OFFICE OF THE SECRETARY OF STATE
BEV CLARNO
SECRETARY OF STATE

A. RICHARD VIAL
DEPUTY SECRETARY OF STATE

ARCHIVES DIVISION
STEPHANIE CLARK
DIRECTOR

800 SUMMER STREET NE
SALEM, OR 97310
503-373-0701

PERMANENT ADMINISTRATIVE ORDER

FILED
12/17/2019 10:12 AM
ARCHIVES DIVISION
SECRETARY OF STATE
& LEGISLATIVE COUNSEL

DMAP 55-2019
CHAPTER 410
OREGON HEALTH AUTHORITY
HEALTH SYSTEMS DIVISION: MEDICAL ASSISTANCE PROGRAMS

FILING CAPTION: New Administrative Rules on Governing Coordinated Care Organizations (CCOs) 3500-3625

EFFECTIVE DATE: 01/01/2020

AGENCY APPROVED DATE: 12/17/2019

CONTACT: Brean Arnold
503-569-0328
brean.n.arnold@dhsoha.state.or.us

500 Summer St. NE
Salem,OR 97301

Filed By:
Brean Arnold
Rules Coordinator

RULES:
410-141-3500, 410-141-3501, 410-141-3505, 410-141-3510, 410-141-3515, 410-141-3520, 410-141-3525, 410-141-3530, 410-141-3540, 410-141-3545, 410-141-3550, 410-141-3555, 410-141-3560, 410-141-3565, 410-141-3570, 410-141-3575, 410-141-3580, 410-141-3585, 410-141-3590, 410-141-3600, 410-141-3601, 410-141-3605, 410-141-3610, 410-141-3615, 410-141-3620, 410-141-3625

ADOPT: 410-141-3500

RULE TITLE: Definitions

NOTICE FILED DATE: 10/16/2019

RULE SUMMARY: These rules are necessary for the State to ensure the appropriate delivery of health services to Oregon Health Plan (OHP) members enrolled in Coordinated Care Organizations (CCOs) as required under state and federal law. The rules are designed to promote accountability of the State's contracted CCOs, provide member protections, and to promote members' physical, behavioral, and oral health.

RULE TEXT:
(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 afford an opportunity for tribal participation on CACs as follows:
(a) In CCO service areas where only one federally recognized tribe exists, the tribe shall appoint one tribal representative to serve on the CAC;
(b) In CCO service areas where multiple federally recognized tribes exist, each tribe shall appoint a tribal representative to serve on the CAC to ensure full representation of all tribes within the service area;
(c) In metropolitan CCO service areas 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) “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.
(20) “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.
(21) “Coordinated Care Services” mean an MCE’s fully integrated physical health, behavioral health services, and oral health services.
(22) “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.
(23) “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.
(24) “The Department” means the Department of Human Services.
(25) “Department of Consumer and Business Services (DCBS)” means Oregon’s business regulatory and consumer protection department.
(26) “Disenrollment” means the act of removing a member from enrollment with an MCE.
(27) "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.
(28) “Enrollment” means the assignment of a member to an MCE for management and coordination of health services.
(29) “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.
(30) “Flexible Services” means those services that are cost-effective services offered as an adjunct to covered benefits.
(31) “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.
(32) “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.
(33) “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.
(34) “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.
(35) “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.
(36) “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.
(37) “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.
(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).
(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).
(40) “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.
(41) “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.
(42) “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.
(43) “Legal Holiday” means the days described in ORS 187.010 and 187.020.
(44) “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.
(45) “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.
(46) “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).
(47) “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.
(48) “Member” means an OHP client enrolled with an MCE.
(49) “Member Representative” means an individual who can make OHP-related decisions for a member who is not able to make such decisions themselves.
(50) “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.
(51) “Non-Participating Provider” means a provider that does not have a contractual relationship with an MCE and is not on their panel of providers.
(52) “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.
(53) “Oral Health” means conditions of the mouth, teeth, and gums.

(54) “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.
(55) “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.
(56) “Participating Provider” means a provider that has a contractual relationship with an MCE and is on their panel of providers.
(57) “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.
(58) “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.
(59) “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.
(60) “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.
(61) “Provider” means, pursuant to OAR 410-120-0000, an individual, facility, institution, corporate entity, or other organization that supplies health services or items, also termed a rendering provider, or bills, obligates, and receives reimbursement on behalf of a rendering provider of services, also termed a billing provider (BP). The term provider refers to both rendering providers and BP unless otherwise specified.
(62) “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.
(63) “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.
(64) “Service Area” means the geographic area within which the MCE agreed under contract with the Authority to

provide health services.
(65) “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.
(66) “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.
(67) “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.
(68) "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.
(69) “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.
(70) “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.

(71) "Trauma-informed services" means those services provided using a Trauma Informed Approach.
(72) “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.
(73) “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.
(74) "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, 414.615, 414.625, 414.635, 414.651

STATUTES/OTHER IMPLEMENTED: ORS 414.610 - 414.685

ADOPT: 410-141-3501

RULE TITLE: Administration of Oregon Integrated and Coordinated Health Care Delivery System Regulation; Rule Precedence

NOTICE FILED DATE: 10/16/2019

RULE SUMMARY: These rules are necessary for the State to ensure the appropriate delivery of health services to Oregon Health Plan (OHP) members enrolled in Coordinated Care Organizations (CCOs) as required under state and federal law. The rules are designed to promote accountability of the State's contracted CCOs, provide member protections, and to promote members' physical, behavioral, and oral health.

RULE TEXT:

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

(2) To the extent possible, the Authority's policies, procedures, rules, and MCE contracts shall be interpreted to avoid a conflict among themselves or with governing state or federal law. In the event of an irreconcilable conflict, the following order of precedence shall govern:

(a) Medicaid Plan and waivers or other directives from CMS;

(b) Federal Statutes;

(c) Federal Regulations;

(d) Oregon Revised Statutes;

(e) Oregon Administrative Rules using the following order of precedence:

(A) This OAR chapter 410 division 141 ("Oregon Health Plan");

(B) OAR chapter 410 division 120 ("Medical Assistance Programs");

(C) Any applicable Provider rules in OAR 410 based on the category of health service;

(D) OAR Chapter 943, Division 120;

(E) OAR Chapter 309;

(F) All other applicable OARs;

(f) The MCE Contract, including any internal order of precedence established therein.

STATUTORY/OTHER AUTHORITY: ORS 413.042, 414.615, 414.625, 414.635, 414.651

STATUTES/OTHER IMPLEMENTED: ORS 414.610 - 414.685

ADOPT: 410-141-3505

RULE TITLE: Use of Subcontractors

NOTICE FILED DATE: 10/16/2019

RULE SUMMARY: These rules are necessary for the State to ensure the appropriate delivery of health services to Oregon Health Plan (OHP) members enrolled in Coordinated Care Organizations (CCOs) as required under state and federal law. The rules are designed to promote accountability of the State's contracted CCOs, provide member protections, and to promote members' physical, behavioral, and oral health.

RULE TEXT:

(1) MCEs may delegate their activities or obligations to subcontractors except as otherwise provided by law or in the MCE contract:

(a) MCEs remain fully accountable for the performance of all subcontracted work;

(b) MCEs shall monitor subcontractor performance on an ongoing basis;

(c) MCEs shall notify the Authority of subcontractor relationships. MCEs shall provide the Authority:

(A) A comprehensive list of subcontractor entities and, for each one, the activities and functions that have been delegated, to be submitted to OHA on an annual basis;

(B) Copies of all subcontracts upon request; and

(C) Adequate documentation demonstrating monitoring of subcontractor compliance or subcontractor auditing, as applicable, in accordance with the contract and with CMS requirements including 42 C.F.R §§ 438.230, 438.602(a) and 438.66.

(2) Each subcontract must include the following elements:

(a) With respect to any MCE activities or obligations defined by law or in the MCE's contract with the Authority that the MCE is delegating to a subcontractor:

(A) The subcontract must specify the delegated activities or obligations, as well as any related reporting responsibilities;

(B) The subcontractor agrees to perform the delegated activities and reporting responsibilities specified in compliance with the MCE's contract obligations; and

(C) The subcontract must either provide for revocation of the delegation or specify other remedies in instances where the Authority or the MCE determines that the subcontractor has not performed satisfactorily.

(b) The subcontractor agrees to comply with all applicable laws, regulations, sub-regulatory guidance, as well as the requirements in the MCE contract:

(A) The subcontractors agree to comply with Section C Part 10 of Attachment I of the 2017-2022 Medicaid 1115 Waiver regarding timely Payment to IHCP Providers;

(B) Timely payments means that IHCPs must be paid the agreed upon rate within 30-90 calendar days of billing;

(C) The subcontractor agrees to perform any activities necessary to support the MCE and the Authority's obligations as specified in the MCE contract, state law, and federal law, including requirements related to:

(i) Program integrity and data submission, including the requirements in 42 CFR, Part 438, Subpart H.;

(ii) Grievances and appeals, including the requirements in 42 CFR, Part 438, Subpart F;

(iii) Exclusions, as noted in 42 CFR § 438.808; and

(iv) Linguistic and disability access for members, as outlined in 42 CFR § 438.10, as well as 42 U.S.C. § 18116 and 45 CFR Part 92.

STATUTORY/OTHER AUTHORITY: ORS 413.042, 414.615, 414.625, 414.635, 414.651

STATUTES/OTHER IMPLEMENTED: ORS 414.610 - 414.685

ADOPT: 410-141-3510

RULE TITLE: Provider Contracting and Credentialing

NOTICE FILED DATE: 10/16/2019

RULE SUMMARY: These rules are necessary for the State to ensure the appropriate delivery of health services to Oregon Health Plan (OHP) members enrolled in Coordinated Care Organizations (CCOs) as required under state and federal law. The rules are designed to promote accountability of the State's contracted CCOs, provide member protections, and to promote members' physical, behavioral, and oral health.

