Table of Contents

OAR 410-120-0000: Acronyms and Definitions

Acronyms and Definitions

Identification of acronyms and definitions within this rule specifically pertain to their use within the Oregon Health Authority (Authority), Health Systems Division (Division) administrative rules, applicable to the medical assistance program. This rule does not include an exhaustive list of Division acronyms and definitions. For more information, see Oregon Health Plan (OHP) program, (i) OAR 410-141-3500 Acronyms and Definitions, (ii) 410-200-0015 General Definitions, and (iii) any appropriate governing acronyms and definitions in the Oregon Department of Human Services (Department) administrative rules set found in chapters 411, 413, or 461 or contact the Division.

(1) "Abuse" means provider practices that are inconsistent with sound fiscal, business, or medical practices and result in an unnecessary cost to the Authority or in reimbursement for services that are not medically necessary or medically appropriate. It also includes recipient practices that result in unnecessary cost to the Authority.

(2) "Action" means a termination, suspension of, or reduction in covered benefits, services, eligibility or an increase in beneficiary liability. This includes a determination by a skilled nursing facility or nursing facility to transfer or discharge a resident, or an adverse determination with regard to the preadmission screening and resident review requirements. For the definition as it is related to a Coordinated Care Organization (CCO) member, refer to OAR 410-141-3500.

(3) "Acupuncturist" means an individual licensed to practice acupuncture by the relevant state licensing board.

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

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

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

(7) "Addictions and Mental Health Division" means the Division within the Authority's Health Systems Division that administers mental health and addiction programs and services.

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

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

(10) "Adults and Youths Discharged from an Institution for Mental Disease (IMD)" means Members who have been discharged from an IMD (as such term is defined in 42 CFR 435.1010) within the last 365 calendar days. Eligibility for HRSN Services shall expire on the 366th calendar day after discharge from an IMD.

(11) "Adults and Youths Released from Incarceration" means Members released from incarceration within the past 365 calendar days, including those released from state and federal prisons, local correctional facilities, juvenile detention facilities, Oregon Youth Authority closed custody corrections or, tribal correctional facilities, or immigration detention facilities. Eligibility for HRSN Services shall expire on the 366th calendar day after release from a carceral facility.

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

(13) "Adverse determination" means a determination made that the individual does not require the level of services provided by a nursing facility or that the individual does or does not require specialized services.

(14) "Adverse Event" means an undesirable and unintentional, though not necessarily unexpected, result of medical treatment.

(15) "Affiliation" means for provider requesting enrollment or revalidation as an Oregon Medicaid provider any of the following:

(a) Five (5) percent or greater direct or indirect ownership interest that an individual or entity has in another organization;

(b) A general or limited partnership interest (regardless of the percentage) that an individual or entity has in another organization;

(c) An interest in which an individual or entity exercises operational or managerial control over, or directly or indirectly conducts, the day-to-day operations of another organization, either under contract or through some other arrangement, regardless of whether or not the managing individual or entity is a W-2 employee of the organization; includes sole proprietorships;

(d) An interest in which an individual is acting as an officer or director of a corporation; or

(e) Any payment assignment relationship under 42 CFR 447.10(g).

(16) "Agent" means any person who has been delegated the authority to obligate or act on behalf of a provider.

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

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

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

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

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

(22) "Ambulatory Payment Classification" means a reimbursement method that categorizes outpatient visits into groups according to the clinical characteristics, the typical resource use,

and the costs associated with the diagnoses and the procedures performed. The groups are called Ambulatory Payment Classifications (APCs).

(23) "Ambulatory Surgical Center (ASC)" means a facility licensed as an ASC by the Authority.

(24) "American Indian/Alaska Native (AI/AN)" means a member of a federally recognized Indian tribe, band, or group, and an Eskimo or Aleut or other Alaska native enrolled by the Secretary of the Interior pursuant to the Alaska Native Claims Settlement Act, 43 U.S.C. 1601, or a person who is considered by the Secretary of the Interior to be an Indian for any purpose.

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

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

(27) "Anesthesia Services" means administration of anesthetic agents to cause loss of sensation to the body or body part.

(28) "Appeal" means a request for review of an adverse determination, action or as it relates to an MCE an adverse benefit determination.

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

(30) "Asynchronous" means not simultaneous or concurrent in time. For the purpose of this general rule, asynchronous telecommunication technologies for telemedicine or telehealth services may include audio and video, audio without video, client or member portal and may include remote monitoring. "Asynchronous" does not include voice messages, facsimile, electronic mail or text messages.

(31) "At Risk of Homelessness" ~~has the meaning assigned to it by the U.S. Department of Housing and Urban Development (HUD) in 24 CFR § 91.5~~ means a Member who:

(a) Has an income that is 30% or less than the area median income where the individual resides according to ~~https://www.huduser.gov/portal/datasets/il/il24/IncomeLimits-30-FY24.pdf~~the most recent available data from the U.S. Department of Housing and Urban Development; and,

(b) Lacks sufficient resources or support networks to prevent homelessness; and,

(c) Meets any HRSN Housing and Nutrition Clinical Risk Factor.

~~(31)~~(32) "Atypical Provider" means an entity able to enroll as a Billing Provider (BP) or rendering provider for medical assistance programs related non-health care services but that does not meet the definition of health care provider for National Provider Identification (NPI) purposes.

~~(32)~~(33) "Audiologist" means an individual licensed to practice audiology by the State Board of Examiners for Speech Pathology and Audiology.

~~(33)~~(34) "Audiology" means the application of principles, methods, and procedures of measurement, testing, appraisal, prediction, consultation, counseling, and instruction related to hearing and hearing impairment for the purpose of modifying communicative disorders involving speech, language, auditory function, including auditory training, speech reading and hearing aid evaluation, or other behavior related to hearing impairment.

~~(34)~~(35) "Audio only" means the use of audio technology, permitting real-time communication between a health care provider and a member for the purpose of diagnosis, consultation or treatment. "Audio only" does not include health services that are customarily delivered by audio telephone technology and customarily not billed as separate services by a health care provider, such as the sharing of laboratory results.

~~(35)~~(36) "Automated Voice Response (AVR)" means a computer system that provides information on clients' current eligibility status from the Division by computerized phone response.

~~(36)~~(37) "Behavioral Health" means mental health, mental illness, addiction disorders, and substance use disorders.

~~(37)~~(38) "Behavioral Health Assessment" means a qualified mental health professional's determination of a member's need for mental health services.

~~(38)~~(39) "Behavioral Health Case Management" means services provided to members who need assistance to ensure access to mental health benefits and services from local, regional, or state allied agencies or other service providers.

~~(39)~~(40) "Behavioral Health Evaluation" means a psychiatric or psychological assessment used to determine the need for mental health or substance use disorder services.

~~(40)~~(41) "Benefit Package" means the package of covered health care services for which the client is eligible.

~~(41)~~(42) "Billing Agent or Billing Service" means third party or organization that contracts with a provider to perform designated services in order to facilitate an Electronic Data Interchange (EDI) transaction on behalf of the provider.

~~(42)~~(43) "Billing Provider (BP)" means an individual, agent, business, corporation, clinic, group, institution, or other entity who submits claims to or receives payment from the Division on behalf of a rendering provider and has been delegated the authority to obligate or act on behalf of the rendering provider.

~~(43)~~(44) "Buying Up" means the practice of obtaining client payment in addition to the Division or managed care plan payment to obtain a non-covered service or item. (See OAR 410-120-1350 Buying Up.)

~~(44)~~(45) "By Report (BR)" means services designated, as BR requires operative or clinical and other pertinent information to be submitted with the billing as a basis for payment determination. This information must include an adequate description of the nature and extent of need for the procedure. Information such as complexity of symptoms, final diagnosis, pertinent physical findings, diagnostic and therapeutic procedures, concurrent problems, and follow-up care shall facilitate evaluation.

~~(45)~~(46) "Case Management Services" means services provided to ensure that CCO members obtain health services necessary to maintain physical, mental, and emotional development and oral health. Case management services include a comprehensive, ongoing assessment of medical, mental health, substance use disorder or dental needs plus the development and implementation of a plan to obtain or make referrals for needed medical, mental, chemical dependency, or dental services, referring members to community services and supports that may include referrals to Allied Agencies.

~~(46)~~(47) "Center of Excellence (COE)" means a hospital, medical center, or other health care provider that meets or exceeds standards set by the agency for specific treatments or specialty care.

~~(47)~~(48) "Child Welfare (CW)" means a division within the Department responsible for administering child welfare programs, including child abuse investigations and intervention, foster care, adoptions, and child safety.

~~(48)~~(49) "Children's Health Insurance Program (CHIP)" means a federal and state funded portion of the Oregon Health Plan (OHP) established by Title XXI of the Social Security Act and administered by the Authority.

~~(49)~~(50) "Chiropractor" means an individual licensed to practice chiropractic by the relevant state licensing board.

~~(50)~~(51) "Chiropractic Services" means services provided by a licensed chiropractor within the scope of practice as defined under state law and federal regulation.

~~(51)~~(52) "Citizenship Waived Medical (CWM) Benefit Package" means the coverage and limitations defined in OAR 410-134-0005(2) for individuals who met the eligibility requirements in OAR 410-200-0240(1). The CWM Benefits Package ended on June 30, 2023. See OARs 410-134-0005 and 410-200-0240.

~~(52)~~(53) "Citizenship Waived Medical Plus (CWX) Benefit Package" means coverage and limitations described in OAR 410-134-0005(2) for CWM individuals who were pregnant or in their post-partum period and meet the eligibility requirements defined in OAR 410-200-0240(2). The CWM Benefits Package which was previously referred to as "CWX", ended on June 20, 2023. See OARs 410-134-0005 and 410-200-0240.

~~(53)~~(54) "Claimant" means an individual who has requested a hearing.

~~(54)~~(55) "Client" means an individual found eligible to receive OHP health services.

~~(55)~~(56) "Climate-Related Supports" means climate-related devices and services provided to HRSN Eligible Members in their own home or non-institutional, non-congregate primary residence and for whom such equipment and support are Clinically Appropriate as a component of health services treatment or prevention. HRSN Eligible Members are eligible for new climate-related devices of the same type only every thirty-six (36) months, provided the member has a demonstrated need and the MCE or the Authority conducts a re-screening and determines they are eligible for HRSN Climate Related Supports.

(a) Clinically Appropriate climate-related devices for Member homes, non-institutional, non-congregate primary residence include:

(i) Air conditioners for individuals at health risk due to significant heat;

(ii) Heaters for individuals at increased health risk due to significant cold;

(iii) Air filtration devices and, as needed, replacement air filters for individuals at health risk due to compromised air quality;

(iv) Mini refrigeration units as needed for individuals for medication storage; and

(v) Portable power supplies (PPSs) for individuals who need access to electricity-dependent equipment (e.g., ventilators, dialysis machines, intravenous equipment, chair lifts, mobility devices, communication devices, etc.) or are at risk of public safety power shutoffs ~~(PSPS)~~ that may compromise their ability to use medically necessary devices.

(b) Climate-Related Support services include, as may be needed by the Member, the provision and service delivery, and, as needed, installation of the climate-related devices identified above and device maintenance. ~~For air conditioners, Climate-Related Support services shall also include installation as needed by the Member~~. Ensuring safe utilization may also include an attestation from the member that they can safely and legally install the device in their primary, non-institutional, non-congregate place of residence.

~~(56)~~(57) "Clinical Nurse Specialist" means a registered nurse who has been approved and certified by the Board of Nursing to provide health care in an expanded specialty role.

