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NOTICE OF PROPOSED RULEMAKING

INCLUDING STATEMENT OF NEED & FISCAL IMPACT

CHAPTER 410
OREGON HEALTH AUTHORITY
HEALTH SYSTEMS DIVISION: MEDICAL ASSISTANCE PROGRAMS

FILED: 10/30/2026 9:10 AM
ARCHIVES DIVISION SECRETARY OF STATE

FILING CAPTION: Update and clarify rule on disenrollment from Coordinated Care Organizations reflecting comprehensive review

LAST DAY AND TIME TO OFFER COMMENT TO AGENCY: 11/21/2026 5:00 PM
The Agency requests public comment on whether other options should be considered for achieving the rule's substantive goals while reducing negative economic impact of the rule on business.

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Filed By:
Darren Coffman
Rules Coordinator

HEARING(S)
Auxiliary aids for persons with disabilities are available upon advance request. Notify the contact listed above.

DATE: 11/17/2026
TIME: 2:00 PM - 2:45 PM
OFFICER: Darren Coffman

REMOTE HEARING DETAILS
MEETING URL: Click here to join the meeting
PHONE NUMBER: 1-669-254-5252
CONFERENCE ID: 1655216507
SPECIAL INSTRUCTIONS:
Meeting ID: 165 521 6507
Passcode: 227596

NEED FOR THE RULE(S):

Perform comprehensive review of rules involving Coordinated Care Organization (CCO) disenrollment, reflect changes

made in the 2027 CCO Model Medicaid Contract and incorporate knowledge gained since they were last amended. These changes were inadvertently left out of the original rulemaking notice of 9/30/26 with other CCO rule changes for a 1/1/27 effective date.

DOCUMENTS RELIED UPON, AND WHERE THEY ARE AVAILABLE:

CCO Model 2027 Medicaid Contract - To be posted at https://www.oregon.gov/oha/HSD/OHP/Pages/CCO-Contract-Forms.aspx

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STATEMENT IDENTIFYING HOW ADOPTION OF RULE(S) WILL AFFECT RACIAL EQUITY IN THIS STATE:

The changes included in this rulemaking do not have a direct impact on OHP members. Any that do would be expected to be experienced across all OHP members without an impact on racial equity.

FISCAL AND ECONOMIC IMPACT:

OHA does not anticipate there will be a fiscal impact from these rule changes.

COST OF COMPLIANCE:
(1) Identify any state agencies, units of local government, and members of the public likely to be economically affected by the rule(s). (2) Effect on Small Businesses: (a) Estimate the number and type of small businesses subject to the rule(s); (b) Describe the expected reporting, recordkeeping and administrative activities and cost required to comply with the rule(s); (c) Estimate the cost of professional services, equipment supplies, labor and increased administration required to comply with the rule(s).

(1) No fiscal impact anticipated.
(2)(a) Providers contracting with CCOs may be impacted indirectly
(b) None
(c) None

DESCRIBE HOW SMALL BUSINESSES WERE INVOLVED IN THE DEVELOPMENT OF THESE RULE(S):

OHP providers were invited to, and did participate in, the RAC.

WAS AN ADMINISTRATIVE RULE ADVISORY COMMITTEE CONSULTED? YES

AMEND: 410-141-3810

RULE SUMMARY: Changes resulting from a comprehensive review of the primary rule on CCO disenrollment that, in addition to generally clarifying language, also: 1) Removes outdated reference to service areas with voluntary enrollment and 2) Breaks out into a new rule those disenrollment requests initiated by a CCO. Replace references to a “member” with “CCO Member” where appropriate.

