receipt of notice of the reassessment triggering event:

(a) For those members receiving ICC services and upon the occurrence of any of the triggering events listed below in subsections (b)(A) through (S) of this section (9), ICC care coordinators shall, if in the ICC care coordinator's professional opinion it is necessary to reassess the members for ICC services, update the members' ICC plan, and ensure care coordination efforts are undertaken in accordance with OAR 410-141-3865 and this rule. Contact shall be made with the member by the ICC care coordinator within

three calendar days of receipt of notice of a reassessment triggering event;

(b) Reassessment triggering events include all of the following events:

(A) New hospital visit (ER or admission);

(B) New high-risk pregnancy diagnosis;

(C) New chronic disease diagnosis (includes behavioral health);

(D) New behavioral health diagnosis;

(E) Opioid drug use;

(F) IV drug use;

(G) Suicide attempt, ideation, or planning (identification may be through the member's care team, through diagnoses, or from the member or member's supports);

(H) New I/DD diagnosis;

(I) Events placing the member at risk for adverse child experiences, such as DHS involvement or new reports of abuse or neglect to Child Welfare Services or Adult Protective Services;

(J) Recent homelessness;

(K) Two or more billable primary Z code diagnoses within one month;

(L) Two or more caregiver placements within past six months;

(M) An exclusionary practice, such as being asked not to return to day care, for children aged 0-6, or suspension, expulsion, seclusion, or in-school suspension, for school-aged children;

(N) Discovery of new or ongoing behavioral health needs;

(O) Discharge from a residential setting or long-term care back to the community;

(P) Severe high level of self-reported or detected alcohol or benzodiazepine usage while enrolled in a program of medication assisted treatment;

(Q) Two or more readmissions to an acute care psychiatric hospital in a 6-month period;

(R) Two or more readmissions to an emergency department for a psychiatric reason in a 6-month period; and

(S) Exit from condition-specific program.

(c) Members shall be reassessed for ICC services and care plans or, if applicable, ICC plans shall be revised annually;

(d) Reassessment for ICC services and care plans, or if applicable, ICC plans, revised if necessary, must be performed upon member request.

(10) Members eligible for ICC shall be assigned an ICC care coordinator:

(a) ICC Care coordinator assignments must be made within three business days of determining a member is eligible for ICC services;

(b) If a member is in a condition-specific program at the time they are determined eligible for ICC services, or enters a condition-specific program while receiving ICC services, then the CCO will appoint the care coordinator of the condition-specific program as the ICC care coordinator for the member while the member is in the condition-specific program. After a member transitions from a condition-specific program, the CCO must reassess the member for ICC services within seven calendar days of the transition and assign a new ICC care coordinator within three business days of the completion of the ICC reassessment;

(c) CCOs shall notify members of their ICC status by at least two means of communication within five business days following the completion of the ICC assessment. Notifications shall include details about the ICC program and the name and contact information of their assigned ICC care coordinator.

(11) CCOs shall implement procedures to share the results of ICC assessment including, without limitation, identifications made as a result of the assessment and intensive care coordination plan (ICCP) created for ICC services. CCOs shall share the results with participating providers serving the member, other parties identified in OAR 410-141-3865 and, for members receiving LTCSS, the results should be shared with the local offices for aging and adults with physical disabilities (APD) and the Office of Developmental Disability Services. Information sharing shall be consistent with ORS 414.679 and applicable state and federal privacy laws and meet timely access standards set forth in in 410-141-3515.

(12) ICC services shall include, without limitation:

(a) Assistance to ensure timely access to and management of medical providers, capitated services, and preventive, physical health, behavioral health, oral health, remedial, and supportive care and services;

(b) Coordination with medical and LTCSS providers to ensure consideration is given to unique needs in treatment planning;

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

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

(13) ICC Care coordinators must provide the following services:

(a) Meet face to face with the member, or make multiple documented attempts to do so, for the initial and exiting appointments. Thereafter, ICC care coordinators must have face-to-face contact with the member individually at least once every three months and make other kinds of contact (face to face when possible) three times a month or more frequently if indicated. If an ICC care coordinator is unable to comply with the member contact requirements, the CCO must document attempts made, barriers, and remediation efforts taken to overcome the barriers to the member contact requirements;