~~(57)~~(58) "Clinical Social Worker" means an individual licensed to practice clinical social work pursuant to state law.

~~(58)~~(59) "Clinical Record" means the medical, dental, or mental health records of a client or member.

~~(59)~~(60) "Clinically Appropriate" means having at least one HRSN Clinical Risk Factor and at least one HRSN Social Risk Factor, each of which must be applicable to the HRSN Service for which the Member is authorized. For example, to determine if a Member should be authorized to receive Climate-Related Supports, the member must, in addition to belonging to an HRSN Covered Population, have at least one HRSN ~~Climate Device~~ Clinical Risk Factor and one HRSN ~~Climate Device~~ Social Risk Factor. HRSN Services are not Clinically Appropriate if they are solely for the convenience or preference of the Member.

~~(60)~~(61) "Closed Loop Referral" means the process of exchanging information between and among an MCE, the Oregon Health Authority (which may include its Fee For Service (FFS) Program), a Member, HRSN Service Providers, HRSN Connectors, and other similar organizations, to make referrals and communicate about the status of referrals and services for a Member.

~~(61)~~(62) "Comfort Care" means medical services or items that give comfort or pain relief to an individual who has a terminal illness, including the combination of medical and related services designed to make it possible for an individual with terminal illness to die with dignity and respect and with as much comfort as is possible given the nature of the illness.

~~(62)~~(63) "Community Health Worker" means an individual who:

(a) Has expertise or experience in public health;

(b) Works in an urban or rural community either for pay or as a volunteer in association with a local health care system;

(c) To the extent practicable, shares ethnicity, language, socioeconomic status, and life experiences with the residents of the community where the worker serves;

(d) Assists members of the community to improve their health and increases the capacity of the community to meet the health care needs of its residents and achieve wellness;

(e) Advocates for the individual patient and community health needs, building individual and community capacity to advocate for their health;

(f) Provides health education and information that is culturally appropriate to the individuals being served;

(g) Assists community residents in receiving the care they require;

(h) May give peer counseling and guidance on health behaviors; and

(i) May provide direct services such as first aid or blood pressure screening.

~~(63)~~(64) "Community Information Exchange" and "CIE" each means a ~~software application~~technology system ~~that is~~ utilized by a network of collaborative partners ~~using technology systems~~ to exchange information for the purpose of connecting individuals to the services and supports they need. CIE functionality must include Closed Loop Referrals, a shared resource directory, and documentation of consent to the use of technology by the Member or other individual being connected to services.

~~(64)~~(65) "Community Mental Health Program (CMHP)" means the organization of all services for individuals with mental or emotional disorders operated by, or contractually affiliated with, a local Mental Health Authority operated in a specific geographic area of the state under an intergovernmental agreement or direct contract with the Authority.

~~(65)~~(66) "Community Partner" means an individual affiliated with an organization contracted, trained, and certified by the Oregon Health Authority's Community Partner Outreach Program to provide free assistance to people applying for health coverage in Oregon that includes but is not limited to:

(a) Helping with health coverage application;

(b) Helping with enrolling in health insurance plans;

(c) Assisting with health coverage renewal assistance;

(d) Helping with Healthcare System Navigation defined in OAR 410-120-0000; and

(e) Outreach and engagement related to subsections (a) through (d) of this rule.

~~(66)~~(67) "Co-morbid Condition" means a medical condition or diagnosis coexisting with one or more other current and existing conditions or diagnoses in the same patient.

~~(67)~~(68) "Condition/Treatment Pair" means diagnoses described in the International Classification of Diseases Clinical Modifications, 10th edition (ICD-10-CM); the Diagnostic and Statistical Manual of Mental Disorders, 5th edition (DSM-5; and treatments described in the Current Procedural Terminology (CPT); or American Dental Association Codes (CDT) or the Authority Behavioral Health Fee Schedule, that, when paired by the Health Evidence Review Commission (HERC), constitute the line items in the Prioritized List of Health Services. Condition/treatment pairs may contain many diagnoses and treatments.

~~(68)~~(69) "Contested Case Hearing" means a proceeding before the Authority under the Administrative Procedures Act when any of the following contests an adverse determination, action, or as it relates to an MCE enrollee, an adverse benefit determination:

(a) A client or member or their representative;

(b) A member of an MCE after resolution of the MCE's appeal process;

(c) An MCE member's provider; or

(d) An MCE.

~~(69)~~(70) "Contiguous Area" means the area up to 75 miles outside the border of the State of Oregon.

~~(70)~~(71) "Contiguous Area Provider" means a provider practicing in a contiguous area.

~~(71)~~(72) "Continuing Treatment Benefit" means a benefit for clients who meet criteria for having services covered that were either in a course of treatment or scheduled for treatment the day

immediately before the date the client's benefit package changed to one that does not cover the treatment.

~~(72)~~(73) "Coordinated Care Organization (CCO)" has the meaning given that term in OAR 410-141-3500(21).

~~(73)~~(74) "Co-Payments" means the portion of a claim or medical, dental, or pharmaceutical expense that a client must pay out of their own pocket to a provider or a facility for each service. It is usually a fixed amount that is paid at the time service is rendered.

~~(74)~~(75) "Cost Effective" means the lowest cost health service or item that, in the judgment of Authority staff or its contracted agencies, meets the medical needs of the client.

~~(75)~~(76) "Cover All Kids (CAK)" meaning defined in OAR 410-200-0015.

~~(76)~~(77) "Covered Services" means medically necessary and appropriate health services and items described in ORS Chapter 414 and applicable administrative rules. Covered services include:

(a) Services described in the Prioritized List of Health Services above the funding line set by the legislature;

(b) Ancillary Services OAR 410-120-0000 (22);

(c) Diagnostic Services OAR 410-120-0000 (82);

(d) Services necessary for compliance with the requirements for parity in mental health and substance use disorder benefits in Code of Federal Regulations (CFR) 42 CFR part 438, subpart k; and

(e) Services necessary for compliance with the requirements for Early and Periodic Screening, Diagnostic and Treatment (EPSDT) as described in chapter 410 Division 151.

~~(77)~~(78) "Current Dental Terminology (CDT)" means a listing of descriptive terms identifying dental procedure codes used by the American Dental Association.

~~(78)~~(79) "Current Procedural Terminology (CPT)" means a medical code set developed by the American Medical Association used to report medical, surgical, and diagnostic procedures and services performed by physicians and other health care providers.

~~(79)~~(80) "Credible Allegation of Fraud" means an allegation for fraud, which has been verified by the Authority or delegate, from any source, including but not limited to: fraud hotline complaints, claims data mining, and patterns identified through provider audits, civil false claims cases, and law enforcement investigations. Allegations are considered to be credible when they have the indicia of reliability and the Agency has reviewed all allegations, facts and evidence carefully and acts judiciously on a case-by-case basis.

~~(80)~~(81) "Date of Receipt of a Claim" means the date on which the Authority receives a claim as indicated by the Internal Control Number (ICN) assigned to a claim. Date of receipt is shown as the Julian date in the 5th through 7th position of the ICN.

~~(81)~~(82) "Date of Service" means the date on which the client receives medical services or items, unless otherwise specified in the appropriate provider rules. For items that are mailed or shipped by the provider, the date of service is the date on which the order was received, the date on which the item was fabricated, or the date on which the item was mailed or shipped.

~~(82)~~(83) "Deactivation" means an action prohibiting a provider's participation where the Authority assigned provider number is terminated as the result of inactivity, as evidenced by failure to submit claims for eighteen (18) months, or relocation, as evidenced by returned/undeliverable mail by the United States Postal Service or any other mail carrier.

~~(83)~~(84) "Declaration for Mental Health Treatment" means a written statement of an individual's decisions concerning their mental health treatment. The individual makes the declaration when they are able to understand and make decisions related to treatment that is honored when the individual is unable to make such decisions.

~~(84)~~(85) "Dental Emergency Services" means dental services provided for severe tooth pain, unusual swelling of the face or gums, or an avulsed tooth.

~~(85)~~(86) "Dental Therapist" means a person licensed to practice dental therapy within the scope of practice as defined under state law.

~~(86)~~(87) "Dentist" means an individual licensed to practice dentistry pursuant to state law of the state in which they practice dentistry or an individual licensed to practice dentistry pursuant to federal law for the purpose of practicing dentistry as an employee of the federal government.

~~(87)~~(88) "Denturist" means an individual licensed to practice denture technology pursuant to state law.

~~(88)~~(89) "Denturist Services" means services provided within the scope of practice as defined under state law by or under the personal supervision of a denturist.

~~(89)~~(90) "Dental Hygienist" means an individual licensed to practice hygiene under the direction of a licensed professional within the scope of practice pursuant to state law.

~~(90)~~(91) "Dental Hygienist with an Expanded Practice Permit" means an individual licensed to practice dental hygiene services as authorized by the Board of Dentistry with an Expanded Practice Dental Hygienist Permit (EPDHP) pursuant to state law.

~~(91)~~(92) "Dentally Appropriate"

(a) means dental services, items or dental supplies that are:

(i) Recommended by a licensed health provider practicing within the scope of their license; and

(ii) Safe, effective and appropriate for the patient based on standards of good dental practice and generally recognized by the relevant scientific or professional community based on the best available evidence; and

(iii) Not solely for the convenience or preference of an OHP client, member or a provider of the service, item or dental supply; and

(iv) The most cost effective of the alternative levels or types of health services, items or supplies that are covered services that can be safely and effectively provided to a client or member in the Division or MCE's judgement.

(b) All covered services must be dentally appropriate for the member or client but not all medically appropriate services are covered services.

(c) For Early and Periodic Screening, Diagnostic and Treatment (EPSDT), see chapter 410, Division 151.

~~(92)~~(93) "Oregon Department of Human Services (Department or ODHS)" means the agency established in ORS Chapter 409, including such divisions, programs and offices as may be established therein.

~~(93)~~(94) "Department Representative" means an individual who represents the Department and presents the Department's position in a hearing.

~~(94)~~(95) "Diagnosis Code" means as identified in the International Classification of Diseases, 10th revision, Clinical Modification (ICD-10-CM). The primary diagnosis code is shown in all billing claims, unless specifically excluded in individual provider rules. Where they exist, diagnosis codes shall be shown to the degree of specificity outlined in OAR 410-120-1280, Billing.

~~(95)~~(96) "Diagnosis Related Group (DRG)" means a system of classification of diagnoses and procedures based on the ICD-10-CM.

~~(96)~~(97) "Diagnostic Services" mean those services required to diagnose a condition, including but not limited to: radiology, ultrasound, other diagnostic imaging, electrocardiograms, laboratory and pathology examinations, and physician or other professional diagnostic or evaluative services.

~~(97)~~(98) "Dietitian" means an individual licensed by the Board of Licensed Dietitians to provide nutrition services as outlined in the Standards of Practice in the OR Administrative Rules, Chapter 834, Division 60 (OAR 834-060-0000).

~~(98)~~(99) "Division" means the Health Systems Division within the Authority. The Division is responsible for coordinating the medical assistance programs within the State of Oregon including the Oregon Health Plan (OHP) Medicaid demonstration, the State Children's Health Insurance Program (SCHIP-Title XXI), and several other programs.

~~(99)~~(100) "Durable Medical Equipment, Prosthetics, Orthotics and Medical Supplies (DMEPOS)" means equipment that can stand repeated use and is primarily and customarily used to serve a medical purpose. Examples include wheelchairs, respirators, crutches, and custom-built orthopedic braces. Medical supplies are non-reusable items used in the treatment of illness or injury. Examples of medical supplies include diapers, syringes, gauze bandages, and tubing.