CHANGES TO RULE:

410-141-3810
Disenrollment from ~~MCE~~CCOs
(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 thirty (30) calendar days of the Authority's automatic or manual enrollment error. If approved, the change would occur on the next available enrollment date;¶
(ii) Members may request to change their MCE enrollment within ninety (90) calendar days of the initial MCE enrollment. If approved, the change would occur on the next available enrollment date;¶
(iii) Members may request to change their MCE enrollment after they have been enrolled with the MCE for at least six (6) 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 MCE 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 FFS at any time subject to the provisions set forth in OAR 410-141-3805(14)(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 an 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 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 MCE 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;¶
(E) If thirty (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 shall 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 MCE within the past three (3) months; or¶
(iii) The member is enrolled with a new 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 sixty (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 MCE in their service area. Where there is a choice among multiple MCEs in the member's service area the member may choose an open plan; however, if the member does not express preference, the Authority shall auto assign on a next weekly basis.¶

(d) Upon approval of a member's disenrollment from a MCE, the member shall join another MCE unless:¶
(A) The member resides in a service area where enrollment is voluntary;¶
(B) The member meets the exemptions to enrollment set forth in OAR 410-141-3805;¶
(C) The member meets disenrollment criteria stated in this rule; or¶
(D) There is not another MCE available and open to new enrollment in the service area.¶
(2) MCE-initiated disenrollment requests for reasons other than fraudulent or illegal acts, uncooperative or disruptive behavior, or credible threats of violence: MCEs may request disenrollment for any of the following reasons. Such requests shall be submitted to the Authority's Client Enrollment Services (CES) unit unless otherwise specified. After review of all necessary documentation submitted with an MCE's request, the Authority shall grant such requests, except the Authority may deny requests based on the reason set forth in subsection (g) below:¶
(a) If the individual is enrolled after the first day of admission to an inpatient setting, the enrollment shall be cancelled as never effective and the individual shall be enrolled in a MCE on the next available enrollment date following discharge from the continuous inpatient stay. This does not apply if the member is a newborn child born to an OHP eligible mother enrolled with an MCE at time of birth in accordance with OARs 410-141-3500 and 410-141-3805;¶
(b) If the MCE determines the member has Third Party Liability (TPL), the MCE 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 MCE shall receive an emailed tracking number following the online report. The MCE 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, the member shall be disenrolled from the MCE effective at the end of the month the TPL is reported, with the exception of:¶
(A) When Good Cause determination is active or concurrently documented, in which case the member shall retain the highest level of CCO coverage as set forth in OAR 410-141-3805(10)(b);¶
(B) Some situations in which the Authority may approve retroactive disenrollment;¶
(C) When the client has dental TPR and is enrolled in the CCOF plan type.¶
(c) If a member has been residing outside the MCE's service area for more than three (3) months unless previously arranged with the MCE, and the member is unable to be reached or has not responded to MCE requests to contact the Authority to update their address. The MCE shall provide written documentation that the member has been residing outside its service area for more than three (3) 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 shall 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 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;¶
(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 from the MCE 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 by an MCE member to law enforcement authorities and to the ODHS Fraud Investigations Unit;¶
(c) When requesting disenrollment based on an MCE 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 the ODHS Fraud Investigations Unit;¶
(d) Based on the evidence presented, the CCO AR shall review the disenrollment request and all submitted evidence with Authority staff. The review process shall be documented and a recommendation for disenrollment shall be submitted to the Authority's management to make a final decision on the appropriateness of disenrolling a