RULE TEXT:

(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;

(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 (4) of this rule including an alternative dispute resolution or peer review process. An aggrieved provider may appeal the determination of the internal review to the Authority.
(4) To resolve appeals made to the Authority under sections (3) and (4) 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, 414.615, 414.625, 414.635, 414.651

STATUTES/OTHER IMPLEMENTED: ORS 414.610 - 414.685

ADOPT: 410-141-3515

RULE TITLE: Network Adequacy

NOTICE FILED DATE: 10/16/2019

RULE SUMMARY: These rules are necessary for the State to ensure the appropriate delivery of health services to Oregon Health Plan (OHP) members enrolled in Coordinated Care Organizations (CCOs) as required under state and federal law. The rules are designed to promote accountability of the State's contracted CCOs, provide member protections, and to promote members' physical, behavioral, and oral health.

RULE TEXT:

(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) CCOs shall ensure all members can access providers within acceptable travel time or distance to patient-centered primary care homes or PCPs; primary care, adult and pediatric; 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. Acceptable travel times and distances 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 shall include how the CCO 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.

(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 care:
(A) Emergency oral care: Seen or treated within 24 hours;
(B) Urgent oral 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) Behavioral health:
(A) Urgent behavioral health care for all populations: Immediately;
(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 complete a quarterly language access and interpreter services data report using the report form provided by the Authority. The quarterly 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 report annually to the Authority such 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) Timely rescheduling of missed appointments, as deemed medically appropriate;
(B) Documentation in the clinical record or non-clinical record of missed appointments;
(C) Recall or notification efforts; and
(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, MCEs 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

ADOPT: 410-141-3520

RULE TITLE: Record Keeping and Use of Health Information Technology

NOTICE FILED DATE: 10/16/2019

RULE SUMMARY: These rules are necessary for the State to ensure the appropriate delivery of health services to Oregon Health Plan (OHP) members enrolled in Coordinated Care Organizations (CCOs) as required under state and federal law. The rules are designed to promote accountability of the State's contracted CCOs, provide member protections, and to promote members' physical, behavioral, and oral health.

RULE TEXT:

(1) MCEs shall have written policies and procedures that ensure maintenance of a record keeping system that includes maintaining the security of records as required by the Health Insurance Portability and Accountability Act (HIPAA), 42 USC §1320-d et seq., the federal regulations implementing the Act, and complete clinical records that document the coordinated care services received by the members. MCEs shall communicate these policies and procedures to subcontractors. MCEs shall regularly monitor its subcontractors' compliance and take any corrective action necessary. MCEs shall document all monitoring and corrective action activities. These policies and procedures shall ensure that records are secured, safeguarded, and stored in accordance with applicable Oregon Revised Statutes and Oregon Administrative Rules. A member must have access to the member's personal health information in the manner provided in 45 C.F.R. 164.524 and ORS 179.505(9) so the member may share the information with others involved in the member's care and make better health care and lifestyle choices.

(2) MCE's participating providers may charge the member for reasonable duplication costs, as set forth in OAR 943-014-0030, when the member requests copies of their records.

(3) Notwithstanding ORS 179.505, an MCE, its provider network, and programs administered by the Department's Aging and People with Disabilities shall use and disclose member information for purposes of service and care delivery, coordination, service planning, transitional services, and reimbursement in order to improve the safety and quality of care, lower the cost of care, and improve the health and well-being of the members.

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

(5) The MCE must document its methods and findings to ensure across the organization and the network of providers there is documentation of the coordinated care services and supports, including transitions of care and access to preventive and wellness services.

(6) MCEs shall support the adoption and use of electronic health records (EHRs) by its provider network, including physical, behavioral, and oral health providers. To achieve EHR adoption, MCEs shall:

(a) Identify EHR adoption rates, divided by provider type (at a minimum, divided by physical, behavioral, and oral health) and geographic region if applicable;

(b) Develop and implement strategies to increase adoption rates of EHRs among all provider types; and

(c) Support EHR adoption.

(7) MCEs shall support access to electronic health information exchange (HIE) for care coordination and hospital event notifications for contracted physical, behavioral, and oral health providers. To achieve improved HIE access rates, MCEs shall:

(a) Identify current and monitor ongoing HIE adoption rates, divided by provider type (at a minimum, divided by physical, behavioral, and oral health) and geographic region if applicable;

(b) Develop and implement strategies to increase access to HIE among all provider types;
(c) Support access to HIE; and
(d) Ensure that providers have access to hospital event notifications. The MCE shall itself use hospital event notifications as appropriate to support care coordination and population health efforts.
(8) MCEs shall maintain health information systems that collect, analyze, integrate, and report data at an individualized member level concerning the provision of covered services and CCO administrative functions, such as enrolment/disenrollment and resolution of grievances and appeals. Based on written policies and procedures, the record keeping system developed and maintained by MCEs and their participating providers shall include sufficient detail and clarity to permit internal and external review to validate encounter submissions and to assure medically appropriate services are provided consistent with the documented needs of the member.
(9) MCEs and their provider network shall cooperate with the Authority, the Department of Justice Medicaid Fraud Control Unit (MFCU), and CMS or other authorized state or federal reviewers for purposes of audits, inspection, and examination of members' clinical records, whether those records are maintained electronically or in physical files. Documentation must be sufficiently complete and accurate to permit evaluation and confirmation that coordinated care services are authorized and provided, referrals are made, and outcomes of coordinated care and referrals are sufficient to meet professional standards applicable to the health care professional and meet the requirements for health oversight and outcome reporting in these rules.
(10) Across the MCE's provider network, all clinical records shall be retained for a minimum of 10 years after the date of services for which claims are made. MCEs shall maintain any other records, books, documents, papers, plans, records of shipments, and payments and writings, whether in paper, electronic, or other form that are pertinent in a manner that clearly documents the MCE's performance. All clinical records, financial records, other records, books, documents, papers, plans, records of shipments, and payments and writings of the MCE whether in paper, electronic, or other form are collectively referred to as "Records." If an audit, litigation, research and evaluation, or other action involving the records is started before the end of the ten-year period, the clinical records must be retained until all issues arising out of the action are resolved.
(11) MCEs shall allow access to the agencies listed in section (9) of all audit records and its subcontractors and participating provider's records to allow the listed agencies to perform examinations and audits and make excerpts and transcripts and to evaluate the quality, appropriateness, and timeliness of services.
(12) MCEs shall allow access to the entities listed in section (9) at any time to inspect the premises, physical facilities, and equipment where Medicaid-related activities or work is conducted. MCEs subject to an audit under this section shall retain records for 10 years from the final date of the contract period or from the date of completion of the most recent state audit, whichever is later. MCEs shall retain and keep accessible all records for a minimum of 10 years. County agencies participating in the Medicaid program are subject to whichever record retention requirement is longer between this rule and OAR chapter 166, division 150 County and Special District Retention Schedule.
(13) MCEs must maintain yearly logs of all appeals and grievances for 10 years following requirements specified in OAR 410-141-3915.

STATUTORY/OTHER AUTHORITY: ORS 413.042, 414.615, 414.625, 414.635, 414.651

STATUTES/OTHER IMPLEMENTED: ORS 414.610 - 414.685

ADOPT: 410-141-3525

RULE TITLE: Outcome and Quality Measures

NOTICE FILED DATE: 10/16/2019

RULE SUMMARY: These rules are necessary for the State to ensure the appropriate delivery of health services to Oregon Health Plan (OHP) members enrolled in Coordinated Care Organizations (CCOs) as required under state and federal law. The rules are designed to promote accountability of the State's contracted CCOs, provide member protections, and to promote members' physical, behavioral, and oral health.

RULE TEXT:

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

(2) The MCE shall inform the Authority if it has been accredited by a private independent accrediting entity. If the MCE has been so accredited, the MCE shall authorize the private independent accrediting entity to provide the Authority a copy of its most recent accreditation review in accordance with CFR 42 CFR §438.332.

(3) As required by health system transformation, MCEs shall be accountable for performance on outcomes, quality, and efficiency measures incorporated into the MCE's contract with the Authority. Measures are selected by OHA; with the incentive measures specifically adopted by the Metrics and Scoring Committee using a public process. Information can be requested from the Authority or viewed online at the Metrics and Scoring Committee website located at https://www.oregon.gov/oha/HPA/ANALYTICS/Pages/CCO-Metrics.aspx.

(4) MCEs shall address objective outcomes, quality measures, and benchmarks for ambulatory care, inpatient care, behavioral health care, oral health care, and all other health services provided by or under the responsibility of the MCE as specified in the MCE's contract with the Authority and federal external quality review requirements in CFR 42 §438.350, §438.358, and §438.364.