(b) Contact the member no more than three calendar days after receiving notification of a reassessment trigger described in section (9) of this rule. If an ICC care coordinator is unable to make contact with the member within three calendar days of a reassessment trigger, the ICC care coordinator must document in the member's case file all efforts made to contact the member. ICC care coordinators must continue brief contacts with members who have experienced a reassessment trigger as long as deemed necessary by the care team before they revert back to the routine contact requirements under subsection (a) of this section (13);

(c) Contact the member's Primary Care Provider (PCP) within one week of ICC assignment, no less than once a month thereafter, or more often if required by the member's circumstances, to ensure integration of care;

(d) Facilitate communication between and among behavioral and physical health service providers regarding member progress and health status, test results, lab reports, medications, and other health care information when necessary to promote optimal outcomes and reduce risks, duplication of services, or errors. This communication shall provide an interdisciplinary, integrative and holistic care update, including a description of clinical interventions being utilized and member's progress towards goals;

(e) Convene and facilitate interdisciplinary team meetings monthly, or more frequently, based on need. Interdisciplinary team meetings must include the member unless the member declines or the member's participation is determined to be significantly detrimental to the member's health, in accordance with OAR 410-141-3865(7)(d). The ICC care coordinator is responsible for arranging for the PCP or PCP staff to bring material to the meeting. The meetings shall provide a forum to:

(A) Describe the clinical interventions recommended to the treatment team;

(B) Create a space for the member to provide feedback on their care, self-reported progress towards their ICC plan goals and their strengths exhibited in between current and prior meeting;

(C) Identify coordination gaps and strategies to improve care coordination with the member's service providers;

(D) Develop strategies to monitor referrals and follow-up for specialty care and routine health care services, including medication monitoring; and

(E) Align with the member's individual ICC plan.

(f) Convening a post-transition meeting of the interdisciplinary team within 14 days of a transition between levels, settings or episodes of care.

(14) If a member is enrolled in other programs, including condition-specific programs, where there is a care manager, the ICC care coordinator remains responsible for the overall care of the member, while the program-specific care manager shall be responsible for supporting specific needs based on their specialty within the interdisciplinary team.

(15) CCOs shall implement processes for documenting all of the ICC services provided and attempted to be provided to members and for creating and implementing ICC plans for members requiring ICC services. CCOs shall produce ICC plans for each member requiring ICC services. Each ICC plan shall:

(a) Be developed in a person-centered process with providers caring for the member, including any community-based support services and LTSS providers and the member's participation;

(b) Include consultations with any specialist(s) caring for the member and Medicaid funded long-term services and supports providers and case managers or for full benefit dual eligible (FBDE) members, Medicare providers or MCE aligned Medicare Advantage or Dual Special Needs Plan care coordinators;

(c) Be approved by the CCO in a timely manner if CCO approval is required;

(d) In alignment with rules outlined in OAR 410-141-3835 CCO Service Authorization; and

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

(16) CCOs shall periodically inform all participating providers of the availability of ICC and other support services available for members. CCOs shall also periodically provide training for patient-centered primary care homes and other primary care provider staff.

(17) CCO staff providing or managing ICC care coordination services shall be required to:

(a) Be available for training, regional OHP meetings, and case conferences involving OHP clients (or their representatives) in the CCO's service areas who are identified as being of a prioritized population;

(b) If a Member is unable to receive services during normal business hours, the CCO shall provide alternative availability options for the member;

(c) Be trained for, and exhibit skills in, person-centered care planning and trauma informed care; and

communication with and sensitivity to the special health care needs of priority populations. CCOs shall have a written position description for its staff responsible for managing ICC services and for staff who provide ICC services;

(d) CCOs shall have written policies that outline how the level of staffing dedicated to ICC is determined. The ICC policies must include, without limitation, care coordination staffing standards such that the complexity, scope, and intensity of the needs of members receiving ICC services can be met.

(18) Consistent with the requirements under this rule, CCOs shall make Integration and Care Coordination services available during normal business hours, Monday through Friday. Information on ICC services shall be made available when necessary to a member's representative during normal business hours, Monday through Friday. If a Member is unable to receive ICC services, including Intensive Care Coordination Assessments and development of Intensive Care Coordination Plans ~~outside of~~ during- normal business hours, the CCO shall provide alternative availability options for member.