~~(100)~~(101) "Early and Periodic Screening, Diagnostic and Treatment (EPSDT)" means the program requiring specific coverage for children and young adults, as described in chapter 410 Division 151.

~~(101)~~(102) "Electronic Data Interchange (EDI)" means the exchange of business documents from application to application in a federally mandated format or, if no federal standard has been promulgated, using bulk transmission processes and other formats as the Authority designates for EDI transactions. For purposes of rules OAR 943-120-0100 through OAR 943-120-0200, EDI does not include electronic transmission by web portal.

~~(102)~~(103) "EDI Submitter" means an individual or an entity authorized to establish an electronic media connection with the Authority to conduct an EDI transaction. An EDI submitter may be a trading partner or an agent of a trading partner.

~~(103)~~(104) "Electronic Verification System (EVS)" means eligibility information that has met the legal and technical specifications of the Authority in order to offer eligibility information to enrolled providers of the Division.

~~(104)~~(105) "Emergency Department" means the part of a licensed hospital facility open 24 hours a day to provide care for anyone in need of emergency treatment.

~~(105)~~(106) "Emergency Health Benefit Funding" means funding for the health benefits defined in 410-134-0004(2)(a-j), included in the Healthier Oregon benefits package that is in part funded with state funding and matched with federal funds (42 CFR 440.255).

~~(106)~~(107) "Emergency Medical Condition" means a medical condition, whether physical, dental, or behavioral, manifesting itself by acute symptoms of sufficient severity such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or with respect to the pregnant person, the health of the person or their pregnancy) in serious jeopardy, serious impairment to bodily functions or serious dysfunction of any bodily organ or part. An emergency medical condition is not based on the final diagnosis but is based on presenting symptoms as perceived by a prudent layperson and includes cases in which the absence of immediate medical attention would not in fact have had the adverse results described in the previous sentence.

~~(107)~~(108) "Emergency Medical Transportation" means transportation necessary for a client with an emergency medical condition as defined in this rule and requires a skilled medical professional such as an Emergency Medical Technician (EMT) and immediate transport to a site, usually a hospital, where appropriate emergency medical service is available.

~~(108)~~(109) "Emergency Services" means health services from a qualified provider necessary to evaluate or stabilize an emergency medical condition, including inpatient and outpatient treatment that may be necessary to assure within reasonable medical probability that the patient's condition is not likely to materially deteriorate from or during a client's discharge from a facility or transfer to another facility.

~~(109)~~(110) "Evidence-Based Medicine" means the conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individual patients. The practice of evidence-based medicine means integrating individual clinical expertise with the best available external clinical evidence from systematic research. By individual clinical expertise we mean the proficiency and judgment that individual clinicians acquire through clinical experience and clinical practice. Increased expertise is reflected in many ways, but especially in more effective and efficient diagnosis and in the more thoughtful identification and compassionate evaluation of individual patients' predicaments, rights, and preferences in

making clinical decisions about their care. By best available external clinical evidence we mean clinically relevant research, often from the basic sciences of medicine, but especially from patient-centered clinical research into the accuracy and precision of diagnostic tests (including the clinical examination), the power of prognostic markers, and the efficacy and safety of therapeutic, rehabilitative, and preventive regimens. External clinical evidence both invalidates previously accepted diagnostic tests and treatments and replaces them with new ones that are more powerful, more accurate, more efficacious, and safer. (Source: BMJ 1996; 312:71-72 (13 January)). In addition, Evidence-Based Medicine considers the quality of evidence and the confidence that may be placed in findings.

~~(110)~~(111) "False Claim" means a claim that a provider knowingly submits or causes to be submitted that contains inaccurate, misleading, or omitted information and such inaccurate, misleading, or omitted information may result, or has resulted, in an overpayment.

~~(111)~~(112) "Family Planning Services" means services for clients of child bearing age (including minors who can be considered to be sexually active) who desire such services and that are intended to prevent pregnancy or otherwise limit family size.

~~(112)~~(113) "Federally Supported Hemophilia Treatment Center" means a hemophilia treatment center (HTC) that:

(a) Receives funding from the U.S. Department of Health and Human Services, Maternal and Child Health Bureau National Hemophilia Program;

(b) Is qualified to participate in 340B discount purchasing as an HTC;

(c) Actively participates in the U.S. Center for Disease Control (CDC) and Prevention surveillance and has an identification number that is listed in the HTC directory on the CDC website;

(d) Is recognized by the Federal Regional Hemophilia Network that includes the State of Oregon; and

(e) Is a direct care provider offering comprehensive hemophilia care consistent with treatment recommendations set by the Medical and Scientific Advisory Council (MASAC) of the National Hemophilia Foundation in their standards and criteria for the care of persons with congenital bleeding disorders.

~~(113)~~(114) "Federally Qualified Health Center (FQHC)" means a federal designation for a medical entity that receives grants under Section 329, 330, or 340 of the Public Health Service Act or a

facility designated as an FQHC by Centers for Medicare and Medicaid (CMS) upon recommendation of the U.S. Public Health Service.

~~(114)~~(115) "Fee-for-Service Provider" means a health care provider who is not reimbursed under the terms of an Authority contract with a Coordinated Care Organization or Prepaid Health Plan (PHP). A medical provider participating in a PHP or a CCO may be considered a fee-for-service provider when treating clients who are not enrolled in a PHP or a CCO.

~~(115)~~(116) "For Cause Termination" means a mandatory or discretionary termination by the Authority as is outlined in OAR 410-120-1400.

~~(116)~~(117) "Fraud" means an intentional deception or misrepresentation made by an individual with the knowledge that the deception may result in some unauthorized benefit to him or some other person. It includes any act that constitutes fraud under applicable federal or state law.

~~(117)~~(118) "Fully Dual Eligible" means for the purposes of Medicare Part D coverage (42 CFR 423.772), Medicare clients who are also eligible for Medicaid, meeting the income and other eligibility criteria adopted by the Authority for full medical assistance coverage.

~~(118)~~(119) "General Assistance (GA)" means medical assistance administered and funded 100 percent with State of Oregon funds through OHP.

~~(119)~~(120) "Grievance" means an expression of dissatisfaction about any matter other than an adverse benefit determination. Grievances may include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the enrollee's rights regardless of whether remedial action is requested.

~~(120)~~(121) "Health Care Interpreter" Certified or Qualified have the meaning given those terms in ORS 413.550.

~~(121)~~(122) "Health Care Professionals" means individuals with current and appropriate licensure, certification, or accreditation in a medical, mental health, or dental profession who provide health services, assessments, and screenings for clients within their scope of practice, licensure, or certification.

~~(122)~~(123) "Healthcare Common Procedure Coding System (HCPCS)" means a method for reporting health care professional services, procedures, and supplies. HCPCS consists of the Level l — American Medical Association's Physician's Current Procedural Terminology (CPT), Level II — National codes, and Level III — Local codes. The Division uses HCPCS codes; however, the

Division uses current Dental Terminology (DT) codes for the reporting of dental care services and procedures.

~~(123)~~(124) "Healthcare System Navigation" means the process by which a Community Partner supports individuals who are in need of health care by:

(a) Assisting with application for or renewal of Oregon Health Plan (OHP);

(b) Assisting with the management of the application process for OHP;

(c) Assisting with accessing available benefits;

(d) Identifying and removing barriers to care;

(e) Providing the information needed to build the knowledge and confidence necessary for utilizing benefits; or

(f) Promoting the establishment of healthcare services and continuity of care.

~~(124)~~(125) "Health Evidence Review Commission" means a commission that, among other duties, develops and maintains a list of health services ranked by priority from the most to the least important representing the comparative benefits of each service to the population served.

~~(125)~~(126) "Health Insurance Portability and Accountability Act of 1996 (HIPAA)" means the federal law (Public Law 104-191, August 21, 1996) with the legislative objective to assure health insurance portability, reduce health care fraud and abuse, enforce standards for health information, and guarantee security and privacy of health information.

~~(126)~~(127) "Health Maintenance Organization (HMO)" means a public or private health care organization that is a federally qualified HMO under Section 1310 of the U.S. Public Health Services Act. HMOs provide health care services on a capitated, contractual basis.

~~(127)~~(128) "Health Plan New/non-categorical client (HPN)" means an individual who is 19 years of age or older, is not pregnant, is not receiving Medicaid through another program, and who must meet all eligibility requirements to become an OHP client.

~~(128)~~(129) "Healthier Oregon" means the medical assistance benefit package that is equal to the OHP Plus benefit package defined in OAR 410-120-1210. The Healthier Oregon is for individuals;

(a) Who do not meet the citizenship and non-citizen status requirements defined in OAR 410-200-0215 and 461-120-0110; and

(b) Who do meet the financial and other non-financial eligibility requirements for a Health Systems Division (HSD) Medical Program (see OAR Chapter 410 Division 200) or an Oregon Supplemental Income Program Medical (OSIPM) Program (see OAR Chapter 461).

~~(129)~~(130) "Health-Related Social Needs" and "HRSN" each means the unmet climate, housing, nutrition, and outreach and engagement-related social needs, ~~the unmet climate-relatedsocial needs, including those related to an individual's housing, nutrition, and environment,~~ that contribute to an individual's poor health and are a result of underlying social and structural determinants of health.

~~(130)~~(131) "Hearing Aid Dealer" means an individual licensed by the Board of Hearing Aid Dealers to sell, lease, or rent hearing aids in conjunction with the evaluation or measurement of human hearing and the recommendation, selection, or adaptation of hearing aids.

~~(131)~~(132) "Home Enteral Nutrition" means services provided in the client's place of residence to an individual who requires nutrition supplied by tube into the gastrointestinal tract as described in the Home Enteral/Parenteral Nutrition and IV Services program provider rules.

~~(132)~~(133) "Home Health Agency" means a public or private agency or organization that has been certified by Medicare as a Medicare home health agency and that is licensed by the Authority as a home health agency in Oregon and meets the capitalization requirements as outlined in the Balanced Budget Act (BBA) of 1997.

~~(133)~~(134) "Home Health Services" means part-time or intermittent skilled nursing services, other therapeutic services (physical therapy, occupational therapy, speech therapy), and home health aide services made available on a visiting basis in a place of residence used as the client's home.

~~(134)~~(135) "Home Intravenous Services" means services provided in the client's place of residence to an individual who requires that medication (antibiotics, analgesics, chemotherapy, hydrational fluids, or other intravenous medications) be administered intravenously as described in the Home Enteral/Parenteral Nutrition and IV Services program administrative rules.

~~(135)~~(136) "Home Parenteral Nutrition" means services provided in the client's residence to an individual who is unable to absorb nutrients via the gastrointestinal tract, or for other medical

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

~~(136)~~(137) "Hospice" means a public agency or private organization or subdivision of either that is primarily engaged in providing care to terminally ill individuals and is certified by the federal Centers for Medicare and Medicaid Services as a program of hospice services meeting current standards for Medicare and Medicaid reimbursement and Medicare Conditions of Participation and is currently licensed by the Oregon Health Authority, Public Health Division.

~~(137)~~(138) "Hospital" means a facility licensed by the Public Health Division as a general hospital that meets requirements for participation in OHP under Title XVIII of the Social Security Act. The Division does not consider facilities certified by CMS as religious non-medical facilities as hospitals for reimbursement purposes. Out-of-state hospitals shall be considered hospitals for reimbursement purposes if they are licensed as a short-term acute care or general hospital by the appropriate licensing authority within that state and if they are enrolled as a provider of hospital services with the Medicaid agency within that state.