(5) MCEs shall implement an ongoing comprehensive quality assessment and performance improvement program (QAPI) for monitoring, evaluating, and improving the access, quality, and appropriateness of services provided to members consistent with the needs and priorities identified in the MCE's community health assessment, community health improvement plan, and the standards in the MCE's contract. This process shall include an internal Quality Improvement (QI) program with written criteria based on written policies, evidenced-based practice guidelines, standards and procedures that are in accordance with the requirements set forth in 42 CFR §438.330, relevant law and the community standards for care, or in accordance with accepted medical practice, whichever is applicable, and with accepted professional standards. MCEs shall have in effect mechanisms to:

(a) Detect both underutilization and overutilization of services;

(b) Evaluate performance and customer satisfaction consistent with MCE contractual requirements, relevant Oregon Administrative Rules, and provide documentation of implementation of interventions to achieve improvement in the access to and quality of care to the Authority and the Authority contracted External Quality Review Organization (EQRO);

(c) Evaluate grievance, appeals, and contested case hearings consistent with OAR 410-141-3890 through 410-141-3915;

(d) Assess the quality and appropriateness of coordinated care services provided to all members with identified special health care needs including those who are aged, blind, or disabled or who have high health care needs, multiple chronic conditions, behavioral health disorders; who receive Medicaid funded long-term care or long-term services and supports benefits; or who are children receiving CAF (Child Welfare) or OYA services; and

(e) Report on the diversity and capacity of the workforce in their service area including capacity to provide services in a culturally responsive and trauma informed manner, relying, as appropriate, on workforce data provided by the Authority;

(f) Undertake performance improvement projects that are designed to improve the access, quality and utilization of services. Projects must be designed to achieve significant improvement in health outcomes and member satisfaction.
(6) MCEs shall implement policies and procedures that assure the timely collection of data including health disparities and other data required by rule or contract (or both) that allows the MCE to conduct and report on its outcome and quality measures and report its performance. MCEs shall submit to the Authority the MCE's annual written evaluation of outcome and quality measures established for the MCE or other reports as the Authority may require in response to the measures adopted by the Metrics and Scoring Committee; including but not limited to output from Electronic Health Records, Chart Reviews, Claim validation reports and other materials required for final assessment of relevant measures and within established deadlines.
(7) MCEs shall adopt practice guidelines consistent with 42 CFR § 438.236 and the MCE contract that addresses assigned contractual responsibilities for physical health care, behavioral health care, or oral health care; goals to increase care coordination with other MCEs, the state, or other providers as outlined in OAR 410-141-0160 and 410-141-3860; and concerns identified by members or their representatives and to implement changes that have a favorable impact on health outcomes and member satisfaction in consultation with its community advisory council or clinical review panel.
(8) MCEs shall be accountable for both core and transformational measures of quality and outcomes:
(a) Core measures will be triple-aim oriented measures that gauge MCE performance against key expectations for care coordination, consumer satisfaction, quality, and outcomes. The measures shall be uniform across MCEs and shall encompass the range of services included in MCE global budgets (e.g., behavioral health, hospital care, women's health) or MHO and DCO contracts. Core measures may be defined as typical standardized medical-centric measures such as The National Committee of for Quality Assurance's (NCQAs) eCQMs or HEDIS that have state or national normative statistics;
(b) Transformational metrics shall assess MCE progress toward the broad goals of health system transformation. This subset may include newer kinds of indicators (for which MCEs have less measurement experience) or indicators that entail collaboration with other care partners, such as social service agencies or other community support services. Additional areas of transformational measures may include culturally informed care, health equity or health-related services not typically associated with medical care. Transformational metrics will also require cooperation from MCEs for pilot or demonstration activities as these newly formed measures are developed over time. Development of different evaluation criteria for acceptance by the metrics selection committees for use by MCEs may also be necessary for transformational metrics.
(9) MCEs shall provide the required data to the All Payer All Claims data system established in ORS 442.464 and 442.466 and the MCE agreement in the manner authorized by OAR 409-025-0130.
(10) The positions of Medical or Dental Director and the QI Coordinator shall have the qualifications, responsibility, experience, authority, and accountability necessary to assure compliance with this rule. MCEs shall designate a QI Coordinator who shall develop and coordinate systems to facilitate the work of the QI Committee. The QI Coordinator is generally responsible for the operations of the QI program and must have the management authority to implement changes to the QI program as directed by the QI Committee. The QI Coordinator shall be qualified to assess the care of Authority members including those who are eligible for intensive care coordination (ICC) services under OAR 410-141-3870 or shall be able to retain consultation from individuals who are qualified.
(11) MCEs shall establish a QI Committee that shall meet at least every two months. The Committee shall retain authority and accountability to the Board of Directors for the assurance of quality of care. Committee membership shall include, but is not limited to, the Medical or Dental Director, the QI Coordinator, and other health professionals who are representative of the scope of the services delivered. If any QI functions are delegated, the QI Committee shall maintain oversight and accountability for those delegated functions. The QI Committee shall:
(a) Record and produce dated minutes of Committee deliberations. Document recommendations regarding corrective actions to address issues identified through the QI Committee review process; and review of results, progress, and effectiveness of corrective actions recommended at previous meetings. These records and minutes shall be made

available to relevant OHA quality staff;
(b) MCEs shall conduct and submit to the Authority an annual written evaluation of the QI Program and of member care as measured against the written procedures and protocols of member care. The evaluation of the QAPI program and member care is to include an assessment of annual activities conducted which includes background and rationale, a plan of ongoing improvement activities to address gaps which will ensure quality of care for MCE members and overall effectiveness of the QI program. MCEs shall submit their evaluations to the Authority contracted External Quality Review Organization (EQRO). The MCEs shall follow the Transformation and Quality Strategy as outlined in the MCE contract for the QAPI and transformational care annual evaluation criteria.
(c) Conduct a quarterly review and analysis of all complaints and appeals received including a focused review of any persistent and significant member complaints and appeals as required in OAR 410–141-3915;
(d) Review written procedures, protocols and criteria for member care no less than every two years, or more frequently as needed to maintain currency with clinical guidelines and administrative principles.

STATUTORY/OTHER AUTHORITY: ORS 413.042, 414.615, 414.625, 414.635, 414.651

STATUTES/OTHER IMPLEMENTED: ORS 414.610 - 414.685

ADOPT: 410-141-3530

RULE TITLE: Sanctions

NOTICE FILED DATE: 10/16/2019

RULE SUMMARY: These rules are necessary for the State to ensure the appropriate delivery of health services to Oregon Health Plan (OHP) members enrolled in Coordinated Care Organizations (CCOs) as required under state and federal law. The rules are designed to promote accountability of the State's contracted CCOs, provide member protections, and to promote members' physical, behavioral, and oral health.

RULE TEXT:

(1) The Authority may establish and impose sanctions on MCEs, pursuant to 42 CFR § 438.700, if the Authority makes a determination specified in paragraph (3) of this rule.

(2) The Authority may base its determinations on findings from onsite surveys, enrollee or other complaints, financial status, or any other source.

(3) The Authority may impose sanctions if the Authority determines that an MCE acts or fails to act as follows:

(a) Fails substantially to provide medically necessary services required under law or under its contract with the Authority to an enrollee covered under the contract;

(b) Imposes on enrollee's premiums or charges that are in excess of the premiums or charges permitted under the Medicaid program;

(c) Acts to discriminate among enrollees on the basis of their health status or need for health care services. This includes termination of enrollment or refusal to re-enroll a beneficiary, except as permitted under the Medicaid program, or any practice that would reasonably be expected to discourage enrollment by beneficiaries whose medical condition or history indicates probable need for substantial future medical services;

(d) Misrepresents or falsifies information that it furnishes to the Centers for Medicare and Medicaid Services (CMS) or to the Authority;

(e) Misrepresents or falsifies information that it furnishes to an enrollee, potential enrollee, or health care provider;

(f) Fails to comply with the requirements for physician incentive plans, as set forth in 42 CFR §§ 422.208 and 422.210;

(g) Distributes directly or indirectly through any agent or independent contractor marketing materials that are not approved by the Authority or that contain false or materially misleading information;

(h) Violates any of the other applicable requirements of state or federal Medicaid law; or

(i) Fails to comply with any legal or contractual requirements that, pursuant to the MCE contract, may form a basis for sanctions.

(4) The Authority may impose a range of sanctions under this rule including the following:

(a) Civil monetary penalties in the amounts specified in section (5) of this rule;

(b) Appointment of temporary management for an MCE as permitted under 42 CFR 438.706;

(c) Granting members the right to terminate enrollment without cause and notifying the affected members of their right to disenroll;

(d) Suspension of all new enrollment, including default enrollment, after the date the Authority notifies the MCE of a determination of a violation of rule or contract requirements;

(e) Suspension of payment for members enrolled after the effective date of the sanction and until the Authority is satisfied that the reason for imposition of the sanction no longer exists and is not likely to recur;

(f) Additional sanctions available under Oregon Revised Statutes and Oregon Administrative Rules that address areas of noncompliance specified in section (3) of this rule or any additional areas of noncompliance.

(5) If the Authority imposes civil monetary penalties:

(a) The maximum civil monetary penalty the Authority may impose varies depending on the nature of the MCE's action or failure to act, subject to the limits in 42 CFR § 438.704;

(b) The Authority may issue penalties as specified on a per event, per member impacted, or per day basis for the duration of noncompliance.

(6) Before imposing any sanctions, the Authority must give the affected MCE timely written notice that explains the following:
(a) The basis and nature of the sanction;
(b) Any appeal rights under this rule and any other appeal rights that the Authority elects to provide.
(7) Administrative review, and if requested mediation:
(a) Are available for review of sanction decisions in accordance with OAR 410-120-1580 and 410-141-3550;
(b) If the Authority determines that there is continued egregious behavior, or that such action is necessary to ensure the health or safety of members, the Authority may impose the sanction before an administrative review opportunity is provided.
(8) Before terminating an MCE's contract for cause, the Authority must provide the MCE the opportunity for a pre-termination hearing. The Authority must do all of the following:
(a) Give the MCE written notice of its intent to terminate, the reason for termination, and the time and place of the hearing;
(b) After the hearing, give the MCE written notice of the decision affirming or reversing the proposed termination of the contract and for an affirming decision the effective date of termination;
(c) For an affirming decision, give enrollees of the MCE notice of the termination and information on their options for receiving Medicaid services following the effective date of termination.

STATUTORY/OTHER AUTHORITY: ORS 413.042

STATUTES/OTHER IMPLEMENTED: ORS 414.065

ADOPT: 410-141-3540

RULE TITLE: Member Protections

NOTICE FILED DATE: 10/16/2019

RULE SUMMARY: These rules are necessary for the State to ensure the appropriate delivery of health services to Oregon Health Plan (OHP) members enrolled in Coordinated Care Organizations (CCOs) as required under state and federal law. The rules are designed to promote accountability of the State's contracted CCOs, provide member protections, and to promote members' physical, behavioral, and oral health.