(19) CCOs shall have a process to provide members with special health care needs who are receiving ICC services or are receiving Medicaid-funded LTSS with direct access to a specialist, e.g., a standing referral or an approved number of visits, as appropriate for the member's condition and identified needs. CCOs shall have processes in place to ensure it reviews member needs for LTSS and mechanisms to identify and refer to the Department of human services, inclusive of its area agency on aging, office of developmental disabilities services, and aging and people with disability programs, or, as may be applicable to a 1915(i) provider for LTSS assessment and services.

Statutory/Other Authority: ORS 413.042, 414.615, 414.625, 414.635 & 414.651
Statutes/Other Implemented: ORS 414.610 - 414.685

410-141-3925 Transportation: Vehicle Equipment and Driver Standards

(Proposed Changes Effective 1/1/22)

(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, aerosolizing or vaporizing of inhalants 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) Compliance with all applicable local, state, and federal transportation laws regarding vehicle and passenger safety standards and comfort. All vehicles shall include, without limitation, 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 securely transport members using wheelchairs or stretchers in accordance with the Americans with Disabilities Act of 1990 (as amended) (ADA), Section 504 of the Rehabilitation Act of 1973, and Oregon Revised Statute 659A.103.

(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 rearview mirrors;

(b) Horn;

(c) Heating, air conditioning, and ventilation systems; and

(d) 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;

(b) The driver shall not be included on the exclusion list maintained by the Office of the Inspector General; and

(c) The driver must pass a criminal background check in accordance with ORS 181A.195 and 181A.200, 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 10 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.

(d) The driver must disclose to the CCO or its Subcontracted transportation provider any violation of a state drug law and his or her driving history, including any traffic violations.

(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 three months of the date of hire and at least every three years thereafter;

(c) Completing and maintaining certification for Red Cross-approved First Aid, Cardiopulmonary Resuscitation, and blood spill procedures courses or equivalent prior to driving any members;

(d) Completing the Passenger Service and Safety course or equivalent course within three months of the date of hire and at least every three years thereafter;

(e) Understanding the CCO's established procedures for responding to a member's needs for emergency care should they arise during the ride; and

(f) Understanding of and compliance with all state driving and transportation laws.

(g) Disclosing to the CCO (or its Subcontracted transportation provider) any violation of a state drug law and any changes in his or her driving history, including any traffic violations.

(6) Emergency Medical Technicians (EMT) licensed under OAR Chapter 333, Division 265 may be hired as an NEMT driver provided the CCO:

(a) Verifies the individual's EMT license is current, is in good standing with the Authority, and then re-verifies the license annually;

(b) Verifies the EMT is not on the exclusion list maintained by the Office of the Inspector General;

(c) Verifies the EMT has successfully completed the training required under subsections 5(b) and (d) of this rule.

(d) Conducts its own criminal background check on the EMT in accordance with section (4)(c) of this rule; and

(e) Completes the training required under subsection (5)(a).

(7) 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.

Statutory/Other Authority: ORS 413.042 & ORS 414.625
Statutes/Other Implemented: ORS 414.625

410-141-5000 FINANCIAL SOLVENCY REGULATION: Definitions (Proposed Change Effective 1/1/22)

When used and not otherwise defined in OAR 410-141-5005 through OAR-141-5380, the following terms shall have the meaning given in this section:

(1) “AICPA” means the American Institute of Certified Public Accountants.

(2) “Applicable Law” means,

(a) S.B. 1041;

(b) OAR 410-141-5000 to OAR-141-5380 and;

(c) Any other state or federal laws, rules, regulations or regulatory guidance applicable to the operations of CCOs in this state.

(3) “Assumption Reinsurance Agreement” means a contract that,

(a) Transfers obligations or risks of existing or in-force Member Contracts from a cedent CCO to a reinsurer that acquires the obligations or risks from the cedent, and

(b) Is intended to effect a novation of the transferred Member Contracts with the result that the reinsurer becomes directly liable to the Members of the transferor and the transferor’s contract obligations to the Members are extinguished.