member from the MCE 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 section (4) of this rule, 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:¶
(A) 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;¶
(B) The probability that potential injury to others shall actually occur; and¶
(C) 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 (4)(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 (4)(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 (4)(f) 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) Provides written documentation of CMS' approval for disenrollment of the member when the member is also enrolled in the CCO's Medicare Advantage plan;¶
(F) Furnishes 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 section (4) of this rule, 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 subsection (5)(c) of this rule 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 listed 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 (5)(d) of this rule, 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 explained 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 (2) 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 shall 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 shall 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 section (6) of this rule shall be documented in the affected member's case file maintained by the Authority.¶~~
~~(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 the Authority 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 fifteen (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 (5) 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 the Authority'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 shall 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, and 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 shall place an enrollment exemption for the appropriate MCE CCOA, CCOB, CCOE, CCOF, and CCOG plans and place the member on Open Card for a twelve (12) month period, after which the CCO AR shall 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 414.611, 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 section (9) of this rule 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 ninety (90)~~OHP Bridge - Basic Health Plan (BHP) members may request to change plans where multiple plans are available, but must remain enrolled at the CCOA level. ¶
(b) All member-initiated requests for disenrollment from a CCO shall be initiated orally or in writing by the primary person in the benefit group enrolled with a CCO where primary person and benefit group are defined in OAR 461-001-0000, 461-001-0035, and 461-110-0750, except that OHP Bridge - BHP members are not eligible for member-initiated requests for disenrollment from a CCO, as CCO enrollment is required for OHP Bridge - BHP. For CCO 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 CCOs. In instances where that is the case, the type of CCO is specified within the applicable section or subsection of this rule;¶
(c) The Authority or CCO shall honor a CCO Member or CCO Member's Representative request for disenrollment for the following reasons¶
(A) Without cause:¶
(i) CCO Members may request to change their CCO enrollment within 30 calendar days of the Authority's automatic or manual enrollment error. If approved, the change would occur on the next available enrollment date;¶
(ii) CCO Members may request to change their CCO enrollment within 90 calendar days of the initial CCO enrollment, or during the 90 days following the date the state sends the member notice of that enrollment, whichever is later. If approved, the change would occur on the next available enrollment date;¶
(iii) CCO Members may request to change their CCO enrollment after they have been enrolled with the CCO for at least six (6) months. If approved, the change would occur on the first day of the next month;¶
(iv) CCO Members may request to change their CCO enrollment at their OHP eligibility renewal. If approved, the change would occur on the first day of the next month;¶
(v) CCO 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 on the first day of the next month.¶
(B) With cause, at any time as follows:¶