RULE TEXT:

(1) In the event of a finding of MCE impairment by the Authority, or of a termination of the MCE contract, members of the MCE shall be offered disenrollment from the MCE and enrollment in accordance with the Authority's rules.

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

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

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

(5) No contracting provider or agent, trustee or assignee of the contracting provider shall bill a member, send a member's bill to a Collection Agency, or maintain a civil action against a member to collect any amounts owed by the MCE for which the member is not liable to the contracting provider in this rule and under 410-120-1280.

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

(a) Health services not covered by the MCE, if a valid OHP Client Agreement to Pay for Health Services form OHP 3165, or facsimile, signed by the client, has been completed as described in OAR 410-120-1280; or

(b) Health services rendered after the termination of the contract between the MCE and the provider, unless the health services were rendered during the confinement in an inpatient facility and the confinement began prior to the date of termination or unless the provider has assumed post-termination treatment obligations under the contract. Before providing a non-covered service, the provider must complete an OHP 3165, or facsimile, as described in OAR 410-120-1280.

STATUTORY/OTHER AUTHORITY: ORS 413.042, 414.615, 414.625, 414.635, 414.651

STATUTES/OTHER IMPLEMENTED: ORS 414.610 - 414.685

ADOPT: 410-141-3545

RULE TITLE: Coordinated Care Organization Behavioral Health Provider, Treatment and Facility Certification and Licensure

NOTICE FILED DATE: 10/16/2019

RULE SUMMARY: These rules are necessary for the State to ensure the appropriate delivery of health services to Oregon Health Plan (OHP) members enrolled in Coordinated Care Organizations (CCOs) as required under state and federal law. The rules are designed to promote accountability of the State's contracted CCOs, provide member protections, and to promote members' physical, behavioral, and oral health.

RULE TEXT:
Behavioral health treatment services are covered for eligible OHP clients when provided by a CCO under the following circumstances:
(1) Provider Organizations (as defined under OAR 410-120-0000) of outpatient behavioral health services shall:
(a) Be certified by the Authority as described in OAR 309-008-0250 for the scope of services provided; and
(b) Comply with applicable rules, including but not limited to, those defined in OAR chapter 309 and any requirements in the CCO contract.
(2) A certificate may not be required for certain types of providers, regardless of whether public funds are received, as outlined in OAR 309-008-0250(4);
(3) Provider organizations (as defined under OAR 410-120-0000) of residential treatment services shall:
(a) Meet the definition of a residential treatment facility under ORS 430.010, 430.306 and 443.400;
(b) Be licensed by the Authority as described in ORS 443.725 and OAR chapter 415 divisions 12 and 50 for the scope of service provided; and
(c) Comply with applicable rules including, but not limited to, those defined in OAR chapter 415 and chapter 309 and any requirements in the CCO contract.

STATUTORY/OTHER AUTHORITY: ORS 413.042, 414.065, 430.010, 430.306, 443.400, 443.725

STATUTES/OTHER IMPLEMENTED: ORS 413.042, 414.065, 430.010, 430.306, 443.400

ADOPT: 410-141-3550

RULE TITLE: Resolving Disputes between MCEs and the Authority

NOTICE FILED DATE: 10/16/2019

RULE SUMMARY: These rules are necessary for the State to ensure the appropriate delivery of health services to Oregon Health Plan (OHP) members enrolled in Coordinated Care Organizations (CCOs) as required under state and federal law. The rules are designed to promote accountability of the State's contracted CCOs, provide member protections, and to promote members' physical, behavioral, and oral health.

RULE TEXT:

(1) If an MCE has a dispute with the Authority as a result of a decision that is perceived as adversely affecting an MCE, the MCE may submit a request to the Director of the Authority, or the Director's designee, requesting an Administrative Review, as prescribed in OAR 410-120-1580.

(a) These disputes primarily address legal or policy issues that may arise in the context of an Authority decision that is perceived by the MCE to adversely affect the MCE and is not otherwise reviewed as a claim redetermination, a contested case, or client appeal. An example of such disputes includes, but is not limited to, Authority decisions made through the OHA Provider Discrimination Review Process as a result of a provider discrimination appeal;

(b) This rule does not address claims that the Authority has breached its contract with an MCE;

(c) This MCE process is not mandatory, and it need not be exhausted before an MCE seeks judicial review or brings any other form of action related to any MCE/Authority dispute related decision.

(2) Within 30 calendar days of the conclusion of the administrative review, or such other time as may be agreed to by the MCE and the Authority, the Authority shall send written results of the administrative review to the initiating MCE and any other affected MCE. Should a resolution be reached through administrative review that is mutually agreeable to all involved, the process shall be considered complete and binding.

(3) If the dispute between the MCE and the Authority remains unresolved as a result of the administrative review, the CCO may request an alternative dispute resolution as set forth below to attempt to resolve the issue. The alternative dispute process is conducted pursuant to the Attorney General's Uniform Model Rules OAR 137-005-0060 and 137-005-0070.

(4) Not more than 10 business days after receipt of the final administrative review decision, the MCE may contact the Director of the Authority indicating the MCE's intent to pursue mediation. In that request, the MCE may request to stay the administrative review decision, which the Authority will grant if the MCE alleges sufficient facts and provides good cause for the stay as provided in OAR 137-004-0090. The Authority shall respond within 10 business days of the date of the stay request.

(5) After both the MCE and the Authority agree to enter into mediation, both shall attempt to agree on the selection of the mediator and complete paperwork required to secure the mediator's services. If the MCE and the Authority are unable to agree on the selection of a mediator, both shall appoint a mediator, and those mediators shall select the final mediator. To be qualified to propose resolutions for disputes under this rule, the mediator shall:

(a) Be a knowledgeable and experienced mediator;

(b) Be familiar with health care and the disputed matters; and

(c) Follow the terms and conditions specified in this rule for the mediation process.

(6) If the dispute is likely to impact another MCE, the Authority shall notify all MCEs potentially impacted by the dispute and provide an opportunity for the impacted MCEs to participate in the dispute resolution process. MCEs that opt into the process have, from that time forward, the same rights and responsibilities as the MCE that initiated the dispute.

(7) The MCE and the Authority shall share in the cost of all mediation expenses, whether the dispute is resolved or not.

(8) Within 10 business days of a selection of a mediator or upon a different schedule, as agreed to by the parties and the mediator, the MCE and the Authority shall submit to each other and to the mediator the following:

(a) Dispute resolution offer; and

(b) Explanation of their position, i.e., advocacy brief.

(9) The parties will engage in mediation as arranged by the mediator.

(10) The Authority shall maintain the confidentiality of proprietary information of all participating MCEs to the extent the information is protected under state or federal law.

STATUTORY/OTHER AUTHORITY: ORS 413.042

STATUTES/OTHER IMPLEMENTED: ORS 413.042, ORS 183.484, 183.502

ADOPT: 410-141-3555

REPEAL: Temporary 410-141-3555 from DMAP 30-2019

RULE TITLE: Resolving Disputes between Health Care Entities and CCOs that Concern CCO Contact Award

NOTICE FILED DATE: 10/16/2019

RULE SUMMARY: These rules are necessary for the State to ensure the appropriate delivery of health services to Oregon Health Plan (OHP) members enrolled in Coordinated Care Organizations (CCOs) as required under state and federal law. The rules are designed to promote accountability of the State's contracted CCOs, provide member protections, and to promote members' physical, behavioral, and oral health.

RULE TEXT:

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

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

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

(c) One or more of the following occurs:

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

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

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

(2) If an applicant and HCE disagree about whether the HCE is necessary for the successful award of a contract to the applicant as a CCO, the applicant or HCE may request the Authority to review the issue.

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

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

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

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

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

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

(5) Pursuant to ORS 414.635, if the applicant and HCE cannot reach agreement on contract terms within 10 calendar days of the face-to-face meeting, either party may request arbitration. The requesting party shall notify the other party in writing to initiate a referral to an independent third-party arbitrator for an HCE's refusal to contract with the CCO or the termination, extension, or renewal of a HCE's contract with a CCO. The party initiating the referral shall provide a copy of the notification to the Authority.

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

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

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

arbitrator the following:
(a) The most reasonable contract offers; or
(b) The HCE's statement that a contract is not desirable and an explanation of why this is reasonable.
(9) Within 10 calendar days of receiving the other party's offer or the HCE's statement that a contract is not desirable, each party shall submit to the arbitrator and the other party the advocacy briefs regarding whether the HCE is reasonably or unreasonably refusing to contract with the applicant.
(10) The arbitrator shall apply the following standards when making a determination about whether an HCE reasonably or unreasonably refused to contract with the applicant:
(a) An HCE may reasonably refuse to contract when an applicant's reimbursement to an HCE for a health service is below the reasonable cost to provide the service. The arbitrator shall apply federal or state statutes or regulations that establish specific reimbursements, such as payments to federally qualified health centers, rural health centers, and tribal health centers; and
(b) An HCE may reasonably refuse to contract if that refusal is justified in fact or by circumstances, taking into consideration the health system transformation legislative policies. Facts or circumstances outlining what is a reasonable or unreasonable refusal to contract include, but are not limited to:
(A) Whether contracting with the applicant would impose demands that the HCE cannot reasonably meet without significant negative impact on HCE costs, obligations, or structure while considering the proposed reimbursement arrangement or other CCO requirements. Some of the requirements include:
(i) Use of electronic health records;
(ii) Service delivery requirements, or
(iii) Quality or performance requirements.
(B) Whether the HCE's refusal affects access to covered services in the applicant's community. This factor alone cannot result in a finding that the refusal to contract is unreasonable; however, the HCE and applicant shall make a good faith effort to work out differences in order to achieve beneficial community objectives and health system transformation policy objectives;
(C) Whether the HCE has entered into a binding obligation to participate in the network of a different CCO or applicant and that participation significantly reduces the HCE's capacity to contract with the applicant.
(11) The following outlines the arbitrator determination and the parties' final opportunity to settle:
(a) The arbitrator shall evaluate the final offers or statement of refusal to contract and the advocacy briefs from each party and issue a determination within 15 calendar days of the receipt of the parties' information;
(b) The arbitrator shall provide the determination to the parties. The arbitrator and the parties may not disclose the determination to the Authority for 10 calendar days to allow the parties an opportunity to resolve the issue themselves. If the parties resolve the issue no later than the end of the tenth day, the arbitrator may not release the determination to the Authority;
(c) If the parties have not reached an agreement after 10 calendar days, the arbitrator shall provide its decision to the Authority. After submission to the Authority, the arbitrator's determination becomes a public record, subject to protection of trade secret information if identified by one of the parties prior to the arbitrator's submission of the determination.
(12) If the parties cannot agree, the Authority shall evaluate the arbitrator's determination and may take the following actions:
(a) The Authority may award a contract to an applicant if the arbitrator determined the applicant made a reasonable attempt to contract with the HCE or the HCE's refusal to contract was unreasonable;
(b) The Authority may refuse to award a contract to an applicant when the arbitrator determined the applicant did not reasonably attempt to contract with the HCE or the HCE's refusal to contract was reasonable, and the Authority determines that participation from the HCE remains necessary for applicant's award of a contract as a CCO;
(c) The Authority may not pay fee-for-service reimbursements to an HCE if the arbitrator determined the HCE unreasonably refused to contract with the applicant. This applies to health services available through a CCO;