(4) “Board” means the board of directors or other equivalent governing body of a company that is vested by the company’s organizational document(s) with responsibility and authority for the governance and overall management of the affairs of the company, irrespective of the name by which the governing body or the members of that governing body are designated, except that:

(a) An individual or a group of individuals is not the board of directors because of powers delegated to the individual or group by provisions in the articles of incorporation or other equivalent organizational documents authorizing the individual or group to exercise some or all of the powers which would otherwise be exercised by a board; and

(b) A coordinated care organization may have a governing body as required by ORS 414.625(2)(o) that is not the board of the CCO entity.

(5) “Capitated Subcontractor” means a third-party provider that enters into a Sub-capitation Arrangement with a CCO for any portion of the health care services covered by the CCO’s agreement with the Authority.

(6) “CGAD Report” means the corporate governance annual disclosure report described at OAR 410-141-5045.

(7) “DCBS” means the Department of Consumer and Business Services.

(8) “Delinquency proceeding” means any proceeding commenced against a CCO for the purpose of liquidating, rehabilitating or conserving the CCO.

(9) “Director” means, as context requires;

(a) A member of the board of directors or other equivalent governing body of a company that is vested by the company's organizational document(s) with the responsibility and authority for the governance and overall management of the affairs of the company; or

(b) The Director of the Authority.

(10) "Impaired" with respect to a CCO means that the CCO's assets do not exceed its liabilities and its required capitalization.

(11) "Loss Protection Program" means a program or set of arrangements maintained by a CCO that collectively are designed and operate to protect the CCO against catastrophic and unexpected loss or expenses related to capitated services the CCO is obligated to provide to its Members.

(12) "Member" means an individual covered by, and entitled to managed health care services under, a CCO's contract with the Authority.

(13) "Member Contract" means the CCO's agreement to provide managed health care services to a Member pursuant to the CCO's contract with the Authority.

(14) "NAIC" means the National Association of Insurance Commissioners.

(15) "NAIC Forms and Instructions" means the current financial statement blanks, forms and instructions for health insurers as published and as revised by the NAIC from time to time.

(16) "Qualified United States Financial Institution" means an institution that,

(a) Is organized, or, in the case of a United States branch or agency office of a foreign banking organization, is licensed, under the laws of the United States or any state thereof and has been granted authority to operate with fiduciary powers, and

(b) Is regulated, supervised and examined by federal or state authorities having regulatory authority over banks and trust companies.

(17) "Political subdivision" means, consistent with ORS 192.005, any city, county, district or any other municipal or public corporation in the State of Oregon

(18~~7~~) "Primary Reserve" means the primary Restricted Reserve Fund required by OAR 410-141-5285.

(19~~8~~) "Receiver" means a receiver, rehabilitator, liquidator or conservator, as the contract may require.

(~~19~~20) "Restricted Reserve Account" means the reserve account required by OAR 410-141-5285.

(2~~0~~1) "Restricted Reserve Funds" means the funds required to be deposited and maintained in the Restricted Reserve Account under OAR 410-141-5285.

(22~~1~~) "Restricted Reserve" means the Restricted Reserve Account, the Primary Reserve, the Secondary Reserve and the Restricted Reserve Funds required by OAR 410-141-5285.

(23~~2~~) "Secondary Reserve" means the secondary Restricted Reserve Fund required by OAR 410-141-5285.

(2~~3~~4) “S.B. 1041” means 2019 Oregon Laws Ch. 478 (Enrolled S.B. 1041), as approved and enacted on June 20, 2019.

(25~~4~~) “Statutory Accounting Principles” means generally accepted statutory accounting principles for health insurers as prescribed, adopted or otherwise approved by DCBS for the financial and solvency regulation of health insurers under Oregon law, as supplemented by generally accepted statutory accounting principles prescribed, adopted or otherwise approved by the NAIC, including without limitation, those accounting practices, principles and procedures set forth in the NAIC’s Accounting Practices and Procedures Manual.

(26~~5~~) “Sub-Capitated Arrangement” means a contract or other arrangement between the CCO and a Sub-Capitated Counterparty under which the Sub-Capitated Counterparty agrees to provide, as subcontractor to the CCO, certain of the health care services required of the CCO under its agreement with the Authority in return for a fixed capitation payment, the effect of which is to transfer claim frequency and utilization risk to the third-party provider.