(i) The CCO Member moves out of the CCO service area; or¶
(ii) Due to moral or religious objections the CCO does not cover the service the CCO Member seeks;¶
(iii) When the CCO 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 CCO Member's primary care provider or another provider determines that receiving the services separately would subject the CCO Member to unnecessary risk.¶
(C) Medicare and Medicaid fully dual eligible CCO Members may change plans or disenroll to Open Card at any time subject to the provisions set forth in OAR 410-141-3805(13)(c) based on enrollment options in the CCO 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 CCO Member's health care needs. Examples of sufficient cause include but are not limited to:¶
(i) The CCO Member is an American Indian or Alaskan Native who wishes to obtain primary care services from their Indian Health Service facility, tribal health clinic/program, or urban clinic and the FFS billing system;¶
(ii) The CCO 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 CCO 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 Open Card for continuity of care and a temporary CCO exemption;¶
(II) Authority decisions to approve or deny the CCO Member's request shall be communicated in a written notice to the CCO Member. A Copy of the notice shall be sent, if applicable, to the providers that participated in the CCO Member's request. The notice to the CCO 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 CCO Member's right to, and how to, file a grievance and other information related to the CCO Member's administrative hearing rights;¶
(E) If 30 calendar days pass without a decision from the Authority on a CCO Member's disenrollment request, the request is considered to be approved and becomes effective on the first calendar day of the following calendar month (unless the Authority takes action before that date).¶
(d) A Member may request a temporary enrollment exemption during pregnancy as follows:¶
(A) A temporary enrollment exemption request shall 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 has not been enrolled with a CCO within the past three (3) months; or¶
(iii) The Member is enrolled with a CCO that does not contract with the Member's current OB provider and the Member wishes to continue obtaining maternity services from that non-participating OB provider.¶
(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 with a CCO in the Member's residential service area. Where there is a choice among multiple CCOs in the Member's service area the Member may choose an open plan. If the Member does not express preference, the Authority shall automatically assign the Member effective the next available enrollment date.¶
(e) Upon approval of a Member's disenrollment from a CCO, the Member shall join another CCO unless:¶
(A) The member meets the exemptions to enrollment set forth in OAR 410-141-3805;¶
(B) The Member meets disenrollment criteria stated in this rule; or¶
(C) There is not another CCO available and open to new enrollment in the service area.¶
(2) CCO-initiated disenrollment requests for reasons other than fraudulent or illegal acts, uncooperative or disruptive behavior, or credible threats of violence: CCOs may request disenrollment for any of the following reasons. Such requests shall be submitted to the Authority's Client Enrollment Services (CES) unit unless otherwise specified. After review of all necessary documentation submitted with a CCO's request, the Authority shall grant such requests, except the Authority may deny requests based on the reason set forth in subsection (g) below:¶
(a) If the individual is enrolled after the first day of admission to an inpatient setting, the enrollment shall be cancelled as never effective and the individual shall be enrolled in a CCO on the next available enrollment date following discharge from the continuous inpatient stay. This does not apply if the individual is a newborn child born to an OHP-eligible mother enrolled with a CCO at time of birth in accordance with OARs 410-141-3500 and 410-141-3805 or if the individual is on Bridge OHP in accordance with OAR 410-141-3806;¶
(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, the Member shall be disenrolled from the CCO effective on the first day of the next month the TPL is reported, with the exception of:¶
(A) When Good Cause determination is active or concurrently documented, in which case the Member shall retain the highest level of CCO coverage as set forth in OAR 410-141-3805(10)(b);¶
(B) When the Member's medical insurance policy, Third Party Liability (TPL) Employer Sponsored Insurance (ESI) is deemed unaffordable (as determined under section 36B(c)(2)(C) of the Internal Revenue Code), in which case the Member shall retain the highest level of CCO coverage as set forth in OAR 410-141-3805(10)(b);¶
(C) Some situations in which the Authority may approve retroactive disenrollment;¶
(D) When the Member has dental TPL and is enrolled with a CCOF plan type.¶
(c) 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 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 CCO shall identify the Member 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; If the Member has been released and OHP eligibility was restored prior to the disenrollment action being taken, re-enrollment with the CCO will coincide with the Member's OHP eligibility effective date.¶
(d) The Medicare Member is enrolled in a Medicare Advantage plan and was receiving hospice services at the time of enrollment in the CCO;¶
(e) The Member had End Stage Renal Disease at the time of enrollment in the CCO.¶
(3) Unless specified otherwise in these rules, or in the Authority notification of disenrollment to the CCO, all disenrollments are effective on the first day of the next month after the Authority approves the disenrollment:¶
(a) If the CCO Member is no longer eligible for OHP, the effective date of disenrollment shall be the date specified by the Authority;¶
(b) If the CCO Member dies, the last date of enrollment shall be the date of the member's death.¶
(4) Transfers of 500 or more CCO Members.¶
(a) As specified in ORS 414.611, the Authority may approve the transfer of 500 or more members from one CCO to another CCO if:¶
(A) The CCO Member's provider has contracted with the receiving CCO and the provider has stopped accepting patients from the CCO from which the Member is being transferred, or has terminated providing services to members who are enrolled with the CCO from which the Member is being transferred;¶
(B) Members are offered the choice of remaining enrolled in the transferring CCO; and¶
(C) The CCO Member and all family (case) members shall be transferred to the provider's new CCO.¶
(b) The transfer shall become effective the date on which the provider's contract with their current CCO terminates or otherwise expires, or on another date approved by the Authority;¶
(c) CCO Members must not be transferred under section (3) of this rule unless the following conditions have been satisfied:¶
(A) The Authority has evaluated the receiving CCO and determined that the receiving CCO meets criteria established by the Authority as stated in OAR 410-141-3705 including, but not limited to, ensuring that the CCO 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 CCO Members; and¶
(B) The Authority has provided notice of a transfer to CCO 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: ORS 414.065