

Certification Criteria for Coordinated Care Organizations

- (1) Applicants shall submit applications to the Authority describing their capacity and plans for meeting the goals and requirements established for the Oregon Integrated and Coordinated Health Care Delivery System, including being prepared to enroll all eligible individuals within the CCO's proposed service area. The Authority shall use the Request for Applications (RFA) procurement process described in OAR 410-141-3010.
- (2) In addition to the requirements for CCOs expressed in the laws establishing Health System Transformation, the Authority interprets the qualifications and expectations for CCO certification within the context of the Oregon Health Policy Board's report, *Coordinated Care Organizations Implementation Proposal: HB 3650 Health System Transformation* (Jan. 24, 2012).
- (3) Applicants must describe their demonstrated experience and capacity for:
 - (a) Managing financial risk and establishing financial reserves;
 - (b) Meeting the following minimum financial requirements:
 - (A) Maintaining restricted reserves of \$250,000 plus an amount equal to 50 percent of the entity's total actual or projected liabilities above \$250,000;
 - (B) Maintaining a net worth in an amount equal to at least 5 percent of the average combined revenue in the prior two quarters of the participating health care entities.
 - (c) Operating within a fixed global budget;
 - (d) Developing and implementing alternative payment methodologies that are based on health care quality and improved health outcomes;
 - (e) Coordinating the delivery of physical health care, mental health and chemical dependency services, oral health care and covered long-term care services;
 - (f) Engaging community members and health care providers in improving the health of the community and addressing regional, cultural, socioeconomic and racial disparities in health care that exist among the entity's enrollees and in the entity's community.
- (4) In selecting one or more CCOs to serve a geographic area, the Authority shall:
 - (a) For members and potential members, optimize access to care and choice of providers;
 - (b) For providers, optimize choice in contracting with CCOs; and
 - (c) Allow more than one CCO to serve the geographic area if necessary to optimize access and choice under this subsection.
- (5) Evaluation of CCO applications shall account for the developmental nature of the CCO system. The Authority recognizes that CCOs and partner organizations will need time to develop capacity, relationships, systems and experience to fully realize the goals envisioned by the Oregon Integrated and Coordinated Health Care Delivery System. The Authority shall pay particular attention to how the application describes community involvement in the governance of the CCO and to the CCO's strategic plan for developing its community health assessment and community health improvement plan:
 - (a) In all cases, CCOs must have plans in place to meet the criteria laid out in these rules and the application process and to make sufficient progress in implementing plans and realizing the goals established in contract;
 - (b) Each criterion will be listed, followed by the elements that must be addressed during the initial certification described in this rule, without limiting the information that is requested in the RFA concerning these criteria.
- (6) Each CCO shall have a governance structure that meets the requirements of ORS 414.625. The applicant must:
 - (a) Clearly describe how it meets governance structure criteria from ORS 414.625, how the governance structure makeup reflects community needs and supports the goals of health care transformation, the criteria used to select governance structure members; and how it will assure transparency in governance;
 - (b) Identify key leaders who are responsible for successful implementation and sustainable operation of the CCO;
 - (c) Describe how its governance structure will reflect the needs of members with severe and persistent mental illnesses and members receiving DHS Medicaid-funded long-term care services and supports.
- (7) Each CCO must convene a community advisory council (CAC) that meets the requirements of ORS 414.625. The applicant must clearly describe how it meets the requirements for selection and implementation of a CAC consistent with ORS 414.625, how the CAC will be administered to achieve the goals of community involvement and the development, adoption and updating of the community health assessment and community health improvement plan.

- (8) CCOs shall partner with their local public health authority, hospital system, type B AAA, APD field office and local mental health authority to develop a shared community health assessment that includes a focus on health disparities in the community:
- (a) Since community health assessments will evolve over time as relationships develop and CCOs learn what information is most useful, initial CCO applicants may not have time to conduct a comprehensive community assessment before becoming certified;
 - (b) The applicant shall describe how it will develop its health assessment, meaningfully and systematically engaging representatives of critical populations and community stakeholders and its community advisory council to create a health improvement plan for addressing community need that builds on community resources and skills and emphasizes innovation.
- (9) The CCO must describe its strategy to adopt and implement a community health improvement plan consistent with OAR 410-141-3145.
- (10) Dental care organizations: On or before July 1, 2014, each CCO shall have a formal contractual relationship with any DCO in its service area.
- (11) CCOs shall have agreements in place with publicly funded providers to allow payment for point-of-contact services including immunizations, sexually transmitted diseases and other communicable diseases, family planning and HIV/AIDS prevention services. Applicants shall confirm that these agreements have been developed, unless good cause can be shown:
- (a) In addition, CCOs shall have agreements in place with the local mental health authority consistent with ORS 414.153. Applicants shall confirm that these agreements have been developed unless good cause can be shown;
 - (b) The Authority shall review CCO applications to ensure that statutory requirements regarding county agreements are met, unless good cause is shown why such agreement is not feasible.
- (12) CCOs must provide integrated person-centered care and services designed to provide choice, independence and dignity:
- (a) The applicant must describe its strategy to assure that each member receives integrated person-centered care and services designed to provide choice, independence and dignity;
 - (b) The applicant must describe its strategy for providing members the right care at the right place and the right time and to integrate and coordinate care across the delivery system.
- (13) CCOs must develop mechanisms to monitor and protect against underutilization of services and inappropriate denials; provide access to qualified advocates; and promote education and engagement to help members be active partners in their own care. Applicants must:
- (a) Describe their planned or established policies and procedures that protect member rights, including access to qualified peer wellness specialists , personal health navigators, and qualified community health workers where appropriate;
 - (b) Describe planned or established mechanisms for a complaint, grievance, and appeals resolution process, including how that process shall be communicated to members and providers.
- (14) CCOs must operate in a manner that encourages patient engagement, activation and accountability for the member's own health. Applicants shall describe how they plan to:
- (a) Actively engage members in the design and, where applicable, implementation of their treatment and care plans;
 - (b) Ensure that member choices are reflected in the development of treatment plans and member dignity is respected.
- (15) CCOs must assure that members have a choice of providers within the CCO's network. CCOs and their network providers must work together to develop best practices for care and service delivery to reduce waste and improve health and well-being of all covered populations:
- (a) Applicants must describe how they will work with their providers to develop the partnerships necessary to allow for access to and coordination with medical, mental health and chemical dependency services providers, and dental care if the CCO includes a dental care organization, and to facilitate access to community social and support services, including DHS Medicaid-funded long-term care services, mental health crisis services and culturally and linguistically appropriate services;
 - (b) Applicants must describe their planned or established tools for provider use to assist in the education of members about care coordination and the responsibilities of both parties in the process of communication.
- (16) CCOs must assure that each member has a consistent and stable relationship with a care team that is responsible for providing preventive and primary care and for comprehensive care management in all settings.

The applicant shall demonstrate how it will support the flow of information, identify a lead provider or care team to confer with all providers responsible for a member's care, and use a standardized patient follow-up approach.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(24) CCOs' health care services must focus on improving health equity and reducing health disparities.

Applicants must:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Stat. Auth.: ORS 414.032

Stats. Implemented: 2011 HB 3650, Chapter 602, Oregon Laws 2011, 2012 SB 1580

410-141-3020

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

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

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

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

(A) Those federal laws and regulations governing the operation of the medical assistance program and any waivers granted the Authority by the Centers for Medicare and Medicaid Services (CMS) to operate medical assistance programs;

(B) Oregon Revised Statutes governing medical assistance programs;

(C) Generally for CCOs, requirements applicable to providing coordinated care services to clients are provided in OAR chapter 410 division 141, administrative rules for the Oregon Integrated and Coordinated Care Delivery System, the Division's General Rules, 410-120-0000 through 410-120-1980 and the provider rules applicable to the category of health service;

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

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

(F) The basic framework for provider enrollment in OAR 943-120-0300 through 943-120-0380 generally applies to providers enrolled with the Authority, subject to more specific requirements applicable to the administration of medical assistance programs. For purposes of this rule, "more specific" means the requirements, laws and rules applicable to the provider type and covered health services.

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

Stat. Auth.: ORS 414.032

Stats. Implemented: 2011 HB 3650, Chapter 602, Oregon Laws 2011, 2012 SB 1580

410-141-3030

Implementation and Transition

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

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

(2) Local and community involvement will be encouraged and the Authority will work with CCOs to achieve flexibilities that may be appropriate to achieve community-directed objectives.

(3) Upon request, the Authority will assign innovator agents to work with CCOs, consistent with SB 1580 (Enrolled) (2012).

Stat. Auth.: ORS 414.032

Stats. Implemented: 2011 HB 3650, Chapter 602, Oregon Laws 2011, 2012 SB 1580

410-141-3050

CCO Enrollment for Children Receiving Health Services

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

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

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

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

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

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

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

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

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

(b) A child receiving CAF services placed in behavioral rehabilitation services (BRS) settings shall be enrolled in the CCO serving the region where the BRS setting is located, unless the CCO requests an out of area exception, and the Authority grants the exception for continuity of care.

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

(a) The child is presumed to continue to be enrolled in the CCO with which the child was most recently enrolled. The Authority considers an admission to a PRTS facility a temporary placement for purposes of CCO enrollment. Any address change associated with the placement in the PRTS facility is not a change of residence for purposes of CCO enrollment and may not be a basis for disenrollment from the CCO, unless the provisions in OAR chapter 410 division 141 apply. If the Authority determines that a child was disenrolled for reasons not consistent with these rules, the Authority or Department shall re-enroll the child with the appropriate CCO and assign an enrollment date that provides for continuous coverage with the appropriate CCO. If the child was enrolled in a different CCO in error, the Authority shall disenroll the child from that CCO and recoup the CCO payments;

(b) Immediately upon discharge from long-term psychiatric care and before admission to a PRTS, the Authority or the Department shall enroll a child in a CCO. At least two weeks before discharge from a long-term psychiatric care facility to a PRTS facility, the long-term care facility shall consult with the Authority about which CCO shall provide health care for the child. The long-term care facility shall make every reasonable effort within the laws governing confidentiality to consult with the assigned CCO in order to provide for continuity of care upon discharge.

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

410-141-3060

Enrollment Requirements

(1) An Oregon Health Plan (OHP) client who is eligible for or receiving health services must be enrolled in a Coordinated Care Organization (CCO) to receive the health services for which the individual is eligible, except as provided in ORS 414.631 (2), (3), (4) and (5) and ORS 414.632(2).

(2) Mandatory enrollment does not apply to:

(a) An individual who is a noncitizen and who is eligible only for labor and delivery services and emergency treatment services;

(b) An individual who is an American Indian and Alaskan Native beneficiary;

(c) An individual who is dually eligible for Medicare and Medicaid and enrolled in a PACE program;

(d) An individual exempted from mandatory enrollment by rule of the Authority;

(e) An individual who resides in an area that is not served by a CCO or where the CCO's provider network is inadequate.

(3) In any area that is not served by a CCO but is served by a prepaid managed care health services organization (PHP), an individual must enroll with the PHP to receive any of the health services offered by the PHP.

(4) Selection of CCOs in accordance with this rule is a condition of eligibility for OHP clients. If, upon reapplication, OHP clients do not select CCOs in accordance with this rule, the Authority shall select the CCO. This selection shall be based on which CCOs the clients were previously enrolled in:

(a) Service areas with sufficient dental care service capacity through DCOs shall be called mandatory DCO service areas. A client shall select a DCO in a mandatory DCO service area;

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

(A) Select any DCO open for enrollment; or

(B) Remain in the Medicaid FFS dental care delivery system.

(c) If unable to enroll in a CCO due to lack of capacity or availability under section (2)(e) or (3), the client may to select any PHP available for enrollment.

(5) The following are exemptions to mandatory enrollment in CCOs that allow clients, to enroll with a PHP or remain in the Medicaid FFS delivery systems for physical, dental or mental health care:

(a) Continuity of Care:

(A) The client has an established relationship with a Division enrolled practitioner from whom the client receives ongoing treatment for a covered medical or dental condition, and;

(B) Subject to OAR 410-141-0080(1)(b)(B)(vi)(III), the Division enrolled practitioner is not a member of the CCO's participating provider panel the client would be enrolled in, and;

(C) Loss of continuity of care for the covered medical or dental condition would have a significant negative effect on the health status of the client, as determined by the Authority through medical review, to change practitioners and receive treatment from the CCO's participating provider panel;

(D) Exemptions from mandatory enrollment in CCOs for continuity of care may be granted for a period of four months. The Authority may grant extensions, upon request, subject to review of unique circumstances. A 12-month exemption may be granted if the reason for the exemption is not likely to change or is due to a chronic or permanent condition or disability.

(b) Clients shall be exempt from mandatory enrollment with a CCO, if the client became eligible through a hospital hold process and is placed in the Adults/Couples category. The client shall remain FFS for the first six months of eligibility unless a change occurs with their eligibility or the category. At that time, the exemption shall be removed and the client shall be enrolled into an open CCO. The exemption shall not affect the mandatory enrollment requirement into a DCO;

(c) The client is a child in the legal custody of the Oregon Youth Authority (OYA) or Children, Adults and Families (CAF) (Child Welfare Services), and the child is expected to be in a substitute care placement for less than 30 calendar days, unless:

(A) There is no FFS access; or

(B) There are continuity of care issues.

(d) The client is in the third trimester of her pregnancy when first determined eligible for OHP, or at redetermination, and wants to continue obtaining maternity services from a practitioner who is not a participating provider with a CCO in the service area:

(A) In order to qualify for such exemption at the time of redetermination, the client must not have been enrolled with an FCHP or PCO or CCO during the three months preceding redetermination;

(B) If the client moves out of her CCO's service area during the third trimester, the client may be exempted from enrollment in the new service area for continuity of care if the client wants to continue obstetric-care with her previous physician, and that physician is within the travel time or distance indicated in 410-141-3220;

(C) If the practitioner is a PCM, the client shall enroll with that practitioner as a PCM member;

(D) If the practitioner is not enrolled with the Division as a PCM, then the client may remain in the Medicaid FFS delivery system until 60 days after the birth of her child. After the 60-day period, the client must enroll in a CCO.

(e) The client has been accepted by the Medically Fragile Children's Unit of the Addictions and Mental Health Division;

(f) Other just causes as determined by the Authority through medical review, which include the following factors:

(A) The cause is beyond the control of the client;

(B) The cause is in existence at the time that the client first becomes eligible for OHP;

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

(D) The lack of reasonable alternatives.

(6) The primary person in the household group and benefit group as defined in OAR 461-110-0110, 461-110-0210, and 461-110-0720, shall select CCOs on behalf of all OHP clients in the benefit group. CCO selection shall occur at the time of application for OHP in accordance with section (4) of this rule:

(a) All OHP clients in the benefit group shall enroll in the same CCO for coordinated care services except for dental care unless exempted under the conditions stated in this rule;

(b) If the client is not able to choose CCOs on his or her own, the client's representative shall make the selection;

(c) CAF or OYA shall select CCOs for a child receiving CAF (Child Welfare Services) or OYA services, consistent with OAR 410-141-3050, with the exception of children in subsidized adoptions;

(d) Enrollment in a CCO of a client receiving Medicare and who resides in a service area served by CCOs shall be as follows:

(A) If the client, who is Medicare Advantage eligible, selects a CCO, the client will be enrolled with the CCO that corresponds to the Medicare Advantage plan;

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

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

(ii) If the client chooses to disenroll from the Medicare Advantage plan and then, within 60 calendar days of disenrollment, chooses the CCO that corresponds to the Medicare Advantage plan from which the client disenrolled, the client shall be allowed to enroll in the CCO even if the CCO is not open for enrollment to other clients;

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

(7) If the OHP client resides in a mandatory service area and fails to select a CCO and a DCO (pending contractual arrangements with a CCO under ORS 414.625) at the time of application for the OHP, the Division may enroll the client with a CCO and a DCO as follows:

(a) The client shall be assigned to and enrolled with a CCO and a DCO which meet the following requirements:

(A) Is open for enrollment;

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

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

(b) The Authority shall send notification to the client, which shall provide information of the assignments and the right to change assignments within 30 calendar days of enrollment. A change in assignment shall be honored if there is another CCO or DCO open for enrollment in the county in which the client resides;

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

(8) The provision of coordinated care services to a member shall begin on the first day of enrollment with the CCO except for:

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

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

(c) For members who are re-enrolled within 30 calendar days of disenrollment, the date of enrollment shall be the date specified by the Authority that may be retroactive to the date of disenrollment;

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

Stat. Auth.: ORS 414.032

Stats. Implemented: 2011 HB 3650, Chapter 602, Oregon Laws 2011, 2012 SB 1580

410-141-3070

Pharmaceutical Drug List Requirements

(1) Prescription drugs are a covered service based on the funded Condition/Treatment Pairs. Coordinated Care Organizations (CCO) shall pay for prescription drugs, except:

(a) As otherwise provided, mental health drugs that are in Class 7 & 11 (based on the National Drug Code (NDC)) as submitted by the manufacturer to First Data Bank);

(b) Depakote, Lamictal and those drugs that the Authority specifically carved out from capitation according to sections (8) and (9) of this rule;

(c) Any applicable co-payments;

(d) For drugs covered under Medicare Part D when the client is fully dual eligible.

(2) CCOs are encouraged, but not required, to use the statewide Practitioner-Managed Prescription Drug Plan under ORS 414.330 to 414.337. CCOs may use a restrictive drug list as long as it allows access to other drug products not on the drug list through some process such as prior authorization (PA). The drug list must:

(a) Include (FDA) Federal Drug Administration- approved drug products for each therapeutic class sufficient to ensure the availability of covered drugs with minimal prior approval intervention by the provider of pharmaceutical services;

(b) Include at least one item in each therapeutic class of over-the-counter medications; and

(c) Be revised periodically to assure compliance with this requirement.

(3) CCOs shall provide their participating providers and their pharmacy subcontractor with:

(a) Their drug list and information about how to make non-drug listed requests;

(b) Updates made to their drug list within 30 days of a change that may include, but is not limited to:

(A) Addition of a new drug;

(B) Removal of a previously listed drug; and

(C) Generic substitution.

(4) If a drug cannot be approved within the 72-hour time requirement for prior authorization of drugs and the medical need for the drug is immediate, CCOs must provide (within 24 hours of receipt of the drug prior authorization request) for the dispensing of at least a 72-hour supply of a drug that requires prior authorization.

(5) CCOs shall authorize the provision of a drug requested by the Primary Care Physician (PCP) or referring provider, if the approved prescriber certifies medical necessity for the drug such as:

(a) The equivalent of the drug listed has been ineffective in treatment; or

(b) The drug listed causes or is reasonably expected to cause adverse or harmful reactions to the member.

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

(7) CCOs may not authorize payment for any Drug Efficacy Study Implementation (DESI) Less Than Effective (LTE) drugs which have reached the FDA Notice of Opportunity for Hearing (NOOH) stage, as specified in OAR 410-121-0420 (DESI)(LTE) Drug List. The DESI LTE drug list is available at: http://www.cms.hhs.gov/MedicaidDrugRebateProgram/12_LTEIRSDrugs.asp.

(8) A CCO may seek to add drugs to the list contained in section (1) of this rule by submitting a request to the Authority no later than March 1 of any given contract year. The request must contain all of the following information:

(a) The name of the drug;

(b) The FDA approved indications that identifies the drug may be used to treat a severe mental health condition; and

(c) The reason that the Authority should consider this drug for carve out.

(9) If a CCO requests that a drug not be paid within the global budget, the Authority shall exclude the drug from global budget for the following January contract cycle if the Authority determines that the drug has an approved FDA indication for the treatment of a severe mental health condition such as major depressive, bipolar, or schizophrenic disorders.

(10) The Authority shall pay for a drug that is not included in the global budget pursuant to the Pharmaceutical Services Program rules (chapter 410, division 121). A CCO may not reimburse providers for carved out drugs.

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

(12) CCOs may not provide payment for drugs made by manufacturers that do not have valid rebate agreements in place with the Centers for Medicare and Medicaid Services (CMS) as part of the Medicaid Drug Rebate Program.

Stat. Auth.: ORS 414.032

Stats. Implemented: 2011 HB 3650, Chapter 602, Oregon Laws 2011, 2012 SB 1580

410-141-3080

Disenrollment from Coordinated Care Organizations

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

(2) Requests for disenrollment shall be honored:

(a) Without cause under the following time frames and effective dates:

(A) After six months of enrollment. The effective date of disenrollment shall be the first of the month following the Authority's approval;

(B) At redetermination and the primary person requests disenrollment without cause. The effective date shall be the first of the month following the date that of redetermination.

(b) With cause: Under the following time frames and effective dates:

(A) At any time;

(B) At time of disenrollment from a Medicare Advantage plan the member shall also be disenrolled from the corresponding FCHP or PCO. The disenrollment effective date shall be the first of the month that the member's Medicare Advantage plan disenrollment is effective;

(C) Members receiving Medicare and enrolled in a FCHP or PCO that has a corresponding Medicare Advantage component may disenroll from the FCHP or PCO at any time if they also request disenrollment from the Medicare Advantage plan. The disenrollment effective date shall be the first of the month following the date of request for disenrollment;

(D) If a CCO does not, because of moral or religious objections, cover the service the member seeks;

(E) The member needs related services (for example a cesarean section and a tubal ligation) to be performed at the same time, and not all related services are available within the network, and the members' PCP or another provider determines that receiving the services separately would subject the member to unnecessary risk; or

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

(i) The member moves out of the CCO's service area;

- (ii) The member is a Native American or Alaskan Native with proof of Indian Heritage who wishes to obtain primary care services from his or her Indian Health Service facility, tribal health clinic/program or urban clinic and the Fee-For-Service (FFS) delivery system;
 - (iii) The need for continuity of care that is not in conflict with OAR 410-141-0060 or this rule. Participation in the OHP, including coordinated and integrated care, does not guarantee that any OHP client has a right to continued care or treatment by a specific provider. A request for disenrollment based on continuity of care shall be denied if the basis for this request is primarily for the convenience of an OHP client or a provider of a treatment, service or supply, including but not limited to a decision of a provider to participate or decline to participate in a CCO.
- (G) For pregnant women disenrollment shall be approved if the following conditions are met:
- (i) The client is in the third trimester of pregnancy and has just been determined eligible for OHP, or is client who has just been re-determined eligible and was not enrolled in a FCHP or PCO within the past 3 months; and
 - (ii) The member's new CCO does not contract with the member's current OB provider and the CCO member wishes to continue obtaining maternity services from that non-participating OB provider; and
 - (iii) The request to change CCO is made prior to the date of delivery.
- (c) In addition to the disenrollment constraints listed in subsections (a) and (b), above, member disenrollment requests are subject to the following requirements:
- (A) The member must join another CCO, unless the member meets the exemptions to enrollment set forth OAR 410-141-0060(4);
 - (B) If the only CCO available in a mandatory service area is the CCO from which the member wishes to disenroll, the member may not disenroll without cause;
 - (C) If the Authority fails to make a disenrollment determination by the first day of the second month following the month in which the member files a request for disenrollment, the disenrollment is considered approved.
- (3) CCO's may request member disenrollment for the following reasons:
- (a) The Authority may disenroll members for cause when requested by the CCO, subject to American with Disabilities Act requirements. Examples of cause include, but are not limited to the following:
 - (A) Missed appointments. The provider or CCO shall establish the number of missed appointments. The number must be the same as for all other patients. The provider must document they have attempted to ascertain the reasons for the missed appointments and must assist the member in receiving services. This rule does not apply to Medicare members who enrolled in a FCHP's or PCO's Medicare Advantage plan;
 - (B) If the member's behavior is disruptive, unruly, or abusive to the point that the member's continued enrollment in the CCO seriously impairs the PHP's ability to furnish services to either the member or other members, subject to the requirements in (2)(a)(B)(vii);
 - (C) If the member commits or threatens an act of physical violence directed at a medical provider or property, the provider's staff, or other patients, or the PHP's staff to the point that his/her continued enrollment in the CCO seriously impairs the CCO's ability to furnish services to either the member or other members, subject to the requirements in this rule;
 - (D) The member commits fraudulent or illegal acts such as: Permitting use of his/her medical ID card by others, altering a prescription, theft or other criminal acts committed in any provider or CCO's premises. The CCO shall report any illegal acts to law enforcement authorities or to the Children, Adults and Families (CAF) Fraud Unit as appropriate;
 - (E) Clients exempted from mandatory enrollment with a CCO, due to the client's eligibility through a hospital hold process and placed in the Adults/Couples category as required under 410-141-0060;
 - (F) Members may not be disenrolled solely because of the following:
 - (i) A physical or mental disability;
 - (ii) An adverse change in the member's health;
 - (iii) The member's utilization of services, either excessive or lack thereof;
 - (iv) The member requests a hearing;
 - (v) The member has been diagnosed with End Stage Renal Disease (ESRD);
 - (vi) The member exercises the option to make decisions regarding medical care with which the CCO disagrees;
 - (vii) The member engages in uncooperative or disruptive behavior, including but not limited to threats or acts of physical violence, resulting from the member's special needs, except when continued enrollment in the CCO seriously impairs the CCO's ability to furnish services to either the member or other members.

(G) CCO requests for disenrollment of members shall be submitted in writing to their CCO coordinator for approval. The CCO must document the reasons for the request, provide written evidence to support the basis for the request, and document that attempts at intervention were made as described below. The procedures cited below must be followed prior to requesting disenrollment:

- (i) The provider shall notify the CCO at the time the problem is identified. The notification must describe the problem and allow time for appropriate intervention by the CCO. The CCO shall document the notification in the member's clinical record;
- (ii) The CCO shall contact the member either verbally or in writing, depending on the severity of the problem, to inform the member of the problem that has been identified, and attempt to develop an agreement with the member regarding the issues. If contact is verbal, the CCO shall document it in the member's record. The CCO shall inform the member that the continued behavior may result in disenrollment from the CCO;
- (iii) The CCO shall provide individual education, counseling, or other interventions with the member in a serious effort to resolve the problem;
- (iv) The CCO shall contact the member's caseworker regarding the problem and, if needed, involve the caseworker and other appropriate agencies' caseworkers in reaching a resolution, within the laws governing confidentiality;
- (v) If the severity of the problem and intervention warrants, the CCO shall develop a care plan that details how the problem is going to be addressed and coordinate a case conference. Involvement of the provider, caseworker, member, family, and other appropriate agencies is encouraged;
- (vi) Any additional information or assessments requested by the Authority's CCO coordinator.

(H) If the member's behavior is uncooperative or disruptive, including but not limited to threats or acts of physical violence, as the result of the member's special needs or disability, the CCO must also document the following:

- (i) A written assessment of the relationship of the behavior to the special needs or disability of the member and whether the member's behavior poses a direct threat to the health or safety of others. Direct threat means a significant risk to the health or safety of others that cannot be eliminated by a modification of policies, practices, or procedures. In determining whether a member poses a direct threat to the health or safety of others, the CCO must make an individualized assessment, based on reasonable judgment that relies on current medical knowledge or best available objective evidence to ascertain the nature, duration and severity of the risk to the health or safety of others; the probability that potential injury to others will actually occur; and whether reasonable modifications of policies, practices, or procedures will mitigate the risk to others;
- (ii) A CCO-staffed interdisciplinary team review that includes a mental health professional or behavioral specialist or other health care professionals who have the appropriate clinical expertise in treating the member's condition to assess the behavior, the behavioral history, and previous history of efforts to manage behavior;
- (iii) If warranted, a clinical assessment of whether the behavior will respond to reasonable clinical or social interventions;
- (iv) Documentation of any accommodations that have been attempted;
- (v) Documentation of the CCO's rationale for concluding that the member's continued enrollment in the CCO seriously impairs the CCO's ability to furnish services to either the member or other members;
- (vi) If PCP terminates the provider/patient relationship, the CCO shall attempt to locate another PCP on their panel who will accept the member as their patient. All terminations of provider/patient relationships must comply with the CCO's policies and must be consistent with CCO or PCP's policies for commercial members.

(I) Requests will be reviewed according to the following process:

- (i) If there is sufficient documentation, the request shall be evaluated by the CCO's coordinator or a team of CCO coordinators who may request additional information from Ombudsman Services, AMH or other agencies as needed; If the request involves the member's mental health condition or behaviors related to substance abuse, the CCO coordinator should also confer with the OHP Coordinator in AMH;
- (ii) If there is not sufficient documentation, the CCO coordinator shall notify the CCO within two business days of what additional documentation is required before the request may be considered;
- (iii) The CCO coordinators shall review the request and notify the CCO of the decision within ten working days from receipt of sufficient documentation. Written decisions, including reasons for denials, shall be sent to the CCO within 15 working days from receipt of request or additional sufficient documentation.

(J) If the request is approved the CCO coordinator must send the member written notification within 14 days after the request was approved, with a copy to the CCO, member's caseworker and the Authority. The notice

must provide the disenrollment date, the reason for disenrollment, and the notice of member's right to file a complaint and request a hearing. If the member requests a hearing, the member shall continue to be disenrolled until a hearing decision reversing that disenrollment has been sent to the member and the CCO:

- (i) In cases where the member is also enrolled in the FCHP's or PCO's Medicare Advantage plan and the plan has received approval from CMS to disenroll the client, the FCHP or PCO shall provide proof of the CMS approval to disenroll the client and the date of disenrollment shall be the date approved by CMS;
- (ii) The disenrollment date shall be 30 days after the approval date, except as otherwise provided in this rule:
 - (I) The CCO coordinator shall determine when enrollment in another CCO is appropriate. If appropriate, the CCO coordinator will contact the member's Authority caseworker to arrange enrollment. The Authority may require the member and the benefit group to obtain services from FFS providers until the time they can be enrolled in another CCO;
 - (II) When the disenrollment date has been determined, the Authority shall send a letter to the member, the member's caseworker and the CCO. The letter shall inform the member of the requirement to be enrolled in another CCO, if applicable;
 - (III) If the CCO coordinator approves a CCO's disenrollment request because of the member's uncooperative or disruptive behavior, including threats or acts of physical violence directed at a medical provider, the provider's staff, or other patients, or because the member commits fraudulent or illegal acts as stated in 410-141-3080(2)(a), the following additional procedures shall apply:
 - (IV) The member shall be disenrolled on the date of the CCO's disenrollment request;
 - (V) All members in the member's benefit group, as defined in OAR 461-110-0720, may be disenrolled if the CCO requests;
 - (VI) At the time of enrollment into another CCO, the CCO shall notify the new CCO that the member and benefit group were previously disenrolled from another CCO at that CCO's request;
 - (VII) If a member has been disenrolled for cause is re-enrolled in the CCO, the CCO may request a disenrollment review by the CCO's coordinator. A member may not be disenrolled from the same CCO for a period of more than 12 months. If the member is reenrolled after the 12-month period and is again disenrolled for cause, the Authority shall review the disenrollment for further action.

(b) CCO's may also request disenrollment for the following:

- (A) If the member is enrolled in the CCO on the same day the member is admitted to the hospital, the CCO shall be responsible for the hospitalization. If the member is enrolled after the first day of the inpatient stay, the member shall be disenrolled, and the date of enrollment shall be the next available enrollment date following discharge from inpatient hospital services;
- (B) The member has surgery scheduled at the time their enrollment is effective with the CCO, the provider is not on the CCO's provider panel, and the member wishes to have the services performed by that provider;
- (C) The Medicare member is enrolled in a Medicare Advantage plan and was receiving Hospice Services at the time of enrollment;
- (D) Excluding the DCO, the CCO determines that the member has a third party insurer. If after contacting the Authority, the disenrollment is not effective the following month, the CCO may contact the Authority to request disenrollment;
- (E) If a CCO has knowledge of a member's change of address, the CCO shall notify the Authority. The Authority shall verify the address information and disenroll the member. If the member no longer resides in the CCO's service area. The Authority shall disenroll members if the member is out of the CCO's service area for more than three 3 months, unless previous arrangements are made with the CCO. The effective date of disenrollment shall be the date specified by the Authority and the Authority shall recoup the balance of that month's CCO payment;
- (F) The member is an inmate serving time for a criminal offense or confined involuntarily in a State or Federal prison, jail, detention facility, or other penal institution. This does not include members on probation, house arrest, living voluntarily in a facility after their case has been adjudicated, infants living with an inmate, or inmates who become inpatients. The CCO is responsible for identifying the members and providing sufficient proof of incarceration to the Authority for review of the disenrollment request. The Authority shall approve disenrollment requests from CCOs for members who have been incarcerated for at least 14 calendar days and are currently incarcerated. CCOs are responsible for inpatient services only during the time a member was an inmate;
- (G) The member is in a state psychiatric institution.

(4) The Authority may initiate and disenroll members as follows:

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

(b) If the member moves out of the CCO's service area, the disenrollment effective date shall be the date specified by the Authority. The Authority will recoup the balance of that month's capitation payment from the CCO;

(c) If the member is no longer eligible under the OHP Medicaid Demonstration Project or CHIP, the Authority shall specify the disenrollment effective date;

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

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

(f) If the Authority determines that the CCO's member has enrolled with their Employer Sponsored Insurance (ESI) through FHIAP the effective date of the disenrollment shall be the member's effective date of coverage with FHIAP:

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

(B) The Authority shall inform the members of the disenrollment decision in writing, including the right to request a contested case hearing. OHP clients may request a Authority hearing if they dispute a disenrollment decision by the Authority;

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

Stat. Auth.: ORS 414.032

Stats. Implemented: 2011 HB 3650, Chapter 602, Oregon Laws 2011, 2012 SB 1580

410-141-3140

Emergency and Urgent Care Services

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

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

(b) Regularly monitor participating providers' compliance with these policies and procedures; and

(c) Take any corrective action necessary to ensure participating provider's compliance. CCOs shall document all monitoring and corrective action activities.

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

(a) Telephone or face-to-face evaluation of the member to determine the nature of the situation and the member's immediate need for services, including but not limited to mental health crisis services and use of community health workers, peer specialists or health care navigators, if applicable;

(b) Capacity to conduct the elements of an assessment that is needed to determine the interventions necessary to begin stabilization;

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

(d) Provision of services and referral needed to address the urgent or emergency situation, begin post-stabilization care or provide outreach services in the case of a member requiring mental health services, a member who cannot be transported or a member who is homebound;

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

(f) Provision for notifying other providers when necessary to request approval to treat members.

(3) CCOs shall ensure the availability of an after-hours call-in system adequate to triage urgent care and emergency calls from members or a member's long-term care provider or facility. The CCO representative shall return urgent calls appropriate to the member's condition but in no event more than 30 minutes after

receipt. If information is not adequate to determine if the call is urgent, the CCO representative shall return the call within 60 minutes to fully assess the nature of the call. If information is adequate to determine the call may be emergent in nature, the CCO shall return the call.

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

(a) The CCO may not retroactively deny a claim for an emergency screening examination because the condition, which appeared to be an emergency medical condition under the prudent layperson standard, turned out to be non-emergency;

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

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

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

(a) Pre-authorized by the CCO;

(b) Not pre-authorized by the CCO if the CCO (or the on-call provider) failed to respond to a request for pre-authorization within one hour of the request, or the member could not contact the CCO or provider on call; or

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

(6) The CCO's responsibility for post-stabilization care it has not authorized ends when:

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

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

(c) A CCO representative and the treating physician reach an agreement concerning the member's care; or

(d) The member is discharged.

(7) CCOs shall have methods for tracking inappropriate use of emergency care and shall take action, including individual member counseling, to improve appropriate use of urgent and emergency care settings. In partnership with CCOs, DCOs shall take action to improve appropriate use of urgent and emergency care settings for dental health related care:

(a) CCOs shall educate members about how to appropriately access care from emergency rooms, urgent care/walk-in clinics and less intensive interventions other than their primary care home;

(b) CCOs shall apply innovative strategies that they could employ to decrease unnecessary hospital utilization.

Stat. Auth.: ORS 414.032

Stats. Implemented: 2011 HB 3650, Chapter 602, Oregon Laws 2011, 2012 SB 1580

410-141-3145

Community Health Assessment and Community Health Improvement Plans

(1) CCOs must develop a community health assessment process, including conducting the assessment and development of the resultant community health improvement plan (Plan). CCOs must use the assessment and plan to inform the model of care and to realize health system transformation triple aim goals for the community served by the CCO.

(2) CCOs must work with the Authority, including the Office of Equity and Inclusion, to identify the components of the community health assessment. CCOs are encouraged to partner with their local public health authority, hospital system, type B AAA, APD field office and local mental health authority, using existing resources when applicable and avoiding duplication where practicable.

(3) In developing and maintaining a needs assessment, CCOs must meaningfully and systematically engage representatives of critical populations and community stakeholders to create a community health improvement plan for addressing community needs that build on community resources and skills and emphasizes innovation including but not limited to the following:

- (a) Emphasis on disproportionate, unmet, health-related need;
 - (b) Emphasis on primary prevention;
 - (c) Building a seamless continuum of care;
 - (d) Building community capacity;
 - (e) Emphasis on collaborative governance of community benefit.
- (4) The CCO's Community Advisory Council shall oversee the community health assessment and adopt a community health improvement plan to serve as a strategic population health and health care system service plan for the community served by the CCO. The Council shall annually publish a report on the progress of the Plan.
- (5) The Plan adopted by the Council must describe the scope of the activities, services and responsibilities that the CCO shall consider upon implementation. The activities, services and responsibilities defined in the plan may include, but are not limited to:
- (a) Analysis and development of public and private resources, capacities and metrics based on ongoing community health assessment activities and population health priorities;
 - (b) Health policy;
 - (c) System design;
 - (d) Outcome and quality improvement;
 - (e) Integration of service delivery; and
 - (f) Workforce development.
- (6) CCOs and their participating providers must work together to develop best practices of culturally and linguistically appropriate care and service delivery to reduce health disparities and improve member health and well-being.
- (7) Through their community health assessment and community health improvement plan, CCOs shall identify health disparities associated with race, ethnicity, language, health literacy, age, disability, gender, sexual orientation, geography, or other factors in their service areas. CCOs shall collect and maintain data on race, ethnicity and primary language for all members on an ongoing basis in accordance with standards jointly established by the Authority and DHS. CCOs shall track and report on any quality measure by these demographic factors and shall develop, implement and evaluate strategies to improve health equity among members.
- (8) CCOs shall develop and periodically review and update its community needs assessment and community health improvement plan to ensure the provision of all medically appropriate covered coordinated care services, including urgent care and emergency services, preventive services and ancillary services, in those categories of services included in CCO contracts or agreements with the Authority.
- (9) CCOs shall communicate these policies and procedures to providers, regularly monitor providers' compliance with these policies and procedures, and take any corrective action necessary to ensure provider compliance. CCOs shall document all monitoring and corrective action activities.

Stat. Auth.: ORS 414.032

Stats. Implemented: 2011 HB 3650, Chapter 602, Oregon Laws 2011, 2012 SB 1580

410-141-3160

Integration and Care Coordination

- (1) In order to achieve the objectives of providing CCO members' integrated person centered care and services, CCOs must assure that health, mental health, chemical dependency and oral health services are consistently provided to members in all age groups and all covered populations when medically appropriate and consistent with the needs identified in the community health assessment and community health improvement plan. CCOs must develop, implement and participate in activities supporting a continuum of care that integrates mental health, addiction, oral health and physical health interventions in ways that are whole to the member and serve members in the most integrated setting appropriate to their needs:
- (a) CCOs provide care coordination, treatment engagement, preventive services, community based service, behavioral health services and follow up services for members with serious mental health or chemical dependency conditions requiring medication-assisted therapies, residential and hospital levels of care. CCOs proactively screen for and identify members with mental health and chemical dependency issues, arranging and facilitating the provision of care, developing crisis intervention plans, as appropriate, and coordinating other services and supports for the member that supports them in the most appropriate and independent setting, including their own home or independent supported living;

- (b) CCOs must enter into contracts with providers of residential chemical dependency treatment services not later than July 1, 2013. CCO must notify the Authority within 30 calendar days of executing a contract with providers of residential chemical dependency treatment, not later than July 1, 2013;
- (c) By July 1, 2014, each CCO must have a formal contractual relationship with any dental care organization that serves members in the area where they reside;
- (d) CCOs must have adequate, timely and appropriate access to hospital and specialty services. Hospital and specialty service agreements must be established that include the role of patient-centered primary care homes and that specify processes for requesting hospital admission or specialty services; performance expectations for communication and medical records sharing for specialty treatments, at the time of hospital admission or discharge, for after-hospital follow up appointments;
- (e) CCOs must demonstrate how hospitals and specialty services will be accountable to achieve successful transitions of care. CCOs shall transition members out of hospital settings into the most appropriate independent and integrated community settings. This includes transitional services and supports for children, adolescents and adults with serious behavioral health conditions facing admission to or discharge from acute psychiatric care, residential treatment settings and the state hospital.
- (2) CCOs shall develop evidence-based or innovative strategies for use within their delivery system networks to ensure access to integrated and coordinated care, especially for members with intensive care coordination needs. CCOs must:
- (a) Demonstrate that each member has a primary care provider or primary care team that is responsible for coordination of care and transitions;
- (b) Ensure that members with high health needs, multiple chronic conditions, mental illness or chemical dependency are involved in accessing and managing appropriate preventive, health, mental health, chemical dependency, remedial and supportive care and services;
- (c) Use and require its provider network to use individualized care plans to the extent feasible to address the supportive and therapeutic needs of each member, particularly those with intensive care coordination needs, including members with severe and persistent mental illness receiving home and community based services covered under the state's 1915(1) State Plan Amendment, and those receiving DHS Medicaid-funded long-term care services. Plans should reflect member or family/caregiver preferences and goals to ensure engagement and satisfaction;
- (d) Implement systems to assure and monitor improved transitions in care so that members receive comprehensive transitional care, and improve members' experience of care and outcomes, particularly for transitions between hospitals and long-term care;
- (e) Demonstrate that participating providers have the tools and skills necessary to communicate in a linguistically and culturally appropriate fashion with members and their families or caregivers and to facilitate information exchange between other providers and facilities (e.g., addressing issues of health literacy, language interpretation, having electronic health record capabilities);
- (f) Work across provider networks to develop partnerships necessary to allow for access to and coordination with social and support services, including crisis management and community prevention and self-managed programs;
- (g) Communicate its integration and coordination policies and procedures to participating providers, regularly monitor providers' compliance with these policies and procedures and take any corrective action necessary to ensure provider compliance. CCOs shall document all monitoring and corrective action activities.
- (3) CCOs must develop and use Patient Centered Primary Care Home (PCPCH) capacity by implementing a network of PCPCHs to the maximum extent feasible:
- (a) PCPCHs should become the focal point of coordinated and integrated care, so that members have a consistent and stable relationship with a care team responsible for comprehensive care management;
- (b) CCOs must develop mechanisms that encourage providers to communicate and coordinate care with the PCPCH in a timely manner, using electronic health information technology, where available;
- (c) Where there is insufficient PCPCH capacity, the CCO must engage other primary care provider (PCP) models to be the primary point of care and care management for members;
- (d) The CCO must develop services and supports for primary care that are geographically located as close as possible to where members reside and are, if available, offered in nontraditional settings that are accessible to families, diverse communities and underserved populations.
- (4) If a CCO implements other models of patient-centered primary health care in addition to the use of PCPCH, the CCO must be able to demonstrate that the other model of patient-centered primary health care will assure

member access to coordinated care services that provide effective wellness and prevention, coordination of care, active management and support of individuals with special health care needs, a patient and family-centered approach to all aspects of care, and an emphasis on whole-person care in order to address a patient's physical and behavioral health care needs.

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

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

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

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

(6) For members who are discharged to post hospital extended care, at the time of admission to a skilled nursing facility (SNF) the CCO shall notify the appropriate AAA/APD office and begin appropriate discharge planning. The CCO is not responsible for the post hospital extended care benefit unless the member was a member of the CCO during the hospitalization preceding the nursing facility placement. The CCO shall notify the SNF and the member no later than two full working days before discharge from post hospital extended care. For members who are discharged to Medicare Skilled Care, the CCO shall notify the appropriate AAA/APD office when the CCO learns of the admission.

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

(8) CCOs shall establish working relationships with the Local Mental Health Authorities (LMHAs) and Community Mental Health Programs (CMHPs) operating in the service area to maintain a comprehensive and coordinated mental health delivery system and to ensure member access to mental health services, some of which are not provided under the global budget.

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

(10) CCOs shall coordinate with Community Emergency Service Agencies (e.g., police, courts and juvenile justice, corrections, and the LMHAs and CMHPs) to promote an appropriate response to members experiencing a mental health crisis.

Stat. Auth.: ORS 414.032

Stats. Implemented: 2011 HB 3650, Chapter 602, Oregon Laws 2011, 2012 SB 1580

410-141-3170

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

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

(2) CCOs shall make intensive care coordination services available to members identified as aged, blind, or disabled, who have complex medical needs, high health care needs, multiple chronic conditions, chemical dependency or mental illness, including members with mental illness and members with severe and persistent mental illness receiving home and community-based services under the state's 1915(1) State Plan Amendment. Intensive care coordination services may be requested by the member, the member's representative, physician, other medical personnel serving the member, or the member's agency case manager.

(3) CCOs shall respond to requests for intensive care coordination services with an initial response by the next working day following the request.

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

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

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

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

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

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

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

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

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

Stat. Auth.: ORS 414.032

Stats. Implemented: 2011 HB 3650, Chapter 602, Oregon Laws 2011, 2012 SB 1580

410-141-3180

Record Keeping and Use of Health Information Technology

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

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

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

(4) A CCO and its provider network shall use and disclose sensitive diagnosis information including HIV and other health and mental health diagnoses, within the CCO for the purpose of providing whole-person care. Individually identifiable health information must be treated as confidential and privileged information subject to ORS 192.553 to 192.581 and applicable federal privacy requirements. Redisclosure of individually identifiable information outside of the CCO and the CCO's providers for purposes unrelated to this section or the requirements of ORS 414.625, 414.632, 414.635, 414.638, 414.653 or 414.655 remains subject to any applicable federal or state privacy requirements.

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

(a) Each member has a consistent and stable relationship with a care team that is responsible for comprehensive care management and service delivery;

- (b) The supportive and therapeutic needs of the member is addressed in a holistic fashion, using patient centered primary care homes and individualized care plans to the extent feasible;
- (c) Members receive comprehensive transitional care, including appropriate follow-up, when entering and leaving an acute care facility or a long-term care setting, including engagement of the member and family in care management and treatment planning;
- (d) Members receive assistance in navigating the health care delivery system and in accessing community and social support services and statewide resources, including the use of certified health care interpreters, as defined in ORS 413.550, community health workers and personal health navigators who meet competency standards established in ORS 414.665 or who are certified by the Home Care Commission under ORS 410.604;
- (e) Members have access to advocates, including qualified peer wellness specialists where appropriate, personal health navigators, and qualified community health workers who are part of the member's care team to provide assistance that is culturally and linguistically appropriate to the member's need to access appropriate services and participate in processes affecting the member's care and services;
- (f) Members are encouraged within all aspects of the integrated and coordinated health care delivery system to use wellness and prevention resources and to make healthy lifestyle choices.
- (6) CCOs shall facilitate the adoption and use of electronic health records (EHRs) by its provider network. To achieve advanced EHR adoption, CCOs shall:
 - (a) Identify EHR adoption rates; rates may be divided by provider type and geographic region;
 - (b) Develop and implement strategies to increase adoption rates of certified EHRs;
 - (c) Consider establishing minimum requirements for EHR adoption over time. Requirements may vary by region or provider type.
- (7) CCOs shall facilitate the adoption and use of electronic health information exchange (HIE) in a way that allows all participating providers to exchange a member's health, mental health, and dental health information with any other provider in that CCO. CCOs shall ensure that every participating provider is:
 - (a) Registered with a statewide or local Direct-enabled Health Information Service Provider (HISP); or
 - (b) A member of an existing Health Information Organization (HIO) with the ability for providers on any EHR system (or with no EHR system) to be able to share electronic information with any other provider within the CCO network.
- (8) CCOs shall establish minimum requirements for HIE, including rates of e-prescribing and electronic lab orders, over time.
- (9) CCOs should initially identify their current HIT capacity and develop and implement a plan for improvement in the following areas:
 - (a) Analytics that are regularly and timely used in reporting to its provider network (e.g. to assess provider performance, effectiveness and cost-efficiency of treatment);
 - (b) Quality reporting (to facilitate quality improvement within the CCO as well as to report the data on quality of care that will allow the Authority to monitor the CCOs performance);
 - (c) Patient engagement through HIT (using existing tools such as e-mail); and
 - (d) Other appropriate uses for HIT (e.g. telehealth, mobile devices).
- (10) CCOs shall maintain health information systems that collect, analyze, integrate, and report data and can provide information on areas including but not limited to the following:
 - (a) Names and phone numbers of the member's primary care physician or clinic, primary dentist and mental health practitioner;
 - (b) Copies of Client Process Monitoring System (CPMS) enrollment forms;
 - (c) Copies of long-term psychiatric care determination request forms;
 - (d) Evidence that the member has been informed of rights and responsibilities;
 - (e) Complaint and appeal records;
 - (f) Disenrollment requests for cause and the supporting documentation;
 - (g) Coordinated care services provided to enrollees, through an encounter data system; and
 - (h) Based on written policies and procedures, the record keeping system developed and maintained by CCOs and their participating providers shall include sufficient detail and clarity to permit internal and external review to validate encounter submissions and to assure medically appropriate services are provided consistent with the documented needs of the member. The system shall conform to accepted professional practice and facilitate an adequate system to allow the CCO to ensure that data received from providers is accurate and complete by:

- (A) Verifying the accuracy and timeliness of reported data;
 - (B) Screening the data for completeness, logic, and consistency; and
 - (C) Collecting service information in standardized formats to the extent feasible and appropriate.
- (11) CCOs and their provider network shall cooperate with the Division, AMH, the Department of Justice Medicaid Fraud Unit, and CMS, or other authorized state or federal reviewers, for purposes of audits, inspection and examination of members' clinical records, whether those records are maintained electronically or in physical files. Documentation must be sufficiently complete and accurate to permit evaluation and confirmation that coordinated care services were authorized and provided, referrals made, and outcomes of coordinated care and referrals sufficient to meet professional standards applicable to the health care professional and meet the requirements for health oversight and outcome reporting in these rules.
- (12) Across the CCO's provider network, all clinical records shall be retained for seven years after the date of services for which claims are made. If an audit, litigation, research and evaluation, or other action involving the records is started before the end of the seven-year period, the clinical records must be retained until all issues arising out of the action are resolved.

Stat. Auth.: ORS 414.032

Stats. Implemented: 2011 HB 3650, Chapter 602, Oregon Laws 2011, 2012 SB 1580

410-141-3200

Outcome and Quality Measures

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

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

(a) Detect both underutilization and overutilization of services;

(b) Evaluate performance and customer satisfaction;

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

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

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

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

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

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

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

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

Stat. Auth.: ORS 414.032

410-141-3220

Accessibility

(1) Consistent with the community health assessment and health improvement plan, CCOs must assure that members have access to high quality care. The CCO shall accomplish this developing a provider network that demonstrates communication, collaboration and shared decision making across the various providers and care settings, developed and implemented over time, that meets access-to-care standards, and allows for appropriate choice for members, with the goal that services and supports should be geographically as close as possible to where members reside and, to the extent necessary, offered in nontraditional settings that are accessible to families, diverse communities, and underserved populations.

(2) CCOs shall ensure access to integrated and coordinated care as outlined in OAR 410-141-3160, which includes access to a primary care provider or primary care team that is responsible for coordination of care and transitions.

(3) In developing its access standards, the CCO should anticipate access needs, so that the members get the right care at the right time and place, using a patient-centered approach.

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

(a) In urban areas — 30 miles, 30 minutes or the community standard, whichever is greater;

(b) In rural areas — 60 miles, 60 minutes or the community standard, whichever is greater.

(5) CCOs shall have an access plan that establishes standards for access, outlines how capacity is determined and establishes procedures for monthly monitoring of capacity and access, and for improving access and managing risk in times of reduced participating provider capacity. The access plan shall also identify populations in need of interpreter services and populations in need of accommodation under the Americans with Disabilities Act.

(6) CCOs shall make the services it provides including: primary care, specialists, pharmacy, hospital, vision, ancillary, mental health and substance abuse services, as accessible to members for timeliness, amount, duration and scope as those services are to other members within the same service area. If the CCO is unable to provide those services locally, it must so demonstrate to the Authority and provide reasonable alternatives for members to access care that must be approved by the Authority. CCOs shall have a monitoring system that will demonstrate to the Authority, that the CCO has surveyed and monitored for equal access of members to referral providers of pharmacy, hospital, vision, ancillary, mental health and substance abuse services:

(a) CCOs must screen all eligible members for mental illness or chemical dependency to promote prevention, early detection, intervention and referral to treatment, especially at initial contact or physical exam or at initial prenatal examination, when a member shows evidence of mental illness or chemical dependency or when a member over utilizes services;

(b) CCOs must use a universal screening process that assesses members for critical risk factors that trigger intensive care coordination for high-needs members.

(7) CCOs shall have policies and procedures and a monitoring system to ensure that members who are aged, blind, or disabled, or who have complex or high health care needs, multiple chronic conditions, mental illness or chemical dependency or who are children receiving Department or OYA services have access to primary care, dental care, mental health providers and referral, and involves those members in accessing and managing appropriate preventive, health, remedial and supportive care and services.

(8) CCOs shall have policies and procedures that ensure scheduling and rescheduling of member appointments are appropriate to the reasons for, and urgency of, the visit. The member shall be seen, treated, or referred as within the following timeframes:

(a) Emergency Care — Immediately or referred to an emergency department depending on the member's condition;

(b) Urgent Care — Within 48 hours or as indicated in initial screening, in accordance with OAR 410-141-0140;

(c) Well Care — Within 4 weeks or within the community standard;

(d) Emergency Dental Care (when dental care is provided by the CCO) — Seen or treated within 24-hours;

(e) Urgent Dental Care (when dental care is provided by the CCO) — Within one to two weeks or as indicated in the initial screening in accordance with OAR 410-123-1060; and

- (f) Routine Dental Care (when dental care is provided by the CCO) — Seen for routine care within an average of eight weeks and within 12 weeks or the community standard, whichever is less, unless there is a documented special clinical reason which would make access longer than 12 weeks appropriate;
- (g) Non-Urgent Mental Health Care or Chemical Dependency Treatment — Seen for an intake assessment within 2 weeks from date of request.
- (9) CCOs shall develop policies and procedures for communicating with, and providing care to members who have difficulty communicating due to a medical condition or who are living in a household where there is no adult available to communicate in English or where there is no telephone:
- (a) The policies and procedures shall provide qualified interpreter services by phone, in person, in CCO administrative offices, especially those of member services and complaint and grievance representatives and in emergency rooms of contracted hospitals;
- (b) CCOs shall ensure the provision of qualified interpreter services for covered coordinated care services including medical, mental health or dental care (when the CCO is responsible for dental care) visits, and home health visits, to interpret for members with hearing impairment or in the primary language of non-English speaking members. All interpreters shall be linguistically appropriate and be capable of communicating in English and the members' primary language and able to translate clinical information effectively. Interpreter services shall be sufficient for the provider to understand the member's complaint; to make a diagnosis; respond to member's questions and concerns; and to communicate instructions to the member;
- (c) CCOs shall ensure the provision of coordinated care services which are culturally appropriate, i.e., demonstrating both awareness for and sensitivity to cultural differences and similarities and the effect on the members' care;
- (d) CCOs shall have written policies and procedures that ensure compliance with requirements of the Americans with Disabilities Act of 1990 in providing access to covered coordinated care services for all members and shall arrange for services to be provided by non- participating referral providers when necessary;
- (e) CCOs shall have a plan for ensuring compliance with these requirements and shall monitor for compliance.
- Stat. Auth.: ORS 414.032
Stats. Implemented: 2011 HB 3650, Chapter 602, Oregon Laws 2011, 2012 SB 1580

410-141-3260

Grievance and Appeal System

- (1) The grievance system means the overall system that includes grievances and appeals handled at the CCO level and access to the state's contested case hearing process.
- (2) The CCO must establish written internal grievance and appeal system procedures, subject to approval by the Authority for:
- (a) Accepting, processing and responding to all grievances and appeals from CCO members, consistent with contractual requirements and OAR 410-141-3260 through 410-141-3266; and
- (b) Under which members, their representatives or subcontractors/providers, with consent from the member, may challenge the denial of coverage of, or payment for, medical assistance;
- (c) The grievance and appeal system must include:
- (A) A grievance process;
- (B) An appeal process; and
- (C) Access to the Division's contested case hearing process.
- (d) The CCO must ensure members' confidentiality in all written, oral and posted material and that there shall be no retaliation for utilizing the grievance system process.
- (3) The CCO must ensure that members' grievances and appeals are handled in confidence consistent with 410-141-3180. The CCO must safeguard the member's right to confidentiality of information about grievances and appeals as follows:
- (a) The CCO must implement and monitor written policies and procedures to:
- (A) Ensure that all information concerning a member's grievance or appeal is kept confidential, consistent with appropriate use or disclosure as treatment, payment, or health care operations of the CCO, as those terms are defined in 45 CFR 164.501; and
- (B) Protect those individuals who file grievances and appeals from retaliation.
- (b) The CCO and any practitioner whose authorizations, treatments, services, items, quality of care or requests for payment are alleged to be involved in the grievance or appeal have a right to use this information without a signed release from the member for purposes of:

- (A) Resolving the grievance or appeal;
 - (B) Maintaining the grievance or appeals log; and
 - (C) Health oversight by the Division.
- (c) The CCO must request an authorization for release of information, except as provided in in this rule or as otherwise authorized by all other applicable confidentiality laws, from the member regarding the grievance or appeal if the CCO needs to communicate with other individuals to resolve the grievance or appeal;
- (d) The CCO must have a copy of this authorization for release of information in the member's appeal records;
- (e) The CCO must have the authorization for release of information form included in their policies and procedures.
- (4) The CCO must provide members with any reasonable assistance in completing forms and taking other procedural steps related to filing and disposition of a grievance, CCO level appeal or request for a contested case hearing including, but not limited to:
- (a) Assistance from qualified community health workers, qualified peer wellness specialists or personal health navigators to participate in processes affecting the member's care and services;
 - (b) Free interpreter services;
 - (c) Toll-free phone numbers that have adequate TTY/TTD and interpreter capabilities; and
 - (d) Reasonable accommodation or policy and procedure modifications as required by any disability of the member.
- (5) The CCO may not discourage a member or their representative from using any aspect of the grievance, appeal, and hearing process or encourage the withdrawal of a grievance, appeal or hearing request already filed.
- (6) The CCO may not request disenrollment of a member:
- (a) On the basis of implementation of a contested case hearing decision; or
 - (b) A member's request for a grievance, appeal or contested case hearing.
- (7) The CCO must make available in all CCO administrative offices and in those medical and dental offices where staff have been designated by the CCO to respond to grievances or appeals a supply of blank:
- (a) Complaint forms;
 - (b) Hearing Request forms (DHS 443);
 - (c) Notice of Hearing Rights forms (DMAP 3030); and
 - (d) Appeal forms.
- (8) Authority to File:
- (a) A member or their representative may:
 - (A) File a grievance;
 - (B) File a CCO level appeal; and
 - (C) Request a contested case hearing.
 - (b) A subcontractor/provider, acting on behalf and with written consent of the member, may file a CCO level appeal;
 - (c) A subcontractor/provider may not act as the member's authorized representative for filing a grievance or requesting a hearing.
- (9) The CCO and its subcontractors/providers must cooperate with DHS' Governor's Advocacy Office, the Authority's Ombudsman and hearing representatives in all of the Authority's activities related to members' grievances, appeals and hearings including providing all requested written materials.
- (10) The CCO must provide the information specified at §438.10 (g)(1) (Information requirements) to all providers and subcontractors at the time they enter into a contract.
- (11) If the CCO chooses to delegate the grievance and appeal process, except the adjudication of final appeals, it must:
- (a) Ensure that all subcontracts, as applicable, meet the requirements consistent with 410-141-3260 through 410-141-3266;
 - (b) Monitor the subcontractor's performance on an ongoing basis;
 - (c) Perform a formal review at least once a year of compliance with these delegated responsibilities and subcontractor performance, deficiencies or areas for improvement; and
 - (d) Upon identification of deficiencies or areas of improvement, ensure corrective action is taken by the subcontractor and monitor ongoing compliance.
- (13) Record Keeping and Reporting Requirements:

(a) A CCO must maintain records of member grievances and appeals, which contain sufficient information to accurately reflect:

(A) The process in place to track requests for OHP services or payment denied by the CCO or any of its subcontractors/providers; and

(B) The number of denied claims for services in the most recent calendar year.

(b) The CCO must:

(A) Maintain logs of all member grievances and appeals; and

(B) Retain grievances and appeals logs for seven years.

(c) The Division must review the CCO's procedures for compliance with grievance system federal, state and contractual requirements as part of the state quality strategy.

Stat. Auth.: ORS 414.032

Stats. Implemented: 2011 HB 3650, Chapter 602, Oregon Laws 2011, 2012 SB 1580

410-141-326

Requirements for CCO Grievance Process

(1) Grievance requirements apply only to those situations in which the member and their representative express concern or dissatisfaction about any matter other than an "action."

(2) The CCO must have written policies and procedures conforming to 42 CFR 438.406 and 438.408, which clearly explain and ensure at a minimum how the CCO acknowledges the receipt, disposition and documentation of each grievance from members or their representative including:

(a) Acknowledging receipt to the member and representative of each grievance;

(b) Consistent with confidentiality requirements, ensuring that the CCO's staff person who is designated to receive grievances begins to obtain documentation of the facts concerning the grievance upon receipt of the grievance;

(c) Informing a member of their right to file a grievance and how to do so, and providing assistance by qualified community health workers, qualified peer specialists or personal health navigators in order to participate in the grievance process;

(d) Promptly transmitting to staff who have authority to act upon the grievance; and

(e) Investigating and resolving the grievance in accordance with these rules;

(f) Ensuring that the practitioner or staff person who make decisions on the grievance are:

(i) Not involved in any previous level of review or decision-making; and

(ii) Health care professionals with appropriate clinical expertise in treating the member's condition or disease if the grievance:

(I) Concerns denial of expedited resolution of an appeal; or

(II) Involves clinical issues.

(g) How the CCO informs members, both orally and in writing, about their grievance procedures;

(h) How the CCO designates staff members or a designee who are responsible for receiving, processing, directing, and responding to grievances;

(i) How the requirement of a log is maintained by the CCO for documentation of all oral and written grievances.

(3) The member or their representative may file a grievance:

(a) Either orally or in writing; and

(b) Either with the Division or the CCO.

(4) The CCO's procedures must provide for the disposition of grievances within the following timeframes:

(a) The CCO must resolve each grievance and provide notice of the disposition as expeditiously as the member's health condition requires within the timeframes established in this rule;

(b) For standard disposition of grievances and notice to the affected parties, within five working days from the date of the CCO's receipt of the grievance, the CCO must either:

(A) Make a decision on the grievance and notify the member and their representative; or

(B) Notify the member and their representative in writing that a delay in the CCO's decision of up to 30 calendar days from the date the grievance was received by the CCO is necessary to resolve the grievance.

The CCO shall specify the reasons the additional time is necessary.

(5) The CCO's decision about the disposition of a grievance must be communicated to the member and their representative orally or in writing within the timeframes specified in section (4) of this rule:

(a) An oral decision about a grievance must address each aspect of the member's grievance and explain the reason for the CCO's decision;

(b) A written decision must be provided if the grievance was received in writing. The written decision on the grievance must review each element of the member's grievance and address each of those concerns specifically, including the reasons for the CCO's decision.

(6) The CCO must address the analysis of all grievances in the context of quality improvement activity pursuant to 410-141-3200 and 410-141-3260.

(7) All grievances that the member chooses to resolve through another process and that the CCO is notified of, must be noted in the grievance log.

(8) Members who are dissatisfied with the disposition of a grievance may present their grievance to DHS' Governor's Advocacy Office.

(9) The CCO must maintain a grievance log of all reported oral and written grievances, which includes:

(a) The member's name and medical care ID number;

(b) Date reported;

(c) The grievance and the nature of the grievance;

(d) Disposition & date of disposition;

(e) A separate and distinct record for each corresponding grievance in the log, which includes:

(A) Documentation of the review or investigation, resolution and reasons for the decision; and

(B) Written decisions and correspondence with the member.

(10) The CCO must:

(a) Have written procedures for the review and analysis of grievances received by the CCO; and

(b) Monitor the completeness and accuracy of the written log on a monthly basis, which includes, at a minimum, completeness, accuracy, timeliness of documentation and compliance with written procedures for receipt, disposition and documentation of grievances and compliance with Division rules.

Stat. Auth.: ORS 414.032

Stats. Implemented: 2011 HB 3650, Chapter 602, Oregon Laws 2011, 2012 SB 1580

410-141-3262

Requirements for CCO Appeal

(1) A member, their representative or a subcontractor/provider, with the member's consent, who disagrees with a notice of action (notice) has the authority to file an appeal with their CCO.

(2) For purposes of this rule, an appeal includes a request from the Division to the CCO for review of action.

(3) The member may request an appeal either orally or in writing directly to their CCO for any action by the CCO unless the member requests an expedited resolution, the member must follow an oral filing with a written, signed and dated appeal. If the member files an oral appeal, the CCO must send the member an appeal request form.

(4) The member must file the appeal no later than 45 calendar days from the date on the notice.

(5) The CCO must have written policies and procedures for handling appeals that:

(a) Address how the CCO will accept, process and respond to such appeals, including how the CCO will acknowledge receipt of each appeal;

(b) Ensure that members who receive a notice are informed of their right to file an appeal and how to do so;

(c) Ensure that each appeal is transmitted timely to staff having authority to act on it;

(d) Consistent with confidentiality requirements, ensure that the CCO's staff person who is designated to receive appeals begins to obtain documentation of the facts concerning the appeal upon receipt of the appeal;

(e) Ensure that each appeal is investigated and resolved in accordance with these rules; and

(f) Ensure that the individuals who make decisions on appeals are:

(A) Not involved in any previous level of review or decision making; and

(B) Health care professionals who have the appropriate clinical expertise in treating the member's condition or disease if an appeal of a denial is based on lack of medical appropriateness; or if an appeal involves clinical issues.

(g) Include a provision that the CC) must document appeals in an appeals log maintained by the CCO that complies with OAR 410-141-3260 and consistent with contractual requirements.

(h) Ensure oral requests for appeal an action are treated as appeals to establish the earliest possible filing date for the appeal; and

(i) Ensure the member is informed that the member must in writing unless the person filing the appeal requests expedited resolution;

- (j) Provide the member a reasonable opportunity to present evidence and allegations of fact or law in person as well as in writing;
- (k) Provide the member an opportunity before and during the appeals process to examine the member's file, including medical records and any other documents or records to be considered during the appeals process.
- (6) Parties to the appeal Include:
 - (a) The CCO;
 - (b) The member and the member's representative, if applicable;
 - (c) The legal representative of a deceased member's estate.
- (7) The CCO must resolve each appeal and provide the member and their representative with a notice of appeal resolution as expeditiously as the member's health condition requires and within the following periods for:
 - (a) Standard resolution of appeal: no later than 16 calendar days from the day, the CCO receives the appeal;
 - (b) Expedited resolution of appeal (when granted by the CCO): no later than three working days from the date the CCO receives the appeal. In addition, the CCO must:
 - (A) Inform the member and their representative of the limited time available;
 - (B) Make reasonable efforts to call the member to tell them of the resolution within three calendar days after receiving the request; and
 - (C) Mail written confirmation of the resolution to the member within three calendar days.
 - (c) The CCO may extend these timeframes up to 14 calendar days if approved to do so by the Division when:
 - (A) The member or their representative requests the extension; or
 - (B) The CCO shows, to the satisfaction of the Division that there is need for additional information; that is unattainable for a 16-day resolution and the delay is in the member's interest.
 - (d) If the Division approves the extension requested by the CCO, the CCO must give the member and their representative a written notice of the reason for the delay.
- (8) For all appeals, the CCO must provide written notice of appeal resolution to the member and also to their representative when the CCO knows there is a representative for the member.
- (9) The written notice of appeal resolution must include the following information:
 - (a) The results of the resolution process and the date the CCO completed the resolution; and
 - (b) For appeals not resolved wholly in favor of the member:
 - (A) Reasons for the resolution and a reference to the particular sections of the statutes and rules involved for each reason identified in the Notice of Appeal Resolution relied upon to deny the appeal;
 - (B) Unless the appeal was referred to the CCO from the Division as part of a contested case hearing process, the right to request a hearing and how to do so;
 - (C) The right to request to receive benefits while the hearing is pending and how to do so; and
 - (D) That the member may be held liable for the cost of those benefits if the hearing decision upholds the CCO's Action.
- (10) Unless the appeal was referred to the CCO as part of a contested case hearing process, a member may request a hearing not later than 45 calendar days from the date on the Notice of Appeal Resolution.
- (11) If the appeal was referred to the CCO from the Division as part of a contested case hearing process, within two business days from the date of the appeal resolution, the CCO must transmit the:
 - (a) Notice of Appeal Resolution; and
 - (b) Complete record of the appeal to the Division's Hearings Unit.
- (12) If the appeal was made directly by the member or their representative, and the Notice of Appeal Resolution was not favorable to the member, the CCO must, if a contested case hearing is requested, submit the record to the Division's Hearings Unit within two business days of the Division's request.
- (13) Documentation:
 - (a) The CCO's records must include, at a minimum, a log of all appeals received by the CCO and contain the following information:
 - (A) Member's name and Medical Care ID number;
 - (B) Date of the Notice;
 - (C) Date and nature of the appeal;
 - (D) Whether continuing benefits were requested and provided; and
 - (E) Resolution and resolution date of the appeal.
 - (b) The CCO must maintain a complete record for each appeal included in the log for no less than 45 days to include:

- (A) Records of the review or investigation; and
 - (B) Resolution, including all written decisions and copies of correspondence with the member.
 - (c) The CCO must review the written appeals log on a monthly basis for:
 - (A) Completeness;
 - (B) Accuracy;
 - (C) Timeliness of documentation;
 - (D) Compliance with written procedures for receipt, disposition and documentation of appeals; and
 - (E) Compliance with OHP rules.
 - (d) The CCO must address the analysis of appeals in the context of quality improvement activity consistent with OAR 410-141-3200 OHP CCO Quality Improvement System and 410-141-3260 General Requirements for CCO Grievance System;
 - (e) The CCO must have written policies and procedures for the review and analysis of all appeals received by the CCO. The analysis of the grievance system must be reviewed by the CCO's Quality Improvement Committee consistent with contractual requirements and comply with the quality improvement standards.
- Stat. Auth.: ORS 414.032
 Stats. Implemented: 2011 HB 3650, Chapter 602, Oregon Laws 2011, 2012 SB 1580

410-141-3263

Notice of Action

- (1) A Notice of Action must be provided to a Division of Medical Assistance Programs (Division) member when a service authorization decision by a coordinated care organization (CCO) or its subcontractor/provider constitutes an action as defined in 410-141-3260 (General Requirements for CCO Grievance System).
- (2) Language and Format Requirements:
 - (a) The Notice must be written in a Division-approved format and meet the language and format requirements in accordance with 410-141-3280 (Potential Member Informational Requirements);
 - (b) Content of Notice: The notice must include, but is not limited, to the following:
 - (A) The date of the Notice;
 - (B) Name of the CCO and telephone number;
 - (C) Primary Care Practitioner's (PCP), Primary Care Dentist's (PCD) or Behavioral Health Professional's name;
 - (D) Member's name and Medical Care ID number;
 - (E) Date of service or date of service request;
 - (F) Name of subcontractor/provider who provided/requested the service;
 - (G) Effective date of the action;
 - (H) The action the CCO or its subcontractor/provider has taken or intends to take;
 - (I) Reasons for the action, with enough specificity to clearly explain the actual reason for the denial including but not limited to the following:
 - (i) The service required pre-authorization and it was not pre-authorized;
 - (ii) The individual was not a member on the date of service or was not a member on the date of a requested service;
 - (iii) The provider was not on the CCO's panel and prior approval was not obtained (if such prior authorization would have been required under Oregon Health Plan (OHP) rules);
 - (iv) If the denial is based on service placement on the OHP Prioritized List, the Notice must specify whether other conditions were considered as a co-morbidity factor.
 - (J) The service or benefit that was requested and whether the service or payment for the service is being denied, terminated, suspended or reduced;
 - (K) If the requested service is not medically appropriate, specifically explain why;
 - (L) A reference to the particular citations of the statutes and rules involved for each reason identified in the Notice pursuant to paragraph (H) of this section, with enough specificity to clearly justify the action taken by the CCO, in compliance with the notice requirements in ORS 183.415;
 - (M) Information about the member's right to:
 - (i) File an appeal with the CCO; and
 - (ii) Request a contested case hearing. The following must be attached to the Notice:
 - (I) Hearing Request (DHS 443); and
 - (II) Notice of Hearing Rights (DMAP 3030).

- (N) The circumstances under which expedited resolution may be requested and instructions for doing so;
- (O) The member's right to:
 - (i) Have benefits continue pending resolution of the appeal;
 - (ii) How to request that benefits be continued.
- (P) The circumstances under which the member may be required to pay the costs of these services.
- (3) Timing of Notice: The CCO must mail the notice within the following timeframes:
 - (a) For termination, suspension, or reduction of previously authorized covered services:
 - (A) At least 10 calendar days before the date of action, except as permitted under paragraphs (B) or (C) of this section;
 - (B) No later than the date of action if:
 - (i) The CCO or subcontractor/provider has factual information confirming the death of the member;
 - (ii) The CCO or subcontractor/provider receives a clear written statement signed by the member that:
 - (I) They no longer wish services; or
 - (II) Gives information that requires termination or reduction of services and indicates that they understand that this must be the result of supplying that information.
 - (iii) The member has been admitted to an institution where they are ineligible under OHP for further services from the CCO;
 - (iv) The member's whereabouts are unknown and the post office returns the mail indicating no forwarding address;
 - (v) The CCO establishes the fact that the member has been accepted for Medicaid services by another State, territory or commonwealth;
 - (vi) A change in the level of medical or dental care is prescribed by the member's PCP or PCD; or
 - (vii) The date of action will occur in less than 10 calendar days, in accordance with 42 CFR 483.12 (a)(5)(ii), (Admission, transfer and discharge rights) which provides exceptions to the 30 days notice requirements of 483.12(a)(5)(i), related to discharges or transfers and long term care facilities.
 - (C) The CCO may shorten the period of advance notice to five calendar days before the date of the action if:
 - (i) The CCO has facts indicating that an action should be taken because of probable fraud by the member; and
 - (ii) When the facts have been verified, if possible, through secondary sources.
 - (b) For denial of payment, at the time of any action affecting the claim;
 - (c) For standard service authorization decisions that deny or limit services, as expeditiously as the member's health condition requires that may not exceed 14 calendar days following receipt of the request for service, except that:
 - (A) A possible extension of up to 14 additional calendar days if the:
 - (i) Member or the subcontractor/provider requests an extension; or
 - (ii) CCO justifies to the Division upon request:
 - (I) A need for additional information; and
 - (II) How the extension is in the member's interest.
 - (B) If the CCO extends the timeframe, in accordance with paragraph (A) of this section, it must:
 - (i) Give the member written notice of the reason for the decision to extend the timeframe; and
 - (ii) Inform the member of the right to file a grievance if they disagree with that decision;
 - (iii) Issue and carry out its determination as expeditiously as the member's health condition requires and no later than the date the extension expires.
 - (d) For service authorization decisions not reached within the timeframes specified in subsection (c) of this section, (which constitutes a denial and is thus an adverse action), on the date that the timeframes expire; and
 - (e) For expedited service authorizations, for cases in which the CCO determines or a subcontractor/provider indicates, that following the standard timeframe could seriously jeopardize the member's life or health or ability to attain, maintain or regain maximum function, as expeditiously as the member's health condition requires and no later than three business days after receipt of the request for service, except that the CCO may extend this time period up to 14 calendar days if the:
 - (A) Member or subcontractor/provider, with the member's consent, requests an extension; or
 - (B) CCO justifies to the Division, upon request:
 - (i) A need for additional information; and
 - (ii) How the extension is in the member's interest.

Stat. Auth.: ORS 414.032

Stats. Implemented: 2011 HB 3650, Chapter 602, Oregon Laws 2011, 2012 SB 1580

410-141-3264

Contested Case Hearings

- (1) An individual who is or was a member at the time of the Notice of Action is entitled to a contested case hearing with the Office of Administrative Hearings (OAH) if a CCO has denied requested coordinated care services, payment of a claim, or terminates, discontinues or reduces a course of treatment or any other action:
 - (a) If the member requests a contested case hearing directly with the Division, the decision in the Notice of Action is the document that will trigger the right to request the hearing;
 - (b) If the member requests a hearing after appealing to the CCO and receiving a CCO's Notice of Appeal Resolution, the decision in the Notice of Appeal Resolution is the document that will trigger the right to request a hearing;
 - (c) Contested case hearings are conducted pursuant to ORS 183.411 to 183.497 and the Attorney General's Uniform and Model Rules of Procedure for OAH, OAR 137-003-0501 to 137-003-0700, OAR 410-120-1860, 410-120-1865, and this rule.
- (2) Except for section (3), the Division must receive a written hearing request no later than the 45th day following the date of the Notice of Action or Notice of Appeal Resolution.
- (3) If the member requests continuation of benefits, and the Authority grants it, during the hearing process, the Division must receive a written hearing request no later than the 10th day following the date of the Notice of Action or Notice of Appeal Resolution. If granted continuation of benefits shall continue until:
 - (a) The member withdraws the request for hearing;
 - (b) The OAH issues a final order in a contested case adverse to the member; or
 - (c) The time period or service limits of a previously authorized service are over.
- (4) The Authority representative shall review the hearing request, documentation related to the hearing issue and computer records to determine:
 - (a) Whether the individual requesting the hearing is or was a member at the time they requested the service; and
 - (b) Whether the hearing request was timely.
- (5) CCOs shall immediately send to the Authority any member's hearing request, including a copy of the Notice of Action or Notice of Appeal Resolution.
- (6) If the member requests a hearing, the Authority shall send a copy of the hearing request to the CCO.
- (7) If the member has not previously asked for an appeal with the CCOs, the CCO shall use the appeal process:
 - (a) The CCO shall review the appeal and issue a decision as a Notice of Appeal Resolution within 16 calendar days;
 - (b) The CCOs shall provide the Notice of Appeal Resolution in writing to the member.
- (8) When a member requests a hearing, the CCO shall provide to the Authority all documentation to support their Notice of Action or Notice of Appeal Resolution, including any attempts to resolve the issue.
- (9) Information about the member used for hearings is confidential and must comply with ORS 411.320, ORS 414.679, 42 CFR 431.300 et seq, the HIPAA Privacy Rules, and other applicable federal and state confidentiality laws and regulations. The OAH and the CCO shall safeguard the member's right to confidentiality of information used in the hearing as follows:
 - (a) The OAH, member and their representative, the CCO and any practitioner whose authorization, treatment, services, items, or request for payment is involved in the hearing may use this information for purposes of the hearing without a signed release from the member. The OAH may also use this information, pursuant to OAR 410-120-1360, for health oversight, and for other purposes authorized or required by law. The information may also be disclosed to the OAH and the assigned Administrative Law Judge and to the Court of Appeals if the member seeks judicial review of the final order;
 - (b) Except as provided in ORS 414.679 or subsection (a) of this section, the OAH must ask the member for a release of information regarding the hearing to other individuals. Before any information related to the hearing is disclosed under this subsection that requires a release, the OAH must have an authorization for release of information documented in the hearing file.
- (10) The Authority shall refer the hearing request, the Notice of Action and the Notice of Appeal Resolution, if applicable, to the OAH. The OAH shall schedule the hearing:
 - (a) The parties to the hearing are the member, the CCO, the member's representative, if applicable, or the representative of a deceased member's estate;

(b) The OAH shall issue a final order ordinarily within 90 calendar days from the earlier of the following: the date the member requested an appeal to the CCO or the date the Authority received a hearing request, not including the number of days the member subsequently took to request a hearing.

(11) If the OAH's final order is adverse to the member, the CCO may recover the cost of the services furnished to the member while the hearing is pending, to the extent that they were furnished solely because of the requirements of this section, and in accordance with 42 CFR 438.420.

(12) If the OAH's final order is adverse to the CCO, the CCO must authorize the service they denied, retroactive to the date of the denial, even if the individual is no longer a member.

(13) The following applies when the OAH's decision or the CCO reverses its action in the appeal process:

(a) The CCO must correct the action, retroactive to the date of the action, even if the individual is no longer a member;

(b) If the action denied, limited, or delayed coordinated care services that the CCO did not provide pending the outcome of the hearing, the CCO must authorize or provide the services promptly and as expeditiously as the member's health, mental health or dental condition requires;

(c) If the action denied authorization of coordinated care service that CCO provided pending outcome of the hearing, the CCO must pay for the services in accordance with the Authority's policy and regulations in effect when the member made the request for services.

Stat. Auth.: ORS 414.032

Stats. Implemented: 2011 HB 3650, Chapter 602, Oregon Laws 2011, 2012 SB 1580

410-141-3265

Request for Expedited Appeal or Contested Case Hearing

(1) Each CCO shall establish and maintain an expedited review process for appeals, when the CCO determines, based upon a member or the provider making or supporting a request on the member's behalf, indicates that taking the time for a standard resolution could seriously jeopardize the member's life, health, mental health or dental health, or ability to attain, maintain or regain maximum function.

(2) The CCO must ensure that punitive action is not taken against a provider who requests an expedited resolution or supports a member's appeal.

(3) If the CCO provides an expedited appeal, but denies the coordinated care services or items requested, the CCO shall inform the member of the right to request an expedited contested case hearing and shall provide the member with a Notice of Appeal Resolution, Hearing Request Form (DHS 443) and Notice of Hearing Rights (DMAP 3030).

(4) If the CCO denies a request for expedited resolution on appeal, it must:

(a) Transfer the appeal within the time frame for standard resolution in accordance with OAR 410-141-0262;

(b) Make reasonable efforts to give the member prompt oral notice of the denial, and follow-up within 2 calendar days with a written notice.

(5) A member who believes that taking the time for a standard resolution of a request for hearing could seriously jeopardize the member's life or health, mental health or dental health, or ability to attain, maintain or regain maximum function may request an expedited hearing.

(6) The CCO shall submit relevant documentation to the Division Medical Director within, 2 working days for a decision as to the necessity of an expedited hearing. The Medical Director shall decide within, 2 working days from the date of receiving the clinical documentation applicable to the request, whether the member is entitled to an expedited hearing.

(7) If the Medical Director denies a request for expedited hearing, the Authority must:

(a) Handle the request for hearing in accordance with OAR 410-141-3264; and

(b) Make reasonable efforts to give the member prompt oral notice of the denial, and follow-up within 2 calendar days with a written notice.

Stat. Auth.: ORS 414.032

Stats. Implemented: 2011 HB 3650, Chapter 602, Oregon Laws 2011, 2012 SB 1580

410-141-3266

CCO Responsibility for Documentation and Quality Improvement Review of the Grievance System

(1) The CCO's documentation shall include, at a minimum, a log of all oral and written complaints and appeals received by the CCO. The log shall identify the member and the following additional information:

- (a) For complaints, the date of the complaint, the nature of the complaint, the disposition and date of disposition;
 - (b) For appeals, the date of the Notice of Action, the date and nature of the appeal, whether continuing coordinated care benefits were requested and provided, the resolution and date of resolution. If a contested case hearing was requested, whether continuing coordinated care benefits were requested and provided, and the effect of the final order of the hearing.
- (2) The CCO shall also maintain a record for each of the complaints and appeals included in the log. The record shall include records of the review or investigation and resolution, including all written decisions and copies of correspondence with the member. The CCO shall retain documentation of complaints and appeals for seven years.
- (3) The CCO shall have written procedures for the review and analysis of the grievance system, including all complaints and appeals received by the CCO. The analysis of the grievance system shall be forwarded to the CCO's committee responsible for quality improvement to comply with the Quality Improvement standards:
- (a) CCOs shall monitor the completeness and accuracy of the written log, monthly;
 - (b) Monitoring of complaints and appeals shall include a review of, at a minimum, completeness, accuracy, timeliness of documentation, and compliance with written procedures for receipt, disposition, and documentation of complaints and appeals, and compliance with rules applicable to the Oregon Integrated and Coordinated Care System.
- (4) The Authority must review the CCO's procedures for compliance with grievance system requirements as part of the State quality strategy and to monitor and enforce consumer rights and protections within the Oregon Integrated and Coordinated Health Care Delivery System and ensure a consistent response to complaints of violations of consumer rights and protections.
- (5) The CCO shall review and report to the Authority complaints that raise issues related to racial/ethnic background, gender, religion, sexual orientation, socioeconomic status, culturally or linguistically appropriate service requests, disability status and other identity factors for consideration in improving services for health equity.

Stat. Auth.: ORS 414.032

Stats. Implemented: 2011 HB 3650, Chapter 602, Oregon Laws 2011, 2012 SB 1580

410-141-3268

Process for Resolving Disputes on Formation of CCO

- (1) The dispute resolution process described in this rule applies only when, under ORS 414.635:
- (a) An entity is applying to the Authority for certification as a CCO (applicant);
 - (b) A health care entity (HCE) and the applicant (together, the "parties" for purposes of this rule) have failed to agree upon terms for a contract; and
 - (c) One or more of the following occurs:
 - (A) The applicant states that the HCE is necessary for the applicant to qualify as a CCO;
 - (B) An HCE states that its inclusion is necessary for the applicant to be certified as CCO; or
 - (C) In reviewing the applicant's information, the Authority identifies the HCE as necessary for the applicant to qualify as a CCO.
- (2) If an applicant and HCE disagree about whether the HCE is necessary for the applicant's certification as a CCO, the applicant or HCE may request the Authority to review the issue.
- (3) If the Authority determines the HCE is not necessary for the applicant's certification, the process described in this rule does not apply.
- (4) If the Authority determines or the parties agree the HCE is necessary for the applicant's certification, the following applies:
- (a) The HCE and the applicant shall participate in good faith contract negotiations. The parties must take the following actions in an attempt to reach a good faith resolution:
 - (A) The applicant must provide a written offer of terms and conditions to the HCE. The HCE must explain the area of disagreement to the applicant;
 - (B) The applicant's or HCE's chief financial officer, chief executive officer, or an individual authorized to make decisions on behalf of the HCE or applicant must have at least one face-to-face meeting in a good faith effort to resolve the disagreement.

- (b) The applicant or HCE may request the Authority to provide technical assistance. The Authority also may offer technical assistance, with or without a request. The Authority's technical assistance is limited to clarifying the CCO certification process, criteria, and other program requirements.
- (5) If the applicant and HCE cannot reach agreement on contract terms within 10 calendar days of the face-to-face meeting, either party may request arbitration. The requesting party must notify the other party in writing to initiate referral to an independent third party arbitrator. The party initiating the referral must provide a copy of the notification to the Authority.
- (6) After notification that one party initiated arbitration, the parties shall attempt to agree upon the selection of the arbitrator and complete the paperwork required to secure the arbitrator's services. If the parties are unable to agree, each party shall appoint an arbitrator, and these arbitrators shall select the final arbitrator.
- (7) The parties shall pay for all arbitration costs. In consideration of potentially varied financial resources between the parties, which may pose a barrier to the use of this process, the parties may ask the arbitrator to allocate costs between the parties based on ability to pay.
- (8) Within 10 calendar days of a referral to an arbitrator, the applicant and HCE must submit to each other and to the arbitrator:
- (a) Their most reasonable contract offer; or
 - (b) The HCE's statement that a contract is not desirable and an explanation of why this is reasonable.
- (9) Within 10 calendar days of receiving the other party's offer or the HCE's statement that a contract is not desirable, each party must submit to the arbitrator and the other party their advocacy briefs regarding whether the HCE is reasonably or unreasonably refusing to contract with the applicant.
- (10) The arbitrator shall apply the following standards when making a determination about whether a HCE reasonably or unreasonably refused to contract with the applicant:
- (a) An HCE may reasonably refuse to contract when an applicant's reimbursement to an HCE for a health service is below the reasonable cost to provide the service. The arbitrator shall apply federal or state statutes or regulations that establish specific reimbursements, such as payments to federally qualified health centers, rural health centers and tribal health centers; and
 - (b) An HCE may reasonably refuse to contract if that refusal is justified in fact or by circumstances, taking into consideration the HST legislative policies. Facts or circumstances outlining what is a reasonable or unreasonable refusal to contract include, but are not limited to:
 - (A) Whether contracting with the applicant would impose demands that the HCE, taking into consideration the legislative policies described in the HST laws, cannot reasonably meet without significant negative impact on HCE costs, obligations or structure, in the context of the proposed reimbursement arrangement or other CCO requirements, including, but not limited to, the use of electronic health records, service delivery requirements or quality or performance requirements;
 - (B) Whether the HCE's refusal affects access to covered services in the applicant's community. This factor alone cannot result in a finding that the refusal to contract is unreasonable; however, the HCE and applicant should make a good faith effort to work out differences in order to achieve beneficial community objectives and HST policy objectives;
 - (C) Whether the HCE has entered into a binding obligation to participate in the network of a different CCO or applicant, and that participation significantly reduces the HCE's capacity to contract with the applicant.
- (11) The following outlines the arbitrator determination and the parties' final opportunity to settle:
- (a) The arbitrator must evaluate the final offers or statement of refusal to contract and the advocacy briefs from each party and issue a determination within 15 calendar days of the receipt of the parties' information;
 - (b) The arbitrator shall provide the determination to the parties. The arbitrator and the parties may not disclose the determination to the Authority for 10 calendar days to allow the parties an opportunity to resolve the issue themselves. If the parties resolve the issue no later than the end of the 10th day, the arbitrator may not release the determination to the Authority;
 - (c) If the parties have not reached an agreement after 10 calendar days, the arbitrator must provide its decision to the Authority. After submission to the Authority, the arbitrator's determination becomes a public record, subject to protection of trade secret information if identified by one of the parties prior to the arbitrator's submission of the determination.
- (12) If the parties cannot agree, the Authority shall evaluate the arbitrator's determination and may take the following actions:
- (a) The Authority may certify an applicant if the arbitrator determined the applicant made a reasonable attempt to contract with the HCE or the HCE's refusal to contract was unreasonable;

(b) The Authority may refuse to certify an applicant when the arbitrator determined the applicant did not reasonably attempt to contract with the HCE or the HCE's refusal to contract was reasonable, and the Authority determines that participation from that the HCE remains necessary for certification of applicant as a CCO;

(c) The Authority may not pay fee-for-service reimbursements to an HCE if the arbitrator determined the HCE unreasonably refused to contract with the applicant; this applies to health services available through a CCO;

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

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

(a) Be a knowledgeable and experienced arbitrator;

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

(c) Be familiar with HST; and

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

Stat. Auth.: ORS 414.032

Stats. Implemented: 2011 HB 3650, Chapter 602, Oregon Laws 2011, 2012 SB 1580

410-141-3270

Marketing Requirements

(1) CCOs may not conduct, directly or indirectly, door-to-door, telephonic, electronic, mail or other cold call marketing practices to seek or influence the Medicaid client to enroll in that CCO.

(2) CCOs may engage in activities to existing members for outreach, health promotion and health education.

(3) The Authority must approve, prior to distribution, any written communication by the CCO or its subcontractors and providers that:

(a) Is intended solely for members; and

(b) Pertains to provider requirements for obtaining coordinated care services, care at service sites or benefits.

(4) CCOs may communicate with providers, caseworkers, community agencies and other interested parties for informational purposes. The intent of these communications should be informational only and not to entice or solicit membership. Communication methodologies may include, but are not limited to brochures, pamphlets, newsletters, posters, fliers, Web sites, health fairs or sponsorship of health-related events.

(5) The creation of name recognition, because of the CCO's health promotion or education activities, shall not constitute an attempt by the CCO to influence a client's enrollment.

(6) CCOs shall cooperate with the Authority in developing a comprehensive explanation of the services available from the CCO for the Division communications.

(7) Subcontractors may post a sign listing all OHP CCOs to which the provider belongs and display CCO-sponsored health promotional materials.

Stat. Auth.: ORS 414.032

Stats. Implemented: 2011 HB 3650, Chapter 602, Oregon Laws 2011, 2012 SB 1580

410-141-3280

Potential Member Information Requirements

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

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

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

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

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

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

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

Stat. Auth.: ORS 414.032

Stats. Implemented: 2011 HB 3650, Chapter 602, Oregon Laws 2011, 2012 SB 1580

410-141-3300

Member Education Requirements

(1) CCOs shall have written procedures, criteria and an ongoing process of member education and information sharing that includes member orientation, member handbook and health education. Member education must:

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

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

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

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

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

(a) Revision date;

(b) Tag lines in English and other languages spoken by substantial populations of members. Substantial means 35 or more households that speak the same language and in which no adult speaks English. The tag lines must describe how members may access interpreter services, including sign interpreters, translations, and materials in other formats;

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

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

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

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

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

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

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

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

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

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

- (m) Member appeal rights, including information on the CCO's complaint process and information on the Authority's contested case hearing procedures;
 - (n) Information on the member's rights and responsibilities, including the availability of the OHP Ombudsman;
 - (o) Information on copayments, charges for non-covered services, and the member's possible responsibility for charges if they go outside of the CCO for non-emergent care;
 - (p) 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 practitioner, or obtain new orders during that period;
 - (q) Information on advance directive policies including:
 - (A) Member rights under federal and Oregon law to make decisions concerning their medical care, including the right to accept or refuse medical or surgical treatment, and the right to formulate advance directives;
 - (B) The CCO's policies for implementation of those rights, including a statement of any limitation regarding the implementation of advanced directives as a matter of conscience.
 - (r) Whether or not the CCO uses physician incentives to reduce cost by limiting services;
 - (s) The member's right to request and obtain copies of their clinical records (and whether they may be charged a reasonable copying fee) and to request that the record be amended or corrected;
 - (t) How and when members are to obtain ambulance services;
 - (u) Possible resources for help with transportation to appointments with providers;
 - (v) 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;
 - (w) How members are to obtain prescriptions including information on the process for obtaining non-formulary and over-the-counter drugs;
 - (x) The CCO's confidentiality policy;
 - (y) How and where members are to access any benefits that are available under OHP but are not covered under the CCO's contract, including any cost sharing;
 - (z) When and how members can voluntarily and involuntarily disenroll from CCOs and change CCOs;
 - (aa) The CCO shall compile a printed provider directory and may offer the directly online, if available, for distribution to members, which may be part of their member handbook or separate, and shall include currently contracted provider names and specialty, non-English languages spoken, office location, telephone numbers including TTY, office hours, and accessibility for members with disabilities;
 - (bb) If the CCO handbook is returned with a new address, the CCO shall re-mail the handbook to the new address;
 - (cc) CCOs shall, at a minimum, annually review their member handbook for accuracy and update it with new and corrected information to reflect OHP program changes and the CCO's internal changes. If changes affect the member's ability to use services or benefits, the CCO shall offer the updated member handbook to all members;
 - (dd) The "Oregon Health Plan Client Handbook" is in addition to the CCO's member handbook and a CCO may not use it to substitute for any component of the CCO's member handbook.
- (5) Member health education shall include:
- (a) Information on specific health care procedures, instruction in self-management of health care, promotion and maintenance of optimal health care status, patient self-care, and disease and accident prevention. A CCO's practitioners or other individuals or programs approved by the CCO may provide health education. CCOs shall endeavor to provide health education in a culturally sensitive manner in order to communicate most effectively with individuals from non-dominant cultures;
 - (b) CCOs shall ensure development and maintenance of an individualized health educational plan for members whom their practitioner has identified as requiring specific educational intervention. The Authority may assist in developing materials that address specifically identified health education problems to the population in need;
 - (c) Explanation of intensive care coordination services, formerly known as ENCC and how to access intensive care coordination, through outreach to members with special health care needs, who are aged, blind or disabled, or who have complex medical needs or high health care needs, multiple chronic conditions, mental illness or chemical dependency;
 - (d) The appropriate use of the delivery system, including proactive and effective education of members on how to access emergency services and urgent care services appropriately;
 - (e) CCOs shall provide written notice to affected members of any significant changes in program or service sites that affect the members' ability to access care or services from CCO's participating providers. The CCO

shall provide the notice at least 30 calendar days before the effective date of that change, or as soon as possible if the participating provider has not given the CCO sufficient notification to meet the 30 day notice requirement. The Authority shall review and approve the materials within two working days.

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

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

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

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

Stat. Auth.: ORS 414.032

Stats. Implemented: 2011 HB 3650, Chapter 602, Oregon Laws 2011, 2012 SB 1580

410-141-3320

Coordinated Care Organization Member Rights and Responsibilities

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

(a) Be treated with dignity and respect;

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

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

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

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

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

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

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

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

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

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

(l) 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;

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

(n) 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 health care interpreters, and advocates, community health workers, peer wellness specialists and personal health navigators who are part of the member's care team to provide cultural and linguistic assistance appropriate to the member's need to access appropriate services and participate in processes affecting the member's care and services;

(o) Obtain covered preventive services;

- (p) Have access to urgent and emergency services 24 hours a day, 7 days a week without prior authorization;
 - (q) Receive a referral to specialty practitioners for medically appropriate covered coordinated care services;
 - (r) Have a clinical record maintained which documents conditions, services received, and referrals made;
 - (s) Have access to one's own clinical record, unless restricted by statute;
 - (t) Transfer of a copy of the clinical record to another Provider;
 - (u) Execute a statement of wishes for treatment, including the right to accept or refuse medical, surgical, chemical dependency, or mental health treatment and the right to execute directives and powers of attorney for health care established under ORS 127;
 - (v) 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;
 - (w) Be able to make a complaint or appeal with the CCO and receive a response;
 - (x) Request a contested case hearing;
 - (y) Receive qualified health care interpreter services; and
 - (z) Receive a notice of an appointment cancellation in a timely manner.
- (2) CCO members shall have the following responsibilities:
- (a) Choose, or help with assignment to, a PCP or service site;
 - (b) Treat the CCO, practitioner, and clinic staff members with respect;
 - (c) Be on time for appointments made with practitioners and other providers and to call in advance to cancel if unable to keep the appointment or if he/she expects to be late;
 - (d) Seek periodic health exams and preventive services from his/her PCP or clinic;
 - (e) Use his/her PCP or clinic for diagnostic and other care except in an emergency;
 - (f) Obtain a referral to a specialist from the PCP or clinic before seeking care from a specialist unless self-referral to the specialist is allowed;
 - (g) Use urgent and emergency services appropriately, and notify the member's PCP or clinic within 72 hours of using emergency services;
 - (h) Give accurate information for inclusion in the clinical record;
 - (i) Help the practitioner, provider or clinic obtain clinical records from other providers which may include signing an authorization for release of information;
 - (j) Ask questions about conditions, treatments, and other issues related to his/her care that is not understood;
 - (k) Use information provided by CCO providers or care teams to make informed decisions about treatment before it is given;
 - (l) Help in the creation of a treatment plan with the provider;
 - (m) Follow prescribed agreed upon treatment plans;
 - (n) Tell the practitioner or provider that his/her health care is covered under the OHP before services are received and, if requested, to show the practitioner or other provider the Division Medical Care Identification form;
 - (o) Tell the Department or Authority worker of a change of address or phone number;
 - (p) Tell the Department or Authority worker if the member becomes pregnant and to notify the worker of the birth of the member's child;
 - (q) Tell the Department or Authority worker if any family members move in or out of the household;
 - (r) Tell the Department or Authority worker if there is any other insurance available;
 - (s) Pay for non-covered services under the provisions described in OAR 410-120-1200 and 410-120-1280;
 - (t) Pay the monthly OHP premium on time if so required;
 - (u) Assist the CCO in pursuing any third party resources available and reimburse the CCO the amount of benefits it paid for an injury from any recovery received from that injury; and
 - (v) Bring issues, or complaints or grievances to the attention of the CCO.

Stat. Auth.: ORS 414.032

Stats. Implemented: 2011 HB 3650, Chapter 602, Oregon Laws 2011, 2012 SB 1580

410-141-3420

Billing and Payment

- (1) Providers must submit all billings for Coordinated Care Organization (CCO) members to the CCO within four months and twelve months, respectively, of the date of service, subject to other applicable Division billing rules. Providers must submit billings to CCOs within the four month time frame except in the following cases:
- (a) Pregnancy;

- (b) Eligibility issues such as retroactive deletions or retroactive enrollments;
 - (c) Medicare is the primary payer, except where the CCO is responsible for the Medicare reimbursement;
 - (d) Other cases that could have delayed the initial billing to the CCO (which does not include failure of provider to certify the member's eligibility); or
 - (e) Third Party Liability (TPL). Pursuant to 42 CFR 36.61, subpart G: Indian Health Services and the amended Public Law 93-638 under the Memorandum of Agreement that Indian Health Service and 638 Tribal Facilities are the payer of last resort and is not considered an alternative liability or TPL.
- (2) Providers must be enrolled with the Authority's Division of Medical Assistance Programs to be eligible for fee-for-service (FFS) payments. Mental health providers, except Federally Qualified Health Centers (FQHC), must be approved by the Local Mental Health Authority (LMHA) and the Authority's Addictions and Mental Health (AMH) Division before enrollment with the Authority or to be eligible for CCO payment for services. Providers may be retroactively enrolled, in accordance with OAR 410-120-1260 (Provider Enrollment).
- (3) Providers, including mental health providers, must be enrolled with the Authority as a Medicaid provider or an encounter-only provider prior to submission of encounter data to ensure the encounter is accepted.
- (4) Providers shall verify, before providing services, that the member is eligible for coordinated care services on the date of service. Providers shall use the Authority tools and the CCO's tools, as applicable, to determine if the service to be provided is covered under the member's Oregon Health Plan Benefit Package of covered services. Providers shall also identify the party responsible for covering the intended service and seek pre-authorizations from the appropriate payer before providing services. For non-covered services, providers shall follow requirements in OAR 141-120-1280.
- (5) CCOs shall pay for all covered coordinated care services. These services must be billed directly to the CCO, unless the CCO or the Authority specifies otherwise. CCOs may require providers to obtain preauthorization to deliver certain coordinated care services.
- (6) Payment by the CCO to participating providers for coordinated care services is a matter between the CCO and the participating provider, except as follows:
- (a) CCOs shall have procedures for processing pre-authorization requests received from any provider. The procedures shall specify time frames for:
 - (A) Date stamping pre-authorization requests when received;
 - (B) Determining within a specific number of days from receipt whether a pre-authorization request is valid or non-valid;
 - (C) The specific number of days allowed for follow up on pended preauthorization requests to obtain additional information;
 - (D) The specific number of days following receipt of the additional information that a redetermination must be made;
 - (E) Providing services after office hours and on weekends that require preauthorization;
 - (F) Sending notice of the decision with appeal rights to the member when the determination is a denial of the requested service as specified in OAR 410-141-3263.
 - (b) CCOs shall make a determination on at least 95% of valid preauthorization requests, within two working days of receipt of a preauthorization or reauthorization request related to urgent services; alcohol and drug services; or care required while in a skilled nursing facility. Preauthorization for prescription drugs must be completed and the pharmacy notified within 24 hours. If a preauthorization for a prescription cannot be completed within the 24 hours, the CCO must provide for the dispensing of at least a 72-hour supply if there is an immediate medical need for the drug. CCOs shall notify providers of the determination within 2 working days of receipt of the request;
 - (c) For expedited prior authorization requests in which the provider indicates, or the CCO determines, that following the standard timeframe could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function:
 - (A) The CCO must make an expedited authorization decision and provide notice as expeditiously as the member's health or mental health condition requires and no later than three working days after receipt of the request for service;
 - (B) The CCO may extend the three working day time period no more than 14 calendar days if the member requests an extension, or if the CCO justifies to the Authority a need for additional information and how the extension is in the member's best interest.
 - (d) For all other preauthorization requests, CCOs shall notify providers of an approval, a denial or the need for further information within 14 calendar days of receipt of the request. CCOs must make reasonable efforts to

obtain the necessary information during the 14-day period. However, the CCO may use an additional 14 days to obtain follow-up information, if the CCO justifies (to the Authority upon request) the need for additional information and how the delay is in the interest of the member. The CCO shall make a determination as the member's health or mental health condition requires, but no later than the expiration of the extension.

(7) CCOs shall have written procedures for processing payment claims submitted from any source. The procedures shall specify time frames for:

- (a) Date stamping claims when received;
- (b) Determining within a specific number of days from receipt whether a claim is valid or non-valid;
- (c) The specific number of days allowed for follow up of pended claims to obtain additional information;
- (d) The specific number of days following receipt of additional information that a determination must be made; and
- (e) Sending notice of the decision with appeal rights to the member when the determination is made to deny the claim;
- (f) CCOs shall pay or deny at least 90% of valid claims within 45 calendar days of receipt and at least 99% of valid claims within 60 calendar days of receipt. CCOs shall make an initial determination on 99% of all claims submitted within 60 calendar days of receipt;
- (g) CCOs shall provide written notification of CCO determinations when the determinations result in a denial of payment for services, for which the member may be financially responsible. The CCO shall provide the notice to the member and the treating provider within 14 calendar days of the final determination. The notice to the member shall be a Division or AMH approved notice format and shall include information on the CCOs internal appeals process, and Hearing Rights (DMAP 3030) shall be attached. The notice to the provider shall include the reason for the denial;
- (h) CCOs may not require providers to delay billing to the CCO;
- (i) CCOs may not require Medicare be billed as the primary insurer for services or items not covered by Medicare, or require non-Medicare approved providers to bill Medicare;
- (j) CCOs may not deny payment of valid claims when the potential TPR is based only on a diagnosis, and no potential TPR has been documented in the member's clinical record;
- (k) CCOs may not delay or deny payments because a co-payment was not collected at the time of service.

(8) CCOs shall pay for Medicare coinsurances and deductibles up to the Medicare or CCOs allowable for covered services the member receives within the CCO, for authorized referral care, and urgent care services or emergency services the member receives from non-participating providers. CCOs may not pay for Medicare coinsurances and deductibles for non-urgent or non-emergent care members receive from non-participating providers.

(9) CCOs shall pay transportation, meals and lodging costs for the member and any required attendant for out-of-state services that the CCO has arranged and authorized when those services are not available within the state, unless otherwise approved by the Authority.

(10) CCOs shall pay for covered services provided by a non-participating provider which was not pre-authorized if the following conditions exist:

- (a) It can be verified that the participating provider ordered or directed the covered services to be delivered by a non-participating provider; and
- (b) The covered service was delivered in good faith without the pre-authorization; and
- (c) It was a covered service that would have been pre-authorized with a participating provider if the CCO's referral procedures had been followed;
- (d) The CCO shall pay non-participating providers (providers enrolled with the Authority that do not have a contract with the CCO) for covered services that are subject to reimbursement from the CCO, in the amount specified in OAR 410-120-1295. This rule does not apply to providers that are Type A or Type B hospitals;
- (e) CCOs shall reimburse hospitals for services provided on or after January 1, 2012 using Medicare Severity DRG for inpatient services and Ambulatory Payment Classification (APC) for outpatient services or other alternative payment methods which incorporate the most recent Medicare payment methodologies for both inpatient and outpatient services established by CMS for hospital services; and alternative payment methodologies, including but not limited to pay-for-performance, bundled payments and capitation. An alternative payment methodology does not include reimbursement payment based on percentage of billed charges. This requirement does not apply to Type A or Type B hospitals as referenced in ORS 442.470. CCO shall attest annually to the Authority, in a manner to be prescribed, to CCO's compliance with these requirements.

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

(a) Certain services must be authorized by the CCO or the Community Mental Health Program (CMHP) for some mental health services, even though the services are then paid by the Authority on a FFS basis. Before providing services, providers must verify a member's eligibility using the web portal or AVR;

(b) Services authorized by the CCO or CMHP are subject to the rules and limitations of the appropriate Authority administrative rules and supplemental information, including rates and billing instructions;

(c) Providers shall bill the Authority directly for FFS services in accordance with billing instructions contained in the Authority administrative rules and supplemental information;

(d) The Authority shall pay at the Medicaid FFS rate in effect on the date the service is provided subject to the rules and limitations described in the relevant rules, contracts, billing instructions;

(e) The Authority may not pay a provider for provision of services for which a CCO has received a CCO payment unless otherwise provided for in rule;

(f) When an item or service is included in the rate paid to a medical institution, a residential facility or foster home, provision of that item or service is not the responsibility of the Authority or a CCO except as provided in Authority administrative rules and supplemental information (e.g., coordinated care services that are not included in the nursing facility all-inclusive rate);

(g) CCOs that contract with FQHCs and RHCs shall negotiate a rate of reimbursement that is not less than the level and amount of payment which the CCO would pay for the same service furnished by a provider, who is not an FQHC nor RHC, consistent with the requirements of BBA 4712(b)(2).

(12) Coverage of services through the Oregon Health Plan Benefit Package of covered services is limited by OAR 410-141-0500, excluded services and limitations for OHP clients.

Stat. Auth.: ORS 414.032

Stats. Implemented: 2011 HB 3650, Chapter 602, Oregon Laws 2011, 2012 SB 1580