(27~~6~~) “Sub-Capitated Counterparty” means the third-party provider under a Sub-Capitated Arrangement with a CCO.

(28~~7~~) “SVO” means the Securities Valuation Office of the NAIC.

Statutory/Other Authority: ORS 413.042, 414.615, 414.625, 414.635 & 414.651
Statutes/Other Implemented: ORS 414.610 - 414.685

410-141-5185 CAPITALIZATION: Restricted Reserve Account (Proposed Change Effective 1/1/22)

(1) A CCO shall establish a Restricted Reserve Account and maintain sufficient Restricted Reserve Funds in the Restricted Reserve Account to meet the Authority's Primary Reserve and Secondary Reserve requirements. Restricted Reserve Funds shall be held for the purpose of:

(a) Making payments to providers in the event of the CCO's insolvency, and

(b) Assuring the CCO's performance in the event its contract with the Authority is terminated.

(2) A CCO's Primary Reserve and Secondary Reserve balances shall be determined by calculating the CCO's average monthly medical expense incurred, unless the Authority agrees upon an exception to the below calculations.

(a) If a CCO has submitted quarterly financial statements for the current quarter and the prior three quarters, the average monthly medical expense incurred shall be 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.

(b) A newly formed CCO will use an average of hospital and medical expense projected for the first four quarters of operation.

(c) Each quarter, the average expense liability will be recalculated using historical quarter data available.

(d) The Authority may allow a CCO to adjust its calculation of its average monthly medical expenses by excluding any commercial line of business or any Medicare line of business from the "total hospital and medical" expense.

(3) The amount a CCO must deposit and maintain in its Restricted Reserve Account shall be calculated as follows:

(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 shall be deposited into, and maintained in, the Restricted Reserve Account. This amount will be referred to as the CCO's "Primary Reserve" and the CCO shall have no "Secondary Reserve" (hereinafter defined) until such time as the CCO's average monthly medical expense exceeds $250,000.

(b) If a CCO's average monthly medical expense is greater than $250,000, an amount equal to fifty percent (50%) of the difference between the average monthly medical expense and the Primary Reserve balance of $250,000 shall be deposited into, and maintained in, the Restricted Reserve Account. This additional amount is referred to as the CCO's "Secondary Reserve."

(c) A CCO's Primary Reserve and, if applicable, its Secondary Reserve shall be recalculated and the balance of the Restricted Reserve Account shall be adjusted accordingly each quarter based upon the CCO's then current average monthly medical expense.

(d) The Authority may allow a CCO to adjust its calculation of its Primary Reserve and Secondary Reserve, based on the CCO's use of value-based payments.

(4) A CCO shall establish its Restricted Reserve Account with a third-party financial institution for the purpose of holding the CCO's Primary Reserve and Secondary Reserve.

(5) The Authority's model depository agreement shall be used by the CCO to establish its 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 prior written approval.

(6) The CCO shall not withdraw funds, change third party financial institutions, or change account numbers within the Restricted Reserve Account without the prior written consent of the Authority.

(7) A CCO shall submit a copy of the model depository agreement at the time of application. If a CCO requests and receives written authorization from the Authority to make a change to its 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.

(8) The following instruments are considered eligible deposits for the purposes of a CCO's Primary Reserve and Secondary Reserve:

(a) Cash;

(b) Certificates of Deposit; or

(c) Amply secured obligations of the United States or a state;

(d), Amply secured obligations ~~or~~ of ~~a state or~~ a political subdivision ~~thereof~~ as determined by the Authority to be acceptable.

(9) If a CCO has multiple contracts or agreements with the Authority, separate Restricted Reserve Accounts shall be maintained for each contract and agreement, except as required in this subsection. Separate Restricted Reserve Accounts shall not be required for state-funded services and Oregon Health Plan contracts. However, the CCO shall be obligated to maintain actuarially sound and sufficient aggregate loss reserves for all its contractual liabilities, including both contractual liabilities that are supported by a Restricted Reserve Account and those which are not so supported.