(d) In any circumstance within the scope of this rule when the parties have failed to agree, the current statutes regarding reimbursement to non-participating providers shall apply to CCOs that hold contracts with OHA and the HCE, consistent with ORS 414.743 for hospitals and consistent with Authority rules for other providers.

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

(a) Be a knowledgeable and experienced arbitrator;

(b) Be familiar with health care provider contracting matters;

(c) Be familiar with health system transformation; and

(d) Follow the terms and conditions specified in this rule for the arbitration process.

STATUTORY/OTHER AUTHORITY: ORS 413.042, 414.615, 414.625, 414.635, 414.651

STATUTES/OTHER IMPLEMENTED: ORS 414.610 - 414.685

ADOPT: 410-141-3560

RULE TITLE: Resolving Contract Disputes Between Health Care Entities and CCOs

NOTICE FILED DATE: 10/16/2019

RULE SUMMARY: These rules are necessary for the State to ensure the appropriate delivery of health services to Oregon Health Plan (OHP) members enrolled in Coordinated Care Organizations (CCOs) as required under state and federal law. The rules are designed to promote accountability of the State's contracted CCOs, provide member protections, and to promote members' physical, behavioral, and oral health.

RULE TEXT:

(1) Pursuant to ORS 414.635, Coordinated Care Organizations (CCOs) and Health Care Entities (HCEs) shall participate in good faith contract negotiations. This rule covers the termination, extension, and renewal of an HCE's contract with a CCO.

(2) In the event of a dispute involving the termination, extension, or renewal of an HCE's contract with a CCO, the parties may take the following actions in an attempt to reach a good faith resolution:

(a) Both parties shall provide a written offer of terms and conditions to the other party. The parties shall explain the basis for their disagreement with the terms and conditions offered by the other party;

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

(c) The CCO or HCE may request the Authority to provide technical assistance. The Authority's technical assistance is limited to clarifying the CCO contractual provisions, subcontracting criteria, current reimbursement requirements, access standards, and other legal requirements.

(3) If the CCO and HCE cannot reach agreement on contract terms, the parties may engage in mediation. Either the CCO or the HCE may request mediation:

(a) After the parties have agreed to enter into mediation, the parties shall attempt to agree on the selection of the mediator and complete paperwork required to secure the mediator's services. If the parties are unable to agree, each party shall appoint a mediator, and those mediators shall select the final mediator;

(b) To be qualified to propose resolutions for disputes under this rule, the mediator shall:

(A) Be a knowledgeable and experienced mediator;

(B) Be familiar with health care and contracting matters; and

(C) Follow the terms and conditions specified in this rule for the mediation process.

(c) The parties shall pay for all mediation costs, whether a conclusion is reached or not. In consideration of potentially varied financial resources between the parties, which may pose a barrier to the use of this process, the parties may ask the mediator to allocate costs between the parties based on the ability to pay;

(d) Within 10 business days of a selection of a mediator, the CCO and HCE shall submit to each other and to the mediator the following:

(A) Contract offer; and

(B) Explanation of their position (i.e., advocacy brief).

(e) Unless an extension is agreed on by all parties, the mediator shall issue a report to the involved parties that will include mediation findings and recommendations no longer than 15 business days from the conclusion of the mediation.

(4) Pursuant to ORS 414.635, if the CCO and HCE cannot reach an agreement on contract terms within ten business days of receipt of the mediator's report, either party may request non-binding arbitration. The requesting party shall notify the other party in writing of the party's intent to refer the matter to arbitration:

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

(b) To be qualified to propose resolutions for disputes under this rule, the arbitrator shall:

(A) Be a knowledgeable and experienced arbitrator;

(B) Be familiar with health care provider contracting matters; and
(C) Follow the terms and conditions specified in this rule for the arbitration process.
(c) The parties shall pay for all arbitration costs. In consideration of potentially varied financial resources between the parties, which may pose a barrier to the use of this process, the parties may ask the arbitrator to allocate costs between the parties based on ability to pay;
(d) Within 10 business days of a selection of an arbitrator, the CCO and HCE shall submit to each other and to the arbitrator the following:
(A) Final contract offers; and
(B) Explanation of their position (i.e., advocacy brief).
(e) The arbitrator shall evaluate the final offers and the advocacy briefs from each party and issue a non-binding determination within 15 business days of the receipt of the parties' submissions.

STATUTORY/OTHER AUTHORITY: ORS 414.615, 414.625, 414.635, ORS 413.042, 414.651

STATUTES/OTHER IMPLEMENTED: ORS 414.610 - 414.685

ADOPT: 410-141-3565

RULE TITLE: Managed Care Entity Billing

NOTICE FILED DATE: 10/16/2019

RULE SUMMARY: These rules are necessary for the State to ensure the appropriate delivery of health services to Oregon Health Plan (OHP) members enrolled in Coordinated Care Organizations (CCOs) as required under state and federal law. The rules are designed to promote accountability of the State's contracted CCOs, provide member protections, and to promote members' physical, behavioral, and oral health.

RULE TEXT:

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

(a) Submit billings within no more than four months 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 billings within 12 months of the date of service in the following cases:

(A) Pregnancy;

(B) Eligibility issues such as retroactive deletions or retroactive enrollments;

(C) Medicare is the primary payer, except where the MCE is responsible for the Medicare reimbursement;

(D) Other cases that delay the initial billing 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.

(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 of the requested service as specified in OAR 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 billing 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

ADOPT: 410-141-3570

RULE TITLE: Managed Care Entity Encounter Claims Data Reporting

NOTICE FILED DATE: 10/16/2019

RULE SUMMARY: These rules are necessary for the State to ensure the appropriate delivery of health services to Oregon Health Plan (OHP) members enrolled in Coordinated Care Organizations (CCOs) as required under state and federal law. The rules are designed to promote accountability of the State's contracted CCOs, provide member protections, and to promote members' physical, behavioral, and oral health.

RULE TEXT:

(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 (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; 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

ADOPT: 410-141-3575

RULE TITLE: MCE Member Relations: Marketing

NOTICE FILED DATE: 10/16/2019

RULE SUMMARY: These rules are necessary for the State to ensure the appropriate delivery of health services to Oregon Health Plan (OHP) members enrolled in Coordinated Care Organizations (CCOs) as required under state and federal law. The rules are designed to promote accountability of the State's contracted CCOs, provide member protections, and to promote members' physical, behavioral, and oral health.

RULE TEXT:

(1) The following definitions apply for purposes of OAR 410-141-3575 through 410-141-3585:

(a) "Alternate Format" means any alternate approach to presenting print information to an individual with a disability. This term includes, at a minimum, the types of alternate formats defined under the Americans with Disabilities Act (ADA) and 45 CFR Part 92, and shall include: braille, large (18 point) print, audio narration, oral presentation, electronic file, sign language interpretation, and sighted guide;

(b) "Cold-call Marketing" means any unsolicited personal contact with a potential member for the purpose of marketing by the MCE;

(c) "Marketing" means any communication from an MCE to a potential member who is not enrolled in the MCE that can reasonably be interpreted as intended to compel or entice the potential member to enroll in that particular MCE;

(d) "Marketing Materials" means materials that are produced in any medium by or on behalf of an MCE and that can reasonably be interpreted as intended to market to potential members;

(e) "Outreach" means any communication from an MCE to any audience that cannot reasonably be interpreted as intended to compel or entice a potential member to enroll in a particular MCE. Outreach activities include, but are not limited to, the act of raising the awareness of the CCO, the MCE's subcontractors and partners, and the MCE contractually required programs and services; and the promotion of healthful behaviors, health education and health related events. For full benefit dual eligible (FBDE) members, outreach to provide information about opportunity to align Medicare and Medicaid benefits, or CMS approved Default or Simplified enrollment for newly Medicare eligible member in the CCO regarding MA or DSNP, is allowable subject to OHA or CMS materials review.

(f) "Outreach Materials" means materials that are produced in any medium, by or on behalf of an MCE that cannot reasonably be interpreted as intended to compel or entice a potential member to enroll in a particular MCE;

(g) "Potential Member" means, as defined in OAR 410-141-3500, a person who meets the eligibility requirements to enroll in the Oregon Health Plan but has not yet enrolled with a specific MCE;

(h) "Prevalent Non-English Language" means all non-English languages that are identified during the eligibility process as the preferred written language by the lesser of:

(A) Five percent of the MCE's total OHP enrollment; or

(B) One thousand of the MCE's members;

(i) "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.

(2) MCEs shall comply with 42 CFR §§ 438.10, 438.100 and 438.104 to ensure that before enrolling OHP clients, the MCE provides accurate oral and written information that potential members need to make an informed decision on whether to enroll in that MCE. MCEs shall distribute the materials to its entire service area as indicated in its MCE contract. The MCEs may not:

(a) Distribute any marketing materials without first obtaining state approval;

(b) Seek to compel or entice enrollment in conjunction with the sale of or offering of any private insurance; and

(c) Directly or indirectly engage in door to door, telephone, or cold-call marketing activities.

(3) The following outreach to members or potential members are expressly permitted:

(a) The creation of name recognition by an MCE. Permissible methods for creating name recognition include, but are not

limited to, brochures, pamphlets, newsletters, posters, fliers, websites, bus wraps, bill boards, web banners, health fairs, or health-related events;
(b) An MCE or its subcontractor's communications that express participation in or support for an MCE by its founding organizations or its subcontractors, so long as the communications do not constitute an attempt to compel or entice a client's enrollment;
(c) The following communications related to full benefit dual-eligible (FBDE) members with affiliated or contracted MA or DSNP plans, and member's Medicare and Medicaid providers, as long as they do not constitute an attempt by the MCE to influence client enrollment:
(A) Communications to notify full benefit dual-eligible (FBDE) members of opportunities to align MCE-provided benefits with Medicare Advantage or Special Needs Plans or access ICC services;
(i) Provision of information about CCO's affiliated Medicare Advantage Plan or Dual Special Needs Plan, contact information to inquire about the plan or provider network, and opt-in enrollment form;
(ii) Provision of aligned Medicare Advantage or Dual Special Needs Plan Simplified or Default enrollment letters, and CMS approved communication materials for newly eligible members.
(B) Improving coordination of care through mechanisms such as referral to LTSS assessment with DHS or providers of Home and Community Based Services, interdisciplinary care conferences, and use of HIE and event notifications;
(C) Communicating with providers serving full benefit dual-eligible (FBDE) members about unique care coordination needs or member needs such as ICC services, service authorizations, goals to ensure preventive screenings and assessments are scheduled as recommended, auxillary aids and services or interpreter services; or
(D) Streamlining communications to the full benefit dual eligible (FBDE) member to improve coordination of benefits including provision of integrated member materials, i.e. handbooks, provider directories, summary of Medicare-Medicaid benefits, and ID cards for members with aligned MA or DSNP and CCO enrollment.
(4) MCEs shall update plan access information with the Authority on a monthly basis for use in updating the Authority's availability charts. The Authority shall confirm information before posting availability charts.
(5) MCEs and when applicable, the aligned Medicare Advantage or Dual Special Needs Plan have sole accountability for producing or distributing materials following Authority approval.
(6) MCEs shall comply with the Authority's marketing materials guidelines or other requirements for the submission, approval, review and correction of marketing materials or other communications with members or potential members. MCEs shall participate, as required, in development of guidelines or other requirements with the Authority through a transparent public process, including stakeholder input. The guidelines include, but are not limited to:
(a) A list of communication or outreach materials subject to review by the Authority;
(b) A clear explanation of the Authority's process for review and approval of marketing materials;
(c) A marketing materials submission form to ensure compliance with MCE marketing rules; and
(d) An update of plan availability information submitted to the Authority on a monthly basis for review and posting.

STATUTORY/OTHER AUTHORITY: ORS 413.042, 414.615, 414.625, 414.635, 414.651

STATUTES/OTHER IMPLEMENTED: ORS 414.610 - 414.685

ADOPT: 410-141-3580

RULE TITLE: MCE Member Relations: Potential Member Information

NOTICE FILED DATE: 10/16/2019

RULE SUMMARY: These rules are necessary for the State to ensure the appropriate delivery of health services to Oregon Health Plan (OHP) members enrolled in Coordinated Care Organizations (CCOs) as required under state and federal law. The rules are designed to promote accountability of the State's contracted CCOs, provide member protections, and to promote members' physical, behavioral, and oral health.

RULE TEXT:

(1) In addition to the requirements below, information for potential members shall comply with the marketing requirements and prohibitions in 42 CFR § 438.104 and OAR 410-141-3575 and any requirements or guidelines adopted by the Authority there under.

(2) MCEs shall develop informational materials for potential members and provide such materials to the Authority. An MCE or the Authority may include informational materials in the application packet for potential members.

(3) MCEs' informational materials shall be sufficient for the potential member to make an informed decision about provider selection.

(4) The MCE shall make available to potential members, upon request, information on participating providers. MCE provider directories for potential members shall include all specified elements and be made readily accessible as defined in 42 CFR 438.10.

(5) MCEs' informational materials shall include the following information for potential members regarding the rights of American Indians and Alaskan Natives:

(a) MCEs' informational materials shall state that American Indians and Alaskan Natives enrolled in the MCEs may select an Indian health care provider (IHCP) that is participating as a primary care provider within the network of the MCE, insofar as the individual is otherwise eligible to receive primary care services from such IHCP and the IHCP has the capacity to provide primary care services to such American Indians and Alaskan Natives.

(b) MCEs shall clearly explain to potential members that American Indians and Alaskan Natives enrolled in an MCE shall also be permitted to obtain primary care services covered under the contract between the state and MCE from out-of-network IHCPs from whom the enrollee is otherwise eligible to receive primary care services. American Indians and Alaskan Natives may be referred by out-of-network IHCPs to a network provider without prior authorization or referral from a participating provider.

(6) MCEs' informational materials for potential members in their service area shall meet the following language requirements:

(a) Materials shall be culturally and linguistically appropriate and be sensitive to people with disabilities or reading limitations, including those whose primary language is not English;

(b) MCEs shall accommodate requests made by potential members, potential members' family members, or potential members' caregivers for language accommodation, translating to the potential member's language needs as requested. Alternate formats shall be provided and may include but are not limited to braille, large (18 point) print, audio narration, oral presentation, and electronic file along with other aids and services for other disabilities, including sign language interpretation and sighted guide.

(c) MCEs shall address health literacy issues by preparing informational materials at a 6th grade reading level, incorporating graphics and utilizing alternate format materials for potential members and using a minimum 12-point font or large print (18 point). MCEs shall make written informational materials available in alternative formats upon request of the potential member at no cost. Auxiliary aids and services and interpreter services must also be made available upon request of the potential member at no cost.

(7) MCEs shall ensure that all staff who have contact with potential members are:

(a) Fully informed of MCE and Authority rules applicable to enrollment, disenrollment, complaint and grievance policies and procedures, the availability of free qualified or certified health care interpreters in any language required by the

member including American Sign Language, and the process for requesting auxiliary aids or alternative format materials;
(b) Able to assist members in determining which participating providers:
(A) Have capacity in languages other than English;
(B) Have offices/facilities that are accessible and have accommodations for people with physical disabilities, including but not limited to offices, exam rooms, restrooms and equipment; and
(C) Are accepting new members.
(c) Trained in cultural competency and trauma-informed care, as those terms are defined in OAR 309-035-0105 and in accordance with CCO Health Equity Plan Training and Education plan described in 410-141-3735.
(8) MCE staff shall be able to provide potential members with information on how to access the Authority Beneficiary Support System, including information for full benefit dual-eligible (FBDE) members on how to receive choice counseling on Medicaid and Medicare options as required in 42 CFR 438.71.

STATUTORY/OTHER AUTHORITY: ORS 413.042, 414.615, 414.625, 414.635, 414.651

STATUTES/OTHER IMPLEMENTED: ORS 414.610 - 414.685

ADOPT: 410-141-3585

RULE TITLE: MCE Member Relations: Education and Information

NOTICE FILED DATE: 10/16/2019

RULE SUMMARY: These rules are necessary for the State to ensure the appropriate delivery of health services to Oregon Health Plan (OHP) members enrolled in Coordinated Care Organizations (CCOs) as required under state and federal law. The rules are designed to promote accountability of the State's contracted CCOs, provide member protections, and to promote members' physical, behavioral, and oral health.

RULE TEXT:

(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 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 410-180-0305and 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 education materials shall comply with the following language and access requirements:

(a) Materials shall be translated or include taglines in the prevalent non-English languages in the state as well as 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 include:
(a) The provider's name as well as any group affiliation;
(b) Street address;
(c) Telephone number;
(d) Website URL, as appropriate;
(e) Provider Specialty, as appropriate;
(f) Whether the provider will accept new members;
(g) Information about the provider's cultural and linguistic capabilities including:
(A) Availability of qualified or certified interpreters at no cost to members ensuring oral interpretation is available in all languages and American Sign Language per CFR §438.10;
(B) Availability of auxiliary aids and services for all members with disabilities upon request and at no cost; and
(C) 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 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);
(D) 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.
(h) 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.
(i) 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;
(j) 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.
(7) 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.
(8) 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.
(9) 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 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.
(10) 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. At a minimum, the member handbook shall contain the following:
(a) Revision date;
(b) Tag lines in English and other prevalent non-English languages, as defined in this rule, spoken by populations of members. The tag lines shall be located at the beginning of the document for the ease of the member and describe how members may access free sign and oral interpreters, as well as translations and materials in alternate formats;
(c) MCE's office location, mailing address, web address, office hours, and telephone numbers including TTY;
(d) Availability and access to coordinated care services through a patient-centered primary care home or other primary care team with the member as a partner in care management. Explain how to choose a PCP, how to make an appointment, and how to change PCPs, and the MCE's policy on changing PCPs;
(e) How to access information on contracted providers currently accepting new members and any restrictions on the member's freedom of choice among participating providers;
(f) Which participating or non-participating provider services the member may self-refer;
(g) Policies on referrals for specialty care, including prior authorization requirements and how to request a referral;
(h) Explanation of ICC services and how eligible members may access those services;
(i) 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;
(j) How and where members are to access urgent care services and advice, including how to access these services and advice when away from home;
(k) How and when members are to use emergency services, both locally and when away from home, including examples of emergencies;
(L) Information on contracted hospitals in the member's service area;
(m) Information on post-stabilization care after a member is stabilized in order to maintain, improve, or resolve the member's condition;
(n) Information on the MCE'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 MCE to the member as outlined in OAR 410-141-3875;
(B) Information about the member's right to continued benefits during the grievance process as provided in OAR 410-141-3885.
(o) Information on the member's rights and responsibilities, including the availability of the OHP Ombudsperson;
(p) Information on charges for non-covered services, and the member's possible responsibility for charges if they go outside of the MCE network for non-emergent care; including information specific to deductibles, copays and coinsurance for dually-enrolled qualified Medicare beneficiaries;
(q) Information about when providers may bill clients for services and what to do if they receive a bill, including information specific to payment responsibilities for dually-enrolled qualified Medicare beneficiaries;
(r) The transitional procedures for new members to obtain prescriptions, supplies, and other necessary items and services in the first month of enrollment if they are unable to meet with a PCP or PCD, other prescribing provider, or obtain new orders during that period; including specific communications for members who are becoming new Medicare enrollees;
(s) Information on advance directive policies including:

(A) Member rights under federal and Oregon law to make decisions concerning their medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives;
(B) The MCE's policies for implementation of those rights, including a statement of any limitation regarding the implementation of advanced directives as a matter of conscience.
(t) Whether or not the MCE uses provider contracts including alternative payment methodologies or incentives;
(u) The member's right to request and obtain copies of their clinical records, whether they may be charged a reasonable copying fee, and that they may request the record be amended or corrected;
(v) How and when members are to obtain ambulance services;
(w) Resources for help with transportation to appointments with providers and scheduling process for use of non-emergency medical transportation (NEMT) services;
(x) Explanation of the covered and non-covered coordinated care services in sufficient detail to ensure that members understand the benefits to which they are entitled;
(y) How to access in-network retail and mail-order pharmacies;
(z) How members are to obtain prescriptions including information on the process for obtaining non-formulary and over-the-counter drugs;
(aa) The MCE's confidentiality policy;
(bb) How and where members may access any benefits that are available under OHP but are not covered under the MCE's contract, including any cost sharing;
(cc) When and how members may voluntarily and involuntarily disenroll from MCEs and change MCEs;
(dd) MCEs 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 MCE's internal changes. If changes affect the member's ability to use services or benefits, the MCE shall offer the updated member handbook to all members;
(ee) The "Oregon Health Plan Client Handbook" is in addition to the MCE's member handbook, and an MCE may not use it to substitute for any component of the MCE's member handbook.
(11) 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 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.
(12) 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, 414.615, 414.625, 414.635, 414.651

STATUTES/OTHER IMPLEMENTED: ORS 414.610 - 414.685

ADOPT: 410-141-3590

RULE TITLE: MCE Member Relations: Member Rights and Responsibilities

NOTICE FILED DATE: 10/16/2019

RULE SUMMARY: These rules are necessary for the State to ensure the appropriate delivery of health services to Oregon Health Plan (OHP) members enrolled in Coordinated Care Organizations (CCOs) as required under state and federal law. The rules are designed to promote accountability of the State's contracted CCOs, provide member protections, and to promote members' physical, behavioral, and oral health.

RULE TEXT:

(1) MCEs shall:

(a) Have written policies and procedures that ensure that members have the rights and responsibilities included in this rule;

(b) Communicate these policies and procedures to participating providers;

(c) Monitor compliance with these policies and procedures, take corrective action as needed, and report findings to the Quality Improvement Committee defined under OAR 410-141-3525.

(2) MCE members shall have the following rights and are entitled to:

(a) Be treated with dignity and respect;

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

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

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

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

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

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

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

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

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

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

(L) Receive oversight, care coordination and transition and planning management from their MCE within the targeted population to ensure culturally and linguistically appropriate community-based care is provided in a way that serves them in as natural and integrated an environment as possible and that minimizes the use of institutional care;

(m) Receive necessary and reasonable services to diagnose the presenting condition;

(n) Receive integrated person-centered care and services designed to provide choice, independence and dignity and that meet generally accepted standards of practice and are medically appropriate;

(o) Have a consistent and stable relationship with a care team that is responsible for comprehensive care management;

(p) Receive assistance in navigating the health care delivery system and in accessing community and social support

services and statewide resources including but not limited to the use of certified or qualified health care interpreters, certified traditional health workers including community health workers, peer wellness specialists, peer support specialists, doulas, and personal health navigators who are part of the member's care team to provide cultural and linguistic assistance appropriate to the member's need to access appropriate services and participate in processes affecting the member's care and services;
(q) Obtain covered preventive services;
(r) Have access to urgent and emergency services 24 hours a day, seven days a week without prior authorization;
(s) Receive a referral to specialty providers for medically appropriate covered coordinated care services in the manner provided in the MCE's referral policy;
(t) Have a clinical record maintained that documents conditions, services received, and referrals made;
(u) Have access to one's own clinical record, unless restricted by statute;
(v) Transfer of a copy of the clinical record to another provider;
(w) Execute a statement of wishes for treatment, including the right to accept or refuse medical, surgical, or behavioral health treatment and the right to execute directives and powers of attorney for health care established under ORS 127;
(x) Receive written notices before a denial of, or change in, a benefit or service level is made, unless a notice is not required by federal or state regulations;
(y) Be able to make a complaint or appeal with the MCE and receive a response;
(z) Request a contested case hearing;
(aa) Receive certified or qualified health care interpreter services; and
(bb) Receive a notice of an appointment cancellation in a timely manner;
(cc) Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation, as specified in other federal regulations on the use of restraints and seclusion.
(3) CCO members shall have the following responsibilities:
(a) Choose or help with assignment to a PCP or service site;
(b) Treat the MCE, provider, and clinic staff members with respect;
(c) Be on time for appointments made with providers and to call in advance to cancel if unable to keep the appointment or if expected to be late;
(d) Seek periodic health exams and preventive services from the PCP or clinic;
(e) Use the PCP or clinic for diagnostic and other care except in an emergency;
(f) Obtain a referral to a specialist from the PCP or clinic before seeking care from a specialist unless self-referral to the specialist is allowed;
(g) Use urgent and emergency services appropriately and notify the member's PCP or clinic within 72 hours of using emergency services in the manner provided in the MCE's referral policy;
(h) Give accurate information for inclusion in the clinical record;
(i) Help the provider or clinic obtain clinical records from other providers that may include signing an authorization for release of information;
(j) Ask questions about conditions, treatments, and other issues related to care that is not understood;
(k) Use information provided by MCE providers or care teams to make informed decisions about treatment before it is given;
(L) Help in the creation of a treatment plan with the provider;
(m) Follow prescribed agreed upon treatment plans and actively engage in their health care;
(n) Tell the provider that the member's health care is covered under the OHP before services are received and, if requested, show the provider the Division Medical Care Identification form;
(o) Tell the Department or Authority worker of a change of address or phone number;
(p) Tell the Department or Authority worker if the member becomes pregnant and notify the worker of the birth of the member's child;
(q) Tell the Department or Authority worker if any family members move in or out of the household;

(r) Tell the Department or Authority worker if there is any other insurance available;
(s) Pay for non-covered services under the provisions described in OAR 410-120-1200 and 410-120-1280;
(t) Pay the monthly OHP premium on time if so required;
(u) Assist the MCE in pursuing any third-party resources available and reimburse the MCE the amount of benefits it paid for an injury from any recovery received from that injury; and
(v) Bring issues or complaints or grievances to the attention of the MCE.

STATUTORY/OTHER AUTHORITY: ORS 413.042, 414.615, 414.625, 414.635, 414.651

STATUTES/OTHER IMPLEMENTED: ORS 414.610 - 414.685

ADOPT: 410-141-3600

RULE TITLE: MCE Assessment: Definitions

NOTICE FILED DATE: 10/16/2019

RULE SUMMARY: These rules are necessary for the State to ensure the appropriate delivery of health services to Oregon Health Plan (OHP) members enrolled in Coordinated Care Organizations (CCOs) as required under state and federal law. The rules are designed to promote accountability of the State's contracted CCOs, provide member protections, and to promote members' physical, behavioral, and oral health.

RULE TEXT:

The following definitions apply for purposes of OAR 410-141-3600 through 3655:

(1) "Deficiency" means the amount by which the assessment as correctly computed exceeds the assessment, if any, reported by the managed care entities (MCEs).

(2) "Delinquency" means the MCE failed to file a report when due or to pay the assessment as correctly computed when the assessment was due.

(3) "MCE Assessment" means the managed care assessment defined under OAR 410-141-3610.

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

STATUTORY/OTHER AUTHORITY: ORS 413.042, 414.025

STATUTES/OTHER IMPLEMENTED: ORS 414.065, 2017 HB 2391

ADOPT: 410-141-3601

RULE TITLE: MCE Assessment: General Administration

NOTICE FILED DATE: 10/16/2019

RULE SUMMARY: These rules are necessary for the State to ensure the appropriate delivery of health services to Oregon Health Plan (OHP) members enrolled in Coordinated Care Organizations (CCOs) as required under state and federal law. The rules are designed to promote accountability of the State's contracted CCOs, provide member protections, and to promote members' physical, behavioral, and oral health.

RULE TEXT:

(1) The purpose of these rules is to govern the administration, enforcement, and collection of the managed care assessment on MCEs.

(2) MCEs shall pay an assessment on the gross amount of premium equivalents received during a calendar quarter:

(a) The MCE assessment rate for the period beginning January 1, 2018 and ending December 31, 2019, is 1.5 percent;

(b) The MCE assessment rate for the period beginning January 1, 2020 and ending December 31, 2026, is 2 percent.

(3) MCE assessments imposed are in addition to and not in lieu of any assessment, surcharge, or other assessment imposed on an MCE.

(4) The Authority may develop forms and reporting requirements and change the forms and reporting requirements as necessary to administer, enforce, and collect the assessments.

STATUTORY/OTHER AUTHORITY: ORS 413.042, 414.025

STATUTES/OTHER IMPLEMENTED: ORS 414.065, 2017 HB 2391

ADOPT: 410-141-3605

RULE TITLE: MCE Assessment: Disclosure of Information

NOTICE FILED DATE: 10/16/2019

RULE SUMMARY: These rules are necessary for the State to ensure the appropriate delivery of health services to Oregon Health Plan (OHP) members enrolled in Coordinated Care Organizations (CCOs) as required under state and federal law. The rules are designed to promote accountability of the State's contracted CCOs, provide member protections, and to promote members' physical, behavioral, and oral health.

RULE TEXT:

(1) Except as otherwise required by law, the Authority may not publicly divulge or disclose the amount of income, expense, or other particulars set forth or disclosed in any report or return required in the administration of the assessments. Particulars include but are not limited to social security numbers, employer numbers, or other organization identification numbers, and any business records required to be submitted to or inspected by the Authority to allow it to determine the amount of any assessments, delinquencies, or deficiencies payable or paid, or otherwise administer, enforce, or collect a health care assessment to the extent that the information would be exempt from disclosure under ORS 192.345(5).

(2) The Authority may:

(a) Upon request, furnish any MCE or its authorized representative with a copy of the MCE's report filed with the Authority for any quarter, or with a copy of any other information filed by the MCE in connection with the report, or as the Authority considers necessary;

(b) Publish information or statistics so classified as to prevent the identification of income or any particulars contained in any report or return; and

(c) Disclose and give access to an officer or employee of the Authority or its designee, or to the authorized representatives of the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, the Controller General of the United States, the Oregon Secretary of State, the Oregon Department of Justice, the Oregon Department of Justice Medicaid Fraud Control Unit, and other employees of the state or federal government unless the Authority deems disclosure or access necessary or appropriate for the performance of official duties in the Authority's administration, enforcement, or collection of these assessments.

STATUTORY/OTHER AUTHORITY: ORS 413.042, 414.025

STATUTES/OTHER IMPLEMENTED: ORS 414.065, 2017 HB 2391

ADOPT: 410-141-3610

RULE TITLE: MCE Assessment: Calculation, Report, Due Date, Verification

NOTICE FILED DATE: 10/16/2019

RULE SUMMARY: These rules are necessary for the State to ensure the appropriate delivery of health services to Oregon Health Plan (OHP) members enrolled in Coordinated Care Organizations (CCOs) as required under state and federal law. The rules are designed to promote accountability of the State's contracted CCOs, provide member protections, and to promote members' physical, behavioral, and oral health.

RULE TEXT:

(1) The MCE assessment on the premium equivalents paid to an MCE on or after January 1, 2018, is based on calendar quarters. Calendar quarter start dates are January 1, April 1, July 1, and October 1. For purposes of this rule, premium equivalents shall be assessed as of the calendar quarter in which the premium equivalents are received by the MCE.

(2) Premium equivalents include all capitation payments received by the MCE for the provision of health services and all other payments received by the MCE from the Authority for providing health services under ORS chapter 414, including maternity payments, quality incentive pool payments, and qualified directed payments as defined in OAR 410-125-0230. Premium equivalents do not include Medicare premiums or any form of payment by Oregon Health Plan (OHP) enrollees.

(3) Adjustments to premium equivalents subject to assessment shall be determined as follows:

(a) Premium equivalents attributable to periods prior to January 1, 2018, except annual quality incentive pool payments, are not subject to the assessment and shall be deducted from the assessable premium equivalents when calculating the assessment due;

(b) Adjustments due to changes in client status and other premium equivalents adjustments resulting in additional payments received by the MCE on or after April 1, 2018, are subject to the assessment;

(c) If premium equivalents are reduced by a recoupment by the Authority for an overpayment, then the assessable premium equivalents shall be the reduced amount after recoupment;

(d) If both an overpayment and recoupment occur, the MCE shall be subject to the assessment on the premium equivalents received in the calendar quarter; and

(e) Sub-capitation payments made to an MCE by another MCE are not included in the total premium equivalents subject to assessment if the paying MCE certifies to the receiving MCE in writing that the paying MCE is already responsible for the managed care assessment on the originating premium equivalents.

(4) The MCE must pay the MCE assessment and file the report on a form approved by the Authority on or before the 45th day following the end of the calendar quarter for which an assessment is due unless the Authority permits a later payment date. The MCE must provide all required information on the report.

(5) Any report, statement, or other document required to be filed shall be certified by the MCE's chief financial officer or designee. The certification must attest, based on best knowledge, information, and belief to the accuracy, completeness, and truthfulness of the document.

(6) Payments may be made electronically or by paper check. If the MCE pays electronically, the accompanying report may either be faxed or mailed to the Authority. If the MCE pays by paper check, the accompanying report must be mailed with the check to the address provided on the report form.

(7) The Authority may charge the MCE a fee of $100 if for any reason the check, draft, order, or electronic funds transfer request is dishonored. This charge is in addition to any penalty for nonpayment of the assessments that may also be due.

STATUTORY/OTHER AUTHORITY: ORS 413.042, 414.025

STATUTES/OTHER IMPLEMENTED: ORS 414.065, 2017 HB 2391

ADOPT: 410-141-3615

RULE TITLE: MCE Assessment: Filing an Amended Report

NOTICE FILED DATE: 10/16/2019

RULE SUMMARY: These rules are necessary for the State to ensure the appropriate delivery of health services to Oregon Health Plan (OHP) members enrolled in Coordinated Care Organizations (CCOs) as required under state and federal law. The rules are designed to promote accountability of the State's contracted CCOs, provide member protections, and to promote members' physical, behavioral, and oral health.

RULE TEXT:

(1) The claims for refunds or payments of additional MCE assessment must be submitted by the MCE on an Authority approved form. The MCE must provide all information required on the report. The Authority may audit the MCE, request additional information, or request an informal conference prior to granting a refund or as part of its review of a payment of a deficiency.

(2) Claim for refund:

(a) If the amount of the MCE assessment imposed is less than the amount paid by the MCE and the MCE does not then owe an assessment for any other calendar period, the Authority may refund the overpayment. In no event shall a refund applicable to a particular calendar quarter exceed the assessment amount actually paid by the MCE;

(b) The MCE may file a claim for refund on an Authority approved form within 180 days after the end of the calendar quarter to which the claim for refund applies;

(c) If there is an amount due from the MCE to the Authority for any past due assessments or penalties, any refund otherwise allowable shall first be applied to the unpaid assessments and penalties, and the Authority shall notify the MCE.

(3) Payment of deficiency:

(a) If the amount of the MCE assessment is more than the amount paid by the MCE, the MCE may file a corrected report and pay the deficiency at any time. The penalty under OAR 410-141-3635 shall stop accruing after the Authority receives full payment of the total deficiency for the calendar quarter;

(b) If there is an error in the determination of the assessment due, the MCE may describe the circumstances of the late additional payment with the late filing of the amended report. The Authority, in its sole discretion, shall determine the penalty for such late additional payments pursuant to OAR 410-141-3635.

(4) If the Authority discovers or identifies information that it determines could give rise to the issuance of a notice of proposed action or the issuance of a refund, the Authority shall issue notification pursuant to OAR 410-141-3640.

STATUTORY/OTHER AUTHORITY: ORS 413.042, 414.025

STATUTES/OTHER IMPLEMENTED: 2017 HB 2391

ADOPT: 410-141-3620

RULE TITLE: MCE Assessment: Determining the Date Filed

NOTICE FILED DATE: 10/16/2019

RULE SUMMARY: These rules are necessary for the State to ensure the appropriate delivery of health services to Oregon Health Plan (OHP) members enrolled in Coordinated Care Organizations (CCOs) as required under state and federal law. The rules are designed to promote accountability of the State's contracted CCOs, provide member protections, and to promote members' physical, behavioral, and oral health.

RULE TEXT:

(1) For the purposes of these rules, any reports, requests, appeals, payments, or other response by the MCE must be either:

(a) Received by the Authority before the close of business on the date due; or

(b) If mailed, postmarked before midnight of the due date.

(2) When the due date falls on a Saturday, Sunday, or legal holiday, the response is due on the next business day.

STATUTORY/OTHER AUTHORITY: ORS 413.042, 414.025

STATUTES/OTHER IMPLEMENTED: ORS 414.065

ADOPT: 410-141-3625

RULE TITLE: MCE Assessment: Authority to Audit Records

NOTICE FILED DATE: 10/16/2019

RULE SUMMARY: These rules are necessary for the State to ensure the appropriate delivery of health services to Oregon Health Plan (OHP) members enrolled in Coordinated Care Organizations (CCOs) as required under state and federal law. The rules are designed to promote accountability of the State's contracted CCOs, provide member protections, and to promote members' physical, behavioral, and oral health.

RULE TEXT:

(1) The MCE must maintain financial records necessary and adequate to determine the amount of premium equivalents for any period for which an MCE assessment may be due.

(2) The Authority may audit the MCE's records at any time for a period of five years following the date the assessment is due to verify or determine the premium equivalents for the MCE.

(3) Any audit, finding, or position may be reopened if there is evidence of fraud, malfeasance, concealment, misrepresentation of material fact, omission of income, or collusion either by the MCE or by the MCE and an Authority representative.

(4) The Authority may notify the MCE of a potential deficiency or issue a refund based upon its audit findings.

STATUTORY/OTHER AUTHORITY: ORS 413.042, 414.025

STATUTES/OTHER IMPLEMENTED: ORS 414.065, 2017 HB 2391