~~(138)~~(139) "Hospital-Based Professional Services" means professional services provided by licensed practitioners or staff based on a contractual or employee/employer relationship and reported as a cost on the Hospital Statement of Reasonable Cost report for Medicare and the Calculation of Reasonable Cost (DMAP 42) report for the Division.

~~(139)~~(140) "Hospital Dentistry" means dental services normally done in a dental office setting, but due to specific client need (as detailed in OAR chapter 410 division 123) are provided in an ambulatory surgical center or inpatient or outpatient hospital setting under general anesthesia (or IV conscious sedation, if appropriate).

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

(142) **"**Housing Related Supports**"** means housing services provided to eligible members to help them maintain healthy and safe housing (as detailed in OAR 410-120-2000). Housing Related Supports include:

(a) Rent and Utility Costs
(b) Hotel/Motel Stays
(c) Utilities Arrears
(d) Utilities Set Up
(e) Storage Fees
(f) Tenancy Services (paid via 15-minute increments)
(g) Tenancy Services (paid per member per month)

(h) Home Modifications

~~(a)~~(i) Home Remediations

~~(140)~~ "HRSN Climate Device Clinical Risk Factor" means any one of the climate device-specific clinical risk factors detailed in in Table 1 below.~~.~~ ~~means any one the climate device-specific clinical risk factors detailed in the CMS approved HRSN services protocol.~~

~~(141) "HRSN Climate Device Social Risk Factor" means an individual who resides in their own home or non-institutional, non-congregate primary residence and for whom an air conditioner, heater, air filtration device, portable power supply (PPS), or mini refrigeration unit (or all or any combination thereof), is Clinically Appropriate as a component of health services, treatment, or prevention.means an individual who resides in their own home or non-institutional, non-congregate primary residence who has a need that will be aided by one of the following devices: air conditioners, heaters, air filtration devices, portable power supplies (PPSs), and mini refrigeration units.~~

~~(142)~~(143) "HRSN Clinical Risk Factor" is the generic term for any one, or combination, or both~~all~~ of the following. All HRSN Clinical Risk Factors are listed in Table 1 and Table 2 below:

(a) HRSN Climate Device and Outreach and Engagement Clinical Risk Factor;

(b) HRSN Housing ~~,and~~ Nutrition and Outreach and Engagement Clinical Risk Factor;

~~(c) HRSN Nutrition Clinical Risk Factor.~~

~~(143)~~(144) "HRSN Connector" means any person or entity, including HRSN Service Providers and other similar social service organizations, that assists Members in documenting the information necessary to make an HRSN Request to an MCE for an HRSN Eligibility Screening and HRSN Service authorization.

~~(144)~~(145) "HRSN Covered Populations" means Members except for individuals receiving the BRG service package defined in OAR 410-135-0030,who belong to one or more of the following populations, as further specified in the HRSN Guidance Document:

(a) Adults and Youth Discharged from an Institution for Mental Diseases (IMD);

(b) Adults and Youth Released from Incarceration;

(c) Individuals currently or previously involved in Oregon's Child Welfare system;

(d) Individuals Transitioning to Dual Medicaid and Medicare Status;

(e) Individuals who meet the definitions of either "HUD Homeless" or "At Risk of Homelessness," as such terms are defined by HUD in 24 CFR § 91.5OAR 410-120-0000;

(f) Individuals who meet the definition of "At Risk of Homelessness" as defined by this OAR 410-120-0000. as defined by HUD in 24 CFR § 91.5 .

(e)(g) Individuals identified as Young Adults with Special Health Care Needs (YSHCN)

(145)(146) "HRSN Eligibility Screening" means the process by which an MCE determines whether an individual:

(a) is enrolled in Medicaid;

(b) belongs to a Covered Population;

(c) has at least one HRSN Clinical Risk Factor applicable to the HRSN Service(s) for which they are being screened;

(d) has at least one HRSN Social Risk Factor applicable to the HRSN Service(s) for which they are being screened;

(e) is not receiving the same or substantially similar service from a state or federally funded program that would be received from the MCE if authorized to receive the HRSN Services; and

(f)(e) meets any other additional required eligibility criteria that may apply in connection with the specific HRSN Services that may be needed.

(146)(147) "HRSN Eligible" means a Member except for individuals receiving the BRG service package defined in OAR 410-135-0030, who meets all of the following criteria:

(a) Belongs to at least one of the HRSN Covered Populations;

(b) Has at least one HRSN Clinical Risk Factor applicable to the HRSN Services for which they are being screened;

(c) Has at least one HRSN Social Risk Factor applicable to the HRSN Services for which they are being screened; and

(d) Meets any additional eligibility criteria and requirements that may apply in connection with the a specific HRSN Services (OAR 410-120-2000).

~~"HRSN HousingNutrition Clinical Risk Factor" means one of the housing nutrition clinical risk factors detailed in the HRSN Services Protocol. The HRSN Services Protocol is available here.~~

~~(147) "HRSN Fee Schedule" means the Oregon Health Authority~~

(148) "HRSN Outreach and Engagement Services" means the activities performed by HRSN Service Providers or Contractor for the purpose of identifying OHP enrolled individuals presumed to be in an HRSN Covered Population with a qualifying HRSN Clinical Risk Factor and HRSN Social Risk Factor, and connecting them to HRSN Services and other services and supports~~presumed eligible for HRSN Climate-Related Services~~, as defined in OAR 410-120-2000.

~~(a) At a minimum, HRSN Outreach and Engagement Services must include~~

~~(i) Contacting and engaging Members who belong to one or more HRSN Covered Populations who are presumed to be eligible for HRSN Climate-Related Services; and~~

~~(ii) Determining whether the Member is enrolled in the FFS Program or a CCO and, if a CCO, which one.~~

~~(b) HRSN Outreach and Engagement activities may also include:~~

~~(i) transmitting to the Member's CCO or to OHA's FFS Program (or its designated third-party contractor) the partial or complete HRSN Request Form, or information contained within, for HRSN eligibility determination and HRSN Service authorization, and/or~~

~~(ii) providing HRSN Eligible Members who may have a need for medical, peer, social, educational, legal, or other related services with information and logistical support necessary to connect them with the needed resource and services.~~

(149) "HRSN Request" means a request from an HRSN Connector organization or individual made to an MCE for the purpose of requesting that the MCE perform an HRSN Eligibility Screening. An HRSN Request is comprised of, at minimum, the name and contact information of the individual being recommended and identification of the anticipated HRSN S~~s~~ervice need. An HRSN Request may also include confirmation of OHP Medicaid enrollment or confirmation the individual is a Member enrolled in the MCE's CCO (or both), as well as any other information regarding the individual's potential HRSN Eligibility. The MCE's or the Authority, as applicable will be required to document its attempts to collect the information needed to determine eligibility.

(150) "HRSN Self-Attestation" means an oral or written attestation made by the Member or Member Representative that they satisfy the applicable requirements necessary to establish the Member is HRSN Eligible to receive one or more HRSN Services.

(151) "HRSN Service Provider" means a private or public social service organization, community organization, or other similar individual or entity that provides HRSN Services.

(152) "HRSN Service Vendor" means any individual or entity that is contracted or procured by an MCE or an HRSN Service Provider to deliver or provide HRSN Services directly to an HRSN Eligible Member who has been approved to receive HRSN Services. Examples of HRSN Service Vendors include, without limitation, entities or individuals that deliver or install air conditioners, heaters, air filtration devices, Portable Power Supply (PPSs) or mini refrigeration units to the homes or non-institutional, non-congregate primary residences of Members, as well as home modification vendors, landlords, hotels/motels, chore service providers, utilities and moving companies, and pest eradication companies and storage facilities, and organizations that assess Members for, plan, prepare, or deliver Medically Tailored Meals~~or in the case of air conditioners, additionally help to install~~.

(153) "HRSN Services" means Climate-Related Supports, Housing Related Supports, Nutrition Related Supports, and ~~associated~~ HRSN Outreach and Engagement services that address a Member's Health-Related Social Needs. Additional information regarding the different components of HRSN Services are detailed in the HRSN Guidance Document.

(154) "HRSN Social Risk Factor" means the need(s) of a Member related to a Health-Related Social Needs service. The HRSN Social Risk Factors are specific to each of the HRSN Services, which are Climate-Related Supports, Housing, ~~and~~ Nutrition and Outreach and Engagement Services. HRSN Social Risk Factors include:

(a) **HRSN Climate Device Social Risk Factor:** An individual who resides in their own home or non-institutional primary residence and for whom an air conditioner, heater, air filtration device, portable power supply (PPSs), and/or refrigeration units for medications is Clinically Appropriate as a component of health services treatment or prevention.

(b) **HRSN Housing-Related Social Risk Factor**: An individual who is homeless as defined by the U.S. Department of Housing and Urban Development (HUD) in 24 CFR 91.5 or at risk of homelessness defined by OAR 410-120-0000 or who requires a clinically appropriate home modification/remediation service.

(c) **HRSN Nutrition-Related Social Risk Factor**: An individual meeting the USDA definition of low food security

(d) **HRSN Outreach and Engagement Social Risk Factor**: An individual requiring support accessing HRSN services and/or other necessary federal, state or local services and supports.

~~(154)~~(155) "HUD Homeless" has the meaning assigned to it by the U.S. Department of Housing and Urban Development (HUD) in 24 CFR § 91.5.

~~(155)~~(156) "Indian Health Care Provider" (IHCP) means an Indian health program operated by the Indian Health Service (IHS) or by an Indian Tribe, Tribal Organization or an urban Indian organization (otherwise known as an I/T/U) as defined in section 4 of the Indian Health Care Improvement Act (25 U.S.C. 1603).

~~(156)~~(157) "Indian Health Program" means any Indian Health Service (IHS) facility, any federally recognized tribe or tribal organization, or any FQHC with a 638 designation.

~~(157)~~(158) "Indian Health Service (IHS)" means an operating division (OPDIV) within the U.S. Department of Health and Human Services (HHS) responsible for providing medical and public health services to members of federally recognized tribes and Alaska Natives.

~~(158)~~(159) "Indian Managed Care Entities" (IMCE) means a CCO, MCO, PIHP, PAHP, PCCM, or PCCM entity that is controlled (section 1903(m)(1)(C) of the Act) by the Indian Health Service, a Tribe, Tribal Organization, or Urban Indian Organization, or a consortium, which may be composed of one or more Tribes, Tribal Organizations, or Urban Indian Organizations, and which may also include the Service.

~~(159)~~(160) "Indigent" means for the purposes of access to the Intoxicated Driver Program Fund (ORS 813.602), individuals with-out health insurance coverage, public or private, who meet standards for indigence adopted by the federal government as defined in ORS 813.602(5).

~~(160)~~(161) "Individual Adjustment Request Form (OHP 1036)" means a form used to resolve an incorrect payment on a previously paid claim, including underpayments or overpayments.

~~(161)~~(162) "Individuals Involved with Child Welfare" means Members who are currently, or have previously been, involved in Oregon's Child Welfare System including members who are currently or have previously been:

(a) in foster/substitute care,
(b) the recipient of adoption or guardianship assistance;
(c) served on an in-home plan; or
~~(a)~~ the subject of an open child welfare case.~~In foster/substitute care;~~

~~(b) Receiving adoption or guardianship assistance or family preservation services; or~~

~~(c) The subject of an open child welfare case in any court.~~

~~(d) This definition is more fully described in the HRSN Guidance Document.~~

~~(162)~~(163) "Individuals Transitioning to Dual Status" means Members enrolled in Medicaid who are transitioning to dual status with Medicare and Medicaid coverage. Members shall be included in HRSN Covered Population for the ninety (90) calendar days preceding the date Medicare coverage is to take effect and 270 calendar days after it takes effect. Eligibility for services must be determined within 270 calendar days after transition to dual status.~~means Members enrolled in Medicaid who are transitioning to dual status with Medicare and Medicaid coverage. Members shall be included in HRSN Covered Population for the ninety (90) calendar days (3 months) preceding the date Medicare coverage is to take effect and the nine (9) months after it takes effect. Eligibility for services must be determined within nine (9) months after transition to dual status.~~

~~(163)~~(164) "Inpatient Hospital Services" means services that are furnished in a hospital for the care and treatment of an inpatient. (See Division Hospital Services program administrative rules in chapter 410, division 125 for inpatient covered services.)

~~(164)~~(165) "Institutional Level of Income Standards (ILIS)" means three times the amount SSI pays monthly to a person who has no other income and who is living alone in the community. This is the standard used for Medicaid eligible individuals to calculate eligibility for long-term nursing care in a nursing facility, Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID), and individuals on ICF/IID waivers or eligibility for services under Aging and People with Disabilities (APD) Home and Community Based Services program.

~~(165)~~(166) "Institutionalized" means a patient admitted to a nursing facility or hospital for the purpose of receiving nursing or hospital care for a period of 30 days or more.

~~(166)~~(167) "International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM) (including volumes 1, 2, and 3, as revised annually)" means a book of diagnosis codes used for billing purposes when treating and requesting reimbursement for treatment of diseases.

~~(167)~~(168) "Joint Fair Hearing Request" means a request for a fair hearing that is included in an appeal request submitted to an Exchange or other insurance affordability program or appeals entity, in accordance with the signed agreement between the agency and an Exchange or Exchange appeals entity or other program or appeals entity described in 42 CFR 435.1200.

~~(168)~~(169) "Laboratory" means a facility licensed under ORS 438 and certified by CMS, Department of Health and Human Services (DHHS), as qualified to participate under Medicare and to provide laboratory services (as defined in this rule) within or apart from a hospital. An entity is considered to be a laboratory if the entity derives materials from the human body for the purpose of providing information for the diagnosis, prevention, or treatment of any disease or impairment of or the assessment of the health of human beings. If an entity performs even one laboratory test, including waived tests for these purposes, it is considered to be a laboratory under the Clinical Laboratory Improvement Act (CLIA).

~~(169)~~(170) "Laboratory Services" means those professional and technical diagnostic analyses of blood, urine, and tissue ordered by a physician or other licensed practitioner of the healing arts within their scope of practice as defined under state law and provided to a patient by or under the direction of a physician or appropriate licensed practitioner in an office or similar facility, hospital, or independent laboratory.

~~(170)~~(171) "Licensed Direct Entry Midwife" means a practitioner who has acquired the requisite qualifications to be registered or legally licensed to practice midwifery by the Public Health Division.

~~(171)~~(172) "Liability Insurance" means insurance that provides payment based on legal liability for injuries or illness. It includes, but is not limited to, automobile liability insurance, uninsured and underinsured motorist insurance, homeowner's liability insurance, malpractice insurance, product liability insurance, Worker's Compensation, and general casualty insurance. It also includes payments under state wrongful death statutes that provide payment for medical damages.

~~(172)~~(173) "Long-Term Acute Care (LTAC) Hospital" means a facility that provides specialty care designed for patients with serious medical problems that require intense, special treatment for an extended period of time.

~~(173)~~(174) "Long-term Care or Long-term Services and Supports" means Medicaid funded Long-term care or long-term services and supports services that include:

(a) "Long-term Care" as defined in OAR 461-001-0000 means the system through which the Department of Human Services provides a broad range of social and health services to eligible adults who are aged, blind, or have disabilities for extended periods of time. This includes nursing homes and behavioral health care outlined in OAR chapter 410, division 172 Medicaid Behavioral Health, including state psychiatric hospitals;

(b) "Long-term Services and Supports" means the Medicaid services and supports provided under a CMS approved waiver to assist individual's needs and to avoid

institutionalization as defined in OAR chapter 411, division 4 and defined as Medicaid Home and Community-Based Settings and Services (HCBS) and as outlined in OAR chapter 410, division 172 (Medicaid Payment for Behavioral Health Services).

(175) "Low Food Security" -means reduced quality, variety, or desirability of diet; little or no indication of reduced food intake as measured by the U.S. Household Food Security Survey Module: Six Item Short Form from the U.S. Department of Agriculture.

~~(174)~~(176) "Managed Care Entity (MCE)" means an entity that enters into a contract to provide services in a managed care delivery system, including but not limited to managed care organizations, prepaid health plans, primary care case managers and Coordinated Care Organizations.

~~(175)~~(177) "Managed Care Organization (MCO)" means a contracted health delivery system providing capitated or prepaid health services, also known as a Prepaid Health Plan (PHP). An MCO is responsible for providing, arranging, and making reimbursement arrangements for covered services as governed by state and federal law. An MCO may be a Chemical Dependency Organization (CDO), Dental Care Organization (DCO), Mental Health Organization (MHO), or Physician Care Organization (PCO).

~~(176)~~(178) "Managing Employee" means a general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operations of the provider, whether the provider is an individual, institution, organization or agency.

~~(177)~~(179) "Maternity Case Management" means a program available to pregnant clients. The purpose of maternity case management is to extend prenatal services to include non-medical services that address social, economic, and nutritional factors. For more information refer to the Division's Medical-Surgical Services program administrative rules.

~~(178)~~(180) "Meaningful access" means client or member-centered access reflecting the following statute and standards:

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

(b) National Culturally and Linguistically Appropriate Services (CLAS) Standards at https://thinkculturalhealth.hhs.gov/clas/standards; and

(c) As applicable to the client or member, Tribal based practice standards: https://www.oregon.gov/OHA/HSD/AMH/Pages/EBP.aspx;

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

~~(179)~~(181) "Medicaid" means a joint federal and state funded program for medical assistance established by Title XIX of the Social Security Act as amended and administered in Oregon by the Authority.

~~(180)~~(182) "Medical Assistance Eligibility Confirmation" means verification through the Electronic Verification System (EVS), AVR, Secure Web site or Electronic Data Interchange (EDI), or an authorized Department or Authority representative.

~~(181)~~(183) "Medical Assistance Program" means a program for payment of health services provided to eligible Oregonians, including Medicaid and CHIP services under the OHP Medicaid Demonstration Project and Medicaid and CHIP services under the State Plan, or Healthier Oregon, or Bridge Program, or any other programs that may be prescribed by the Authority from time to time, in accordance with ORS 414.025(17).

~~(182)~~(184) "Medical Care Identification" means the card commonly called the "medical card" or medical ID issued to clients (called the Oregon Health ID starting Aug. 1, 2012).

~~(183)~~(185) "Medical Services" means care and treatment provided by a licensed medical provider directed at preventing, diagnosing, treating, or correcting a medical problem.

~~(184)~~(186) "Medical Transportation" means transportation to or from covered medical services.

~~(185)~~(187) "Medically Appropriate"

(a) Means health services, items, or medical supplies that are:

(i) Recommended by a licensed health provider practicing within the scope of their license; and

(ii) Safe, effective, and appropriate for the patient based on standards of good health practice and generally recognized by the relevant scientific or professional community based on the best available evidence; and

(iii) Not solely for the convenience or preference of an OHP client, member, or a provider of the service item or medical supply; and

(iv) The most cost effective of the alternative levels or types of health services, items, or medical supplies that are covered services that can be safely and effectively provided to a Division client or member in the Division or MCE's judgment.

(b) All covered services must be medically appropriate for the member or client, but not all medically appropriate services are covered services.

(c) For Early and Periodic Screening, Diagnostic and Treatment (EPSDT), see chapter 410 Division 151.

~~(186)~~(188) "Medically Necessary" means:

(a) Health services and items that are required to address one or more of the following:

(i) The prevention, diagnosis, or treatment of a client or member's disease, condition, or disorder that could result in health impairments or a disability; or

(ii) The client's or member's ability to achieve age-appropriate growth and development; or

(iii) The client's or member's ability to attain, maintain, or regain independence in self-care, ability to perform activities of daily living or improve health status; or

(iv) The client's or member's ability to have access to the benefits of non-institutionalized community living, to achieve person centered care goals, and to live and work in the setting of their choice, when they are receiving Long Term Services or Supports (as defined in these rules);

(b) A medically necessary service must also be medically appropriate. All covered services must be medically necessary, but not all medically necessary services are covered services.

(c) For Early and Periodic Screening, Diagnostic and Treatment (EPSDT), see chapter 410 Division 151.

~~(187)~~(189) "Medicare" means a federally administered program offering health insurance benefits for persons aged 65 or older and certain other aged or disabled persons. This program includes:

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

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

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

~~(188)~~(190) "Medical Nutrition Therapy means" an evidence-based application of the Nutrition Care Process provided by licensed dietitians; focused on prevention, delay or management of diseases and conditions; and involving an in-depth assessment, periodic reassessment and intervention(s). (OAR 834-020-0000)

~~(189)~~(191) "Medicare Advantage" means an organization approved by CMS to offer Medicare health benefits plans to Medicare beneficiaries.

~~(190)~~(192) "Member" means an OHP client enrolled with a pre-paid health plan or coordinated care organization.

~~(191)~~(193) "National Correct Coding Initiative (NCCI)" means the Centers for Medicare and Medicaid Services (CMS) developed the National Correct Coding Initiative (NCCI) to promote national correct coding methodologies and to control improper coding leading to inappropriate payment.

~~(192)~~(194) "National Drug Code or (NDC)" means a universal number that identifies a drug. The NDC number consists of 11 digits in a 5-4-2 format. The Food and Drug Administration assigns the first five digits to identify the manufacturer of the drug. The manufacturer assigns the

remaining digits to identify the specific product and package size. Some packages shall display less than 11 digits, but the number assumes leading zeroes.

~~(193)~~(195) "National Provider Identification (NPI)" means federally administered provider number mandated for use on HIPAA covered transactions; individuals, provider organizations, and subparts of provider organizations that meet the definition of health care provider (45 CFR 160.103) and who conduct HIPAA covered transactions electronically are eligible to apply for an NPI. Medicare and Medicaid covered entities are required to apply for an NPI.

~~(194)~~(196) "Naturopathic physician" means an individual licensed to practice naturopathic medicine by the Oregon Board of Naturopathic Medicine.

~~(195)~~(197) "Naturopathic Services" means services provided within the scope of practice as defined under state law and by rules of the Oregon Board of Naturopathic Medicine.

~~(196)~~(198) "Non-Billing Provider" also referred to as non-payable, means a provider who is issued a provider number for purposes of rendering, ordering, referring, prescribing, data collection, encounters, or non-claims-use of the Provider Web Portal (e.g., eligibility verification).

~~(197)~~(199) "Non-covered Services" means services or items for which the Authority is not responsible for payment or reimbursement. Non-covered services are identified in:

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

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

(c) OAR 410-141-3820 OHP Benefit Package of Covered Services;

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

(e) Any other applicable Division administrative rules.

~~(198)~~(200) "Non-Emergent Medical Transportation Services (NEMT)" means transportation to or from a source of covered service, that does not involve a sudden, unexpected occurrence which creates a medical crisis requiring emergency medical services as defined in OAR 410-120-0000 and requiring immediate transportation to a site, usually a hospital, where appropriate emergency medical care is available. NEMT does not cover the cost of transportation to authorized HRSN services.

~~(199)~~(201) "Nurse Anesthetist, C.R.N.A." means a registered nurse licensed in the State of Oregon as a CRNA who is currently certified by the National Board of Certification and Recertification for Nurse Anesthetists.

~~(200)~~(202) "Nurse Practitioner" means an individual licensed as a registered nurse and certified by the Board of Nursing to practice as a nurse practitioner pursuant to state law.

~~(201)~~(203) "Nurse Practitioner Services" means services provided within the scope of practice of a nurse practitioner as defined under state law and by rules of the Board of Nursing.

~~(202)~~(204) "Nursing Facility" means a facility licensed and certified by the Department and defined in OAR 411-070-0005.

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

(206) "Nutrition Related Supports" means nutrition services provided to eligible members to improve their access to food and health (as detailed in OAR 410-120-2000). Nutrition Related Supports include the following:

(a) Assessment for Medically Tailored Meals,
(b) Medically Tailored Meals,
(c) Meals,
(d) Pantry Stocking,
(e) Fruit and Vegetable Benefit, and
(f) Nutrition Education.

~~(203)~~(207) "Nutritional Counseling" means counseling that takes place as part of the treatment of an individual with a specific condition, deficiency, or disease such as diabetes, hypercholesterolemia, or phenylketonuria.

~~(204)~~(208) "Occupational Therapist" means an individual licensed by the State Board of Examiners for Occupational Therapy.

~~(205)~~(209) "Occupational Therapy" means the functional evaluation and treatment of individuals whose ability to adapt or cope with the task of living is threatened or impaired by developmental deficiencies, physical injury or illness, the aging process, or psychological disability. The treatment utilizes task-oriented activities to prevent or correct physical and emotional difficulties or minimize the disabling effect of these deficiencies on the life of the individual.

~~(206)~~(210) "Ombudsman Services" means advocacy services provided by the Authority to clients whenever the client is reasonably concerned about access to, quality of, or limitations on the health services provided.

~~(207)~~(211) "Oregon Health ID" means a card the size of a business card that lists the client's name, client ID (prime number), and the date it was issued.

~~(208)~~(212) "Oregon Health Plan (OHP)" means the Medicaid and Children's Health Insurance (CHIP) Demonstration Project that expands Medicaid and CHIP eligibility beyond populations traditionally eligible for Medicaid to other low-income populations and Medicaid and CHIP services under the State Plan.

~~(209)~~(213) "Optometric Services" means services provided within the scope of practice of optometrists as defined under state law.

~~(210)~~(214) "Optometrist" means an individual licensed to practice optometry pursuant to state law.

~~(211)~~(215) "Oregon Health Authority (Authority)" means the agency established in ORS Chapter 413 that administers the funds for Titles XIX and XXI of the Social Security Act. It is the single state agency for the administration of the medical assistance program under ORS chapter 414. For purposes of these rules, the agencies under the authority of the Oregon Health Authority are the Public Health Division, Health Systems Division, External Relations, Health Policy and Analytics, Fiscal and Operations, Health System Division, Office of Equity and Inclusion, and the Oregon State Hospital.

~~(212)~~(216) "Oregon Youth Authority (OYA)" means the state department charged with the management and administration of youth correction facilities, state parole and probation services, and other functions related to state programs for youth corrections.

~~(213)~~(217) "Out-of-State Providers" means any provider located outside the borders of the State of Oregon:

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

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

~~(214)~~(218) "Outpatient Hospital Services" means services that are furnished in a hospital for the care and treatment of an outpatient. For information on outpatient-covered services, see the Division's Hospital Services administrative rules chapter 410, division 125.

~~(215)~~(219) "Overdue Claim" means a valid claim that is not paid within 45 days of the date it was received.

~~(216)~~(220) "Overpayment" means a payment made by the Authority to a provider in excess of the correct Authority payment amount for a service. Overpayments are subject to repayment to the Authority.

~~(217)~~(221) "Overuse" means use of medical goods or services at levels determined by Authority medical staff or medical consultants to be medically unnecessary or potentially harmful.

~~(218)~~(222) 'Ownership interest' means the possession of equity in the capital, the stock, or the profits of the disclosing entity. A person with an ownership or control interest is a person or corporation that:

(a) Has an ownership interest totaling 5 percent or more in a disclosing entity;

(b) Has an indirect ownership interest equal to 5 percent or more in a disclosing entity;

(c) Has a combination of direct and indirect ownership interests equal to 5 percent or more in a disclosing entity;

(d) Owns an interest of 5 percent or more in any mortgage, deed of trust, note, or other obligation secured by the disclosing entity if that interest equals at least 5 percent of the value of the property or assets of the disclosing entity;

(e) Is an officer or director of a disclosing entity that is organized as a corporation; or

(f) Is a partner in a disclosing entity that is organized as a partnership.

~~(219)~~(223) "Participating provider" means a provider that has a contractual relationship with an MCE. A Participating Provider is not a Subcontractor solely by virtue of a Participating Provider agreement with an MCE. "Network Provider" has the same meaning as Participating Provider.

~~(220)~~(224) "Payable Provider" means a provider who is issued a provider number for purposes of submitting medical assistance program claims directly to the Authority for payment.

~~(221)~~(225) "Payment Authorization" means authorization granted by the responsible agency, office, or organization for payment prior or subsequent to the delivery of services, as described in these general rules and the appropriate program rules. See the individual program rules for services requiring authorization.

~~(222)~~(226) "Peer Review Organization (PRO)" means an entity of health care practitioners of services contracted by the state to review services ordered or furnished by other practitioners in the same professional field.

~~(223)~~(227) "Peer Support Specialist" means an individual providing services to another individual who shares a similar life experience such as (i) addiction to addiction, (ii) mental health condition to mental health condition, or (iii) family member of an individual with a mental health condition to family member of an individual with a mental health condition. A peer support specialist shall be a self-identified individual:

(a) Currently or formerly receiving addictions or mental health services;

(b) In recovery from an addiction disorder who meets the abstinence requirements for recovering staff in alcohol or other drug treatment programs;

(c) In recovery from problem gambling.

~~(224)~~(228) "Peer Wellness Specialist" including Family Support Specialist and Youth Support Specialist means an individual who is responsible for assessing mental health service and support needs of the individual's peers through community outreach, assisting individuals with access to available services and resources, addressing barriers to services and providing education and information about available resources and mental health issues in order to reduce stigmas and discrimination toward consumers of mental health services, and to provide direct services to assist individuals in creating and maintaining recovery, health, and wellness.

~~(225)~~(229) "Person Centered Care" means care that reflects the individual patient's strengths and preferences, reflects the clinical needs of the patient as identified through an individualized assessment, is based upon the patient's goals, and shall assist the patient in achieving the goals.

~~(226)~~(230) "Person-Centered Service Plan" and "PCSP" each means the HRSN-related component of the care plan that is developed in consultation with the Member upon authorization of ~~Climate-Related Supports~~HRSN Services. The PCSP must be reviewed and revised upon reassessment of need at least every twelve (12) months, when the Member's circumstances or needs change significantly, or at the request of the Member.

~~(227)~~(231) "Personal Health Navigator" means an individual who provides information, assistance, tools, and support to enable a patient to make the best health care decisions in the patient's particular circumstances and considering the patient's needs, lifestyle, combination of conditions, and desired outcome.

~~(228)~~(232) "Pharmaceutical Services" means services provided by a pharmacist, including medications dispensed in a pharmacy upon an order of a licensed practitioner prescribing within the scope of practice.

~~(229)~~(233) "Pharmacist" means an individual licensed to practice pharmacy pursuant to state law.

~~(230)~~(234) "Physical Capacity Evaluation" means an objective, directly observed measurement of a person's ability to perform a variety of physical tasks combined with subjective analysis of abilities of the individual.

~~(231)~~(235) "Physical Therapist" means an individual licensed by the relevant state licensing authority to practice physical therapy.

~~(232)~~(236) "Physical Therapy" means treatment comprising exercise, massage, heat or cold, air, light, water, electricity, or sound for the purpose of correcting or alleviating any physical or mental disability, or the performance of tests as an aid to the assessment, diagnosis, or treatment of a human being. Physical therapy may not include radiology or electrosurgery.

~~(233)~~(237) "Physician" means an individual licensed to practice medicine pursuant to state law of the state in which they practice medicine or an individual licensed to practice medicine pursuant to federal law for the purpose of practicing medicine under a contract with the federal government. A physician may be an individual licensed under ORS 677 or ORS 685.

~~(234)~~(238) "Physician Assistant" means an individual licensed as a physician assistant in accordance with ORS 677. Physician assistants provide medical services under the direction and supervision of an Oregon licensed physician according to a practice description approved by the Board of Medical Examiners.

~~(235)~~(239) "Physician Services" means services provided within the scope of practice as defined under state law by or under the personal supervision of a physician.

~~(236)~~(240) "Podiatric Services" means services provided within the scope of practice of podiatrists as defined under state law.

~~(237)~~(241) "Podiatrist" means an individual licensed to practice podiatric medicine pursuant to state law.

~~(238)~~(242) "Post-Payment Review" means review of billings or other medical information for accuracy, medical appropriateness, level of service, or for other reasons subsequent to payment of the claim.

~~(239)~~(243) "Practitioner" or "Practitioner of the Healing Arts" means an individual licensed pursuant to state law to engage in the provision of health care services within the scope of the practitioner's license or certification.

~~(240)~~(244) "Prepaid Health Plan (PHP)" means a managed health, dental, chemical dependency, or mental health organization that contracts with the Authority on a case managed, prepaid, capitated basis under OHP. PHPs may be a Chemical Dependency Organization (CDO), Dental Care Organization (DCO), Mental Health Organization (MHO), or Physician Care Organization (PCO)

~~(241)~~(245) "Primary Care Dentist (PCD)" means a dental practitioner responsible for supervising and coordinating initial and primary dental care within their scope of practice for their members.

~~(242)~~(246) "Primary Care Provider (PCP)" means any enrolled medical assistance provider who has responsibility for supervising, coordinating, and providing initial and primary care within their scope of practice for identified clients. PCPs initiate referrals for care outside their scope of practice, consultations, and specialist care and assure the continuity of medically appropriate client care. A Federally qualified PCP means a physician with a specialty or subspecialty in family medicine, general internal medicine, or pediatric medicine as defined in OAR 410-130-0005.

~~(243)~~(247) "Prior Authorization (PA)" means payment authorization for specified medical services or items given by Authority staff or its contracted agencies before providing the service. A physician referral is not a PA.

~~(244)~~(248) "Prioritized List of Health Services" means the listing of conditions and treatment pairs developed by the Health Evidence Review Commission for the purpose of administering OHP.

~~(245)~~(249) "Private Duty Nursing Services" means nursing services provided within the scope of license by a registered nurse or a licensed practical nurse under the general direction of the patient's physician to an individual who is not in a health care facility.

~~(246)~~(250) "Provider" means an individual, facility, institution, corporate entity, or other organization enrolled or not enrolled that provides or supplies health services or items, also termed a rendering provider or participating provider, or bills, obligates, and receives reimbursement on behalf of a rendering provider of services, also termed a Billing Provider (BP). The term provider refers to both rendering providers and BP unless otherwise specified.

~~(247)~~(251) "Provider Organization" means a group practice, facility, or organization that is:

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

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

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

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

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

~~(248)~~(252) "Psychiatric Emergency Services (PES)" means medical and behavioral health services provided to individuals experiencing an acute disturbance of thought, mood, behavior, or social relationship that requires an immediate intervention as defined by the patient, family, or the community to prevent harm to the patient or others.

~~(249)~~(253) "Public Health Clinic" means a clinic operated by a county government.

~~(250)~~(254) "Public Rates" means the charge for services and items that providers, including hospitals and nursing facilities, made to the general public for the same service on the same date as that provided to Authority clients.

~~(251)~~(255) "Public Safety Power Shutoff" and "~~(~~PSPS~~)~~" means the temporary shutdown of electricity for the purpose of protecting communities in high fire-risk areas when experiencing extreme weather events, which could cause the electrical system to spark wildfires. The decision to implement a PSPS is usually made by the utility provider of the affected service area.

~~(252)~~(256) "Qualified Medicare Beneficiary (QMB)" means a Medicare beneficiary as defined by the Social Security Act and its amendments.

~~(253)~~(257) "Qualified Medicare and Medicaid Beneficiary (QMM)" means a Medicare beneficiary who is also eligible for Division coverage.

~~(254)~~(258) "Quality Improvement" means the efforts to improve the level of performance of a key process or processes in health services or health care.

~~(255)~~(259) "Quality Improvement Organization (QIO)" means an entity that has a contract with CMS under Part B of Title XI to perform utilization and quality control review of the health care furnished, or to be furnished, to Medicare and Medicaid clients; formerly known as a Peer Review Organization.

~~(256)~~(260) "Radiological Services" means those professional and technical radiological and other imaging services for the purpose of diagnosis and treatment ordered by a physician or other licensed practitioner of the healing arts within the scope of practice as defined under state law and provided to a patient by or under the direction of a physician or appropriate licensed practitioner in an office or similar facility, hospital, or independent radiological facility.

~~(257)~~(261) "Recipient" means an individual who is currently eligible for medical assistance (also known as a client).

~~(258)~~(262) "Recreational Therapy" means recreational or other activities that are diversional in nature (includes, but is not limited to, social or recreational activities or outlets).

~~(259)~~(263) "Recoupment" means an accounts receivable system that collects money owed by the provider to the Authority by withholding all or a portion of a provider's future payments.

~~(260)~~(264) "Reduction of Services" means situations in which the agency authorizes an amount, duration or scope of a service which is less than that requested by the beneficiary or provider. For example, if the individual has requested 20 physical therapy visits and the Division denies the individual's coverage of 20 visits, covering instead only 10 visits—this is considered a denial of a service and could be appealed.

~~(261)~~(265) "Referral" means the transfer of total or specified care of a client from one provider to another. As used by the Authority, the term referral also includes a request for a consultation or evaluation or a request or approval of specific services. In the case of clients whose medical care is contracted through a Prepaid Health Plan (PHP), or managed by a Primary Care Physician, a referral is required before non-emergency care is covered by the PHP or the Authority.

~~(262)~~(266) "Remittance Advice (RA)" means the automated notice a provider receives explaining payments or other claim actions. It is the only notice sent to providers regarding claim actions.

~~(263)~~(267) "Rendering provider" means an individual, facility, institution, corporate entity, or other organization that supplies health services or items, also termed a provider, or bills, obligates, and receives reimbursement on behalf of a provider of services, also termed a billing provider (BP). The term rendering provider refers to both providers and BP unless otherwise specified.

~~(264)~~(268) "Request for Hearing" means a clear expression in writing by an individual or representative that the individual wishes to appeal a Department or Authority decision or action and wishes to have the decision considered by a higher authority.

~~(265)~~(269) "Representative" means an individual who can make OHP-related decisions for a client who is not able to make such decisions themselves.

~~(266)~~(270) "Retroactive Medical Eligibility" means eligibility for medical assistance granted to a client retroactive to a date prior to the client's application for medical assistance.

~~(267)~~(271) "Ride" means non-emergent medical transportation services for a client either to or from a location where covered services are provided. "Ride" does not include client-reimbursed medical transportation or emergency medical transportation in an ambulance.

~~(268)~~(272) "Rural" means a geographic area that is ten or more map miles from a population center of 30,000 people or less.

~~(269)~~(273) "Sanction" means an action against providers taken by the Authority in cases of misuse or abuse of Oregon Health Authority requirements or fraud, waste and abuse, in accordance with OAR 410-120-1400.

~~(270)~~(274) "School Based Health Service" means a health service required by an Individualized Education Plan (IEP) during a child's education program that addresses physical or mental disabilities as recommended by a physician or other licensed practitioner.

~~(271)~~(275) "Self-Sufficiency" means the division in the Department of Human Services that administers programs for adults and families.

~~(272)~~(276) "Service Agreement" means an agreement between the Authority and a specified provider to provide identified services for a specified rate. Service agreements may be limited to services required for the special needs of an identified client. Service agreements do not preclude the requirement for a provider to enroll as a provider.

~~(273)~~(277) "Service location" means the location of a provider when services are rendered.

~~(274)~~(278) "Sliding Fee Schedule" means a fee schedule with varying rates established by a provider of health care to make services available to indigent and low-income individuals. The sliding-fee schedule is based on ability to pay.

~~(275)~~(279) "Social Worker" means an individual licensed by the Board of Clinical Social Workers to practice clinical social work.

~~(276)~~(280) "Speech-Language Pathologist" means an individual licensed by the Oregon Board of Examiners for Speech Pathology.

~~(277)~~(281) "Speech-Language Pathology Services" means the application of principles, methods, and procedure for the measuring, evaluating, predicting, counseling, or instruction related to the development and disorders of speech, voice, or language for the purpose of preventing, habilitating, rehabilitating, or modifying such disorders in individuals or groups of individuals.

~~(278)~~(282) "State Facility" means a hospital or training center operated by the State of Oregon that provides long-term medical or psychiatric care.

~~(279)~~(283) "Supplemental Health Benefit State Funding" means funding for the health benefits included in the Healthier Oregon benefits package described in OAR 410-134-0004(3)(a-m).

~~(280)~~(284) "Subparts (of a Provider Organization)" means for NPI application, subparts of a health care provider organization may meet the definition of health care provider (45 CFR 160.103) if it were a separate legal entity and if it conducted HIPAA-covered transactions electronically or has an entity do so on its behalf and could be components of an organization or separate physical locations of an organization.

~~(281)~~(285) "Subrogation" means right of the state to stand in place of the client in the collection of Third Party Resources (TPR).

~~(282)~~(286) "Substance Use Disorder (SUD) Services" means assessment, treatment, and rehabilitation on a regularly scheduled basis or in response to crisis for alcohol or other drug abuse for dependent members and their family members or significant others, consistent with Level I, Level II, or Level III of the most currently published edition of the American Society of Addiction Medicine Patient Placement Criteria (ASAM PPC). SUD is an interchangeable term with Chemical Dependency (CD), Alcohol and other Drug (AOD), and Alcohol and Drug (A & D).

~~(283)~~(287) "Supplemental Security Income (SSI)" means a program available to certain aged and disabled persons that is administered by the Social Security Administration through the Social Security office.

~~(284)~~(288) "Surgical Assistant" means an individual performing required assistance in surgery as permitted by rules of the State Board of Medical Examiners.

~~(285)~~(289) "Suspension" means a temporary sanction prohibiting a provider's participation in the medical assistance programs by suspending the provider's Authority-assigned provider number for a specified period of time for one or more of the reasons in OAR 410-120-1400.

No payments, Title XIX, or State Funds shall be made for services provided while the provider is suspended.

~~(286)~~(290) "Targeted Case Management (TCM)" means activities that assist the client in a target group in gaining access to needed medical, social, educational, and other services. This includes locating, coordinating, and monitoring necessary and appropriate services. TCM services are often provided by allied agency providers.

~~(287)~~(291) "Telecommunication technologies" means the use of devices and services for telemedicine or telehealth delivered services. These technologies include videoconferencing, store-and-forward imaging, streaming media including services with information transmitted via landlines, and wireless communications, including the Internet and telephone networks.

~~(288)~~(292) "Telehealth" includes telemedicine and includes the use of electronic information and telecommunications technologies to support remote clinical healthcare, client or member and professional health-related education, public health, and health administration.

~~(289)~~(293) "Telemedicine" means the mode of delivering remote clinical health services using information and telecommunication technologies to provide consultation and education or to facilitate diagnosis, treatment, care management or self-management of a client or member's healthcare.

~~(290)~~(294) "Termination" means a sanction prohibiting a provider's participation in the Authority's programs by canceling the provider's Authority-assigned provider number and provider agreement for one or more of the reasons in OAR 410-120-1400 and the provider has exhausted all applicable appeal rights or the timeline for appeal has expired. No payments, Title XIX, or state funds shall be made for services provided after the date of termination. Termination is permanent unless:

(a) The exceptions to mandatory exclusion are met; or

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

~~(291)~~(295) "Third Party Liability (TPL), Third Party Resource (TPR), or Third party payer" means a medical or financial resource that, under law, is available and applicable to pay for medical services and items for an Authority client.

~~(292)~~(296) "Traditional Health Worker" means a community health worker, peer wellness specialist, personal health navigator, peer support specialist, birth doula, or other similar health workers not regulated or certified by the State of Oregon.

~~(293)~~(297) "Traditional Health Worker" means a community health worker, peer wellness specialist, personal health navigator, peer support specialist, or birth doula not otherwise regulated or certified by the State of Oregon. OAR 950-060-0010(19)

~~(294)~~(298) "Transportation" means medical transportation.

~~(295)~~(299) "Trauma informed approach" means approach undertaken by providers and healthcare or human services programs, organizations, or systems in providing mental health and substance use disorders treatment where there is a recognition and understanding of the signs and symptoms of trauma in, and the intensity of such trauma on, individuals, families, and others involved within a program, organization, or system, and then takes into account those signs, symptoms, and their intensity and fully integrates that knowledge when implementing and providing potential paths for recovery from mental health or substance use disorders. The Trauma Informed Approach also means that providers and healthcare or human services programs, organizations, or systems actively resist re-traumatization of the individuals being served within their respective entities.

~~(296)~~(300) "Trauma Informed Services" means those services provided using a trauma informed approach.

~~(297)~~(301) "Service Authorization Request" means a member's initial or continuing request for the provision of a service including member requests made by their provider or the member's authorized representative.

~~(298)~~(302) "Type A Hospital" means a hospital identified by the Office of Rural Health as a Type A hospital.

~~(299)~~(303) "Type B AAA" means an AAA administered by a unit or combination of units of general purpose local government for overseeing Medicaid, financial and adult protective services, and regulatory programs for the elderly or the elderly and disabled.

~~(300)~~(304) "Type B AAA Unit" means a Type B AAA funded by Oregon Project Independence (OPI), Title III—Older Americans Act, and Title XIX of the Social Security Act.

~~(301)~~(305) "Type B Hospital" means a hospital identified by the Office of Rural Health as a Type B hospital.

~~(302)~~(306) "Urban" means a geographic area that is less than ten map miles from a population center of 30,000 people or more.

~~(303)~~(307) "Urgent Care Services" means health services that are medically appropriate and immediately required to prevent serious deterioration of a client's health that are a result of unforeseen illness or injury.

~~(304)~~(308) "Usual Charge (UC)" means the lesser of the following unless prohibited from billing by federal statute or regulation:

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

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

(c) Where the provider has established a written sliding fee scale based upon income for individuals and families with income equal to or less than 200 percent of the federal poverty level, the fees paid by these individuals and families are not considered in determining the usual charge. Any amounts charged to Third Party Resources (TPR) are to be considered.

~~(305)~~(309) "Utilization Review (UR)" means the process of reviewing, evaluating, and assuring appropriate use of medical resources and services. The review encompasses quality, quantity, and appropriateness of medical care to achieve the most effective and economic use of health care services.

~~(306)~~(310) "Valid Claim" means an invoice received by the Division or the appropriate Authority or Department office for payment of covered health care services rendered to an eligible client that:

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

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

~~(307)~~(311) "Valid Preauthorization" means a document the Authority, a PHP, or CCO receives requesting a health service for a member who may be eligible for the service at the time of the service, and the document contains:

(a) A beginning and ending date not exceeding twelve months, except for cases of PHP or CCO enrollment where four months may apply; and

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

~~(308)~~(312) "Vision Services" means provision of corrective eyewear, including ophthalmological or optometric examinations for determination of visual acuity and vision therapy and devices.

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

(314) "Young Adults with Special Health Care Needs" or "YSHCN" means an eligibility category for OHP Plus defined at OAR 410-200-0455.

(315) "YSHCN Benefits" means individuals enrolled as YSHCN (defined at OAR 410-200-0455) will receive the OHP Plus benefit, as well as additional benefits, which include:

(a) Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Services, as defined in chapter 410, division 151;

(b) HRSN Services (if the YSHCN Member also meets other qualifying criteria); and

(c) Enhanced vision and dental benefits, meaning those benefits otherwise offered to individuals age 21 and under, as described in OAR 410-123-1260 and OAR 410-140-0140.

Table 1. Climate Device-Specific and Related Outreach and Engagement Clinical Risk Factors (Condition must have been active in the past 12 months. Members must meet age or pregnancy criteria at the time of eligibility determination, as relevant.)	**Eligible Climate Device**
Schizophrenia spectrum and other psychotic disorders	Air Conditioner, Air Filtration Device, Heater
Bipolar and related disorders	
Major depressive disorder with an acute care need in the past 12 months including a suicide attempt, crisis services utilization (emergency department, mobile crisis team, etc.), acute psychiatric hospitalization, or residential treatment.	
One or more of the following substance use disorders: alcohol use disorder, hallucinogen use disorders, inhalant use disorder, opioid use disorder, stimulant use disorder	
Major neurocognitive disorders	
Chronic lower respiratory condition including chronic obstructive pulmonary disease (COPD), asthma requiring regular use of asthma controlling medications, restrictive lung disease, fibrosis, chronic bronchitis, bronchiectasis	
Chronic cardiovascular disease, including cerebrovascular disease and heart disease	

Table 1. Climate Device-Specific and Related Outreach and Engagement Clinical Risk Factors (Condition must have been active in the past 12 months. Members must meet age or pregnancy criteria at the time of eligibility determination, as relevant.)	Eligible Climate Device
Spinal cord injury	
In-home hospice	
Any sensory, physical, intellectual, or developmental disability that increases health risks during extreme climate events	
Child less than 6 years of age and currently has, has a history of, or is at risk for at least one of the following: • Heat stroke or heat exhaustion • Hypothermia, frostbite, or chilblains • Malnutrition • Dehydration • Child maltreatment as defined by the CDC (https://www.cdc.gov/violenceprevention/pdf/CM_Surveillance-a.pdf)	
• Is a child with a special healthcare need (CYSHCN) as defined by HRSA (https://mchb.hrsa.gov/programs-impact/focus-areas/children-youth-special-health-care-needs-cyshcn#i) • An acute or chronic respiratory condition • A respiratory or gastrointestinal infectious disease, or becoming febrile with an infectious illness • Low birth weight of <2500 grams	
Pregnant and currently has, has a history of, or is at risk for at least one of the following: • Heat stroke or heat exhaustion • Hypothermia, frostbite, or chilblains • An acute or chronic respiratory condition • Infection • High-risk pregnancy as defined by the NIH (https://www.nichd.nih.gov/health/topics/high-risk/conditioninfo) • History of previous pregnancy, delivery, or birth complication including gestational diabetes, preeclampsia, preterm labor, preterm birth, placental abruption, newborn low birth weight, stillbirth • Abuse or interpersonal violence • Malnutrition • Hyperemesis gravidarum and other causes of dehydration • Maternal low birth weight of <2500 grams • Multiple pregnancy • Mental health condition	
Adult 65 years and older and currently has, has a history of, or is at risk for at least one of the following:	

Table 1. Climate Device-Specific and Related Outreach and Engagement Clinical Risk Factors (Condition must have been active in the past 12 months. Members must meet age or pregnancy criteria at the time of eligibility determination, as relevant.)	Eligible Climate Device
• Heat stroke or heat exhaustion • Hypothermia, frostbite, or chilblains • Malnutrition • Dehydration • Currently taking medications that impact heat tolerance, including for upper respiratory infections, allergies, COPD, muscle spasms, blood pressure, diuresis, diarrhea, constipation, anti-inflammation, mental health conditions, and sleep • Abuse or neglect • A respiratory or gastrointestinal infectious disease, or becoming febrile with an infectious illness • Mental health condition • Two or more chronic health conditions	
Chronic kidney disease	Air Conditioner, Heater
Diabetes mellitus, requiring any medication, oral or insulin	
Multiple sclerosis	
Parkinson's disease	
Previous heat-related or cold-related illness requiring urgent or acute care, e.g. emergency room and urgent care visits	
Individual requires home oxygen use: home oxygen, oxygen concentrators, home ventilator	Air Filtration Device
Individual uses medications requiring refrigeration. Examples include: • Medications for diabetes mellitus, glaucoma, and asthma; • TNF inhibitors	Mini-refrigerator
Enteral and parenteral nutrition	
Individual needs durable medical equipment (DME) requiring electricity for use. Examples include but are not limited to: • Oxygen delivery systems, including concentrators, humidifiers, nebulizers, and ventilators • Intermittent positive pressure breathing machines • Cardiac devices • In home dialysis and automated peritoneal dialysis • Feeding Pumps • IV infusions • Suction pumps • Power wheelchair and scooter • Lift systems and electric beds • Breast pumps for first 6mo post-partum • Other DME medically required for sustaining life	Portable Power Supply
Individual requires assistive technologies requiring electricity necessary for communication or ADLs.	

Table 1. Climate Device-Specific and Related Outreach and Engagement Clinical Risk Factors (Condition must have been active in the past 12 months. Members must meet age or pregnancy criteria at the time of eligibility determination, as relevant.)	Eligible Climate Device
Other conditions approved by medical exception in an individual review for medical exception aligned with OHA's Medical Management Committee Process and CCO exception review process	Any of the above devices

Table 2. Housing, Nutrition, and Related Outreach and Engagement Clinical Risk Factors	
HRSN Clinical Risk Factor	**Risk Factor Description**
Complex Behavioral Health Need	• An individual with a persistent, disabling, progressive or life-threatening mental health condition or substance use disorder that requires treatment or supports, or both treatment and supports, in order to achieve stabilization, prevention of exacerbation, or maintain health goals.
Developmental Disability Need	• An individual with an Intellectual Disability or Developmental Disability (as defined by OAR 411-320-0080) that requires services or supports to achieve and maintain care goals.
Complex Physical Health Need	• An individual with a persistent, disabling, progressively or life-threatening physical health condition(s) requiring treatment for stabilization or prevention of exacerbation. • Examples may include conditions such as: congenital anomalies that adversely impact health or function, blindness, disabling dental disorders, neurological diseases, cardiovascular diseases, pulmonary diseases, gastrointestinal diseases, liver diseases, renal diseases, endocrine diseases, hematologic disorders, musculoskeletal conditions, infectious diseases, cancers, autoimmune disorders, immunodeficiency disorders or immunosuppression
Needs Assistance with ADLs/IADLs or Eligible for LTSS	• An individual who needs assistance with one or more Activities of Daily Living (ADLs) as defined in OAR 411-015-0006 or Instrumental Activities of Daily Living (iADLs) as defined in OAR 411-015-0007; or • Receives or are determined eligible for Medicaid-funded Long-Term Services and Supports (LTSS) provided by the Oregon Department of Human Services (ODHS) Office of Aging and People with Disabilities (APD) or ODHS Office of Developmental Disabilities Services (ODDS), as defined in 410-141-3500.
Interpersonal Violence Experience	• An individual who is experiencing or has experienced interpersonal violence (IPV), including domestic violence (DV), sexual violence (SV), or psychological violence
Repeated Emergency Department Use and Crisis Encounters	An individual: • With repeated use of emergency department care (defined as two or more visits in the past six months or five or more visits within the past 12 months);

Table 2. Housing, Nutrition, and Related Outreach and Engagement Clinical Risk Factors	
HRSN Clinical Risk Factor	**Risk Factor Description**
	• With two or more crisis encounters in the past six months or five or more crisis encounters in the past 12 months, which represent an exacerbation of mental health distress, defined to include: receipt of crisis/outreach team services; use of behavioral health mobile crisis, crisis respite services, or school behavioral health crisis services; any length of stay in an adult jail or youth detention facility; or any length of stay in emergency foster care. • Who was exited from a housing or behavioral healthcare program (e.g., shelter setting, day habilitation program, etc.) or from a school or an early childhood program in the past 12 months due to behaviors that are likely manifestations of a behavioral health condition, significant life stress, adversity, or trauma.
Pregnant/Postpartum	An individual who is currently pregnant or up to 12 months postpartum and currently has, has a history of, or is at risk for at least one of the following: • Infection • High-risk pregnancy as defined by the NIH (https://www.nichd.nih.gov/health/topics/high-risk/conditioninfo) • Pregnancy-related death • History of previous pregnancy, delivery, or birth complication including gestational diabetes, preeclampsia, hyperemesis gravidarum, preterm labor, preterm birth, placental abruption, newborn low birth weight, stillbirth • Abuse or interpersonal violence • Malnutrition • Maternal low birth weight of <2500 grams • Multiple pregnancy • A mental health condition or substance use disorder, including a postpartum mental health condition • Significant life stress, adversity, or trauma •
Children less than 6 years of age	A child who is less than six years of age and currently has, has a history of, or is at risk for at least one of the following: • Malnutrition or at risk of developmental or growth delay or impairment as a result of insufficient nutrition • Child maltreatment as defined by the CDC (https://www.cdc.gov/violenceprevention/pdf/CM_Surveillance- a.pdf) • Is a child with a special healthcare need (CYSHCN) as defined by HRSA (https://mchb.hrsa.gov/programs-impact/focus- areas/children-youth-special-health-care-needs-cyshcn#i)

Table 2. Housing, Nutrition, and Related Outreach and Engagement Clinical Risk Factors	
HRSN Clinical Risk Factor	**Risk Factor Description**
	• Low birth weight of <2500 grams • Mental health condition • Significant life or family stress, adversity, or trauma
Adults 65 years of age or older	An adult who is 65 years of age or over and currently has, has a history of, or is at risk for at least one of the following: • Two or more chronic health conditions • Social isolation placing the individual at risk for early death, neurocognitive disorders, sleep disruption, cardiovascular disease, and elder abuse • Malnutrition • Dehydration • Abuse or neglect • Significant life adversity stress, adversity, or trauma
Young Adults with Special Health Care Needs	An individual aged 19 to 26, with the following clinical risk factors defined in STC 4.6(a): • Have one or more complex chronic conditions as identified in the Pediatric Medical Complexity Algorithm (PCMA); • Have a serious emotional disturbance or serious mental health issue indicated by qualifying behavioral health diagnosis; • Have a diagnosed intellectual or developmental disability; • Have an "Elevated Service Need" or functional limitations as determined by two or more affirmative responses to a screener; or • Starting no earlier than January 1, 2026, have two or more chronic conditions as represented by a subset of the PMCA's non-complex chronic conditions as described in the New Initiatives Implementation Plan.

OAR 410-