(10) CCOs that enter into Sub-Capitation Arrangements for any portion of the health care services covered by the CCO's agreement with the Authority may require that the Capitated Subcontractor establish, fund and maintain a Restricted Reserve Account and Restricted Reserve Funds for the Capitated Subcontractor's portion of the risk assumed. Alternatively, the CCO may elect to establish, fund and maintain a single Restricted Reserve Account for all risk assumed under the agreement with the Authority (including the portion of those risks assumed by the Capitated Subcontractor). In either event, the CCO shall assure that the aggregate of the Restricted Reserve Account(s) and Restricted Reserve Funds comply with the requirements of this section.

(11) All the requirements of this section in respect of a CCO's Restricted Reserve Account shall respectively apply to a Restricted Reserve Account established, funded and maintained by a Capitated Subcontractor under subsection (10).

(12) If a Restricted Reserve Fund of a CCO is held in a combined account or pool with other entities, the CCO and its subcontractors, as applicable, shall provide a statement from the pool or account manager or custodian confirming that the proceeds of the Restricted Reserve Fund shall be available for payment to the CCO and the Authority, on demand, and that no other payee has the contractual right to withdraw the proceeds of the Restricted Reserve Account under or pursuant to the agreement(s) governing administration of the Restricted Reserve Account.

(13) If a CCO wishes to withdraw proceeds from its Restricted Reserve Account in order to cover services under its Member Contracts, the CCO shall provide advance notice to the Authority of the amount to be withdrawn, the reason for withdrawal, when and how the Restricted Reserve Fund will be replenished, and measures to avoid the need for future withdrawals from the Restricted Reserve Account. No such withdrawal shall be made without the prior written approval of the Authority.

Statutory/Other Authority: ORS 413.042, 414.615, 414.625, 414.635 & 414.651
Statutes/Other Implemented: ORS 414.610 - 414.685

NEW RULE: 410-141-5186 CAPITALIZATION: Restricted Reserve Account—Permitted Investments in Obligations with Political Subdivisions; Public Supported Housing (Proposed Effective Date 1/1/22)

(1) With prior written approval from the Authority, a CCO may invest up to 25% of its Primary Reserve and Secondary Reserve with one or more public housing authorities created under ORS 456.055 to 456.235 and governed by a county in the CCO's service area.

(a) The housing authority(ies) must address a documented social determinant of health need for that community.

(b) The CCO shall complete and file with the Authority a Form D as described and required under OAR 410-141-5320 for each housing authority that the CCO contracts with under this section.

(c) The CCO shall complete and file with the Authority the Model Depository Agreement specific to any obligation described in this section that will not be held with a third-party financial institution.

(2) The obligation shall be supported by an agreement between the CCO, the county and the housing authority which outlines the terms of the agreement.

(a) The agreement shall describe the use of the funds provided (e.g. newly constructed vs. purchased; public housing vs. affordable housing vs. mixed income housing; owned vs. operated; type of housing unit such as single-family dwellings, multifamily dwellings, emergency shelters, dwelling accommodations, living accommodations, manufactured dwelling parks, residential units) and how the funds will address a documented social determinant of health need for that community.

(b) The agreement shall require and describe financial reporting requirements including but not limited to audited financial statements.

(c) A draft copy of the agreement shall be included with the Form D submission and reviewed by the Authority.

(3) The obligation will be secured through written guarantees by both the county that governs the housing authority and an entity related to the CCO through ownership, control, or contract that is regulated by or reports to either the Authority or by DCBS.

(a) Separate guarantees shall be obtained from both the county and the entity related to the CCO.

(b) The guarantees shall be unconditional and absolute for the full and prompt payment and performance of all obligations under the promissory note.

(c) The guarantees shall remain in full force and effect and be binding upon guarantors until the promissory note is paid and performed in full.

(d) A draft copy of each guarantee shall be included with the Form D submission and reviewed by the Authority.

(4) The obligation shall be supported by a promissory note between the housing authority and the CCO.

(a) The promissory note shall mature no later than the date of the end of the CCO's current contract.

(b) The promissory note may be extended in the event that the CCO's contract is extended.

(c) A draft copy of the promissory note shall be included with the Form D submission and reviewed by the Authority.

Statutory/Other Authority: ORS 413.042, 414.615, 414.625, 414.635 & 414.651
Statutes/Other Implemented: ORS 414.610 - 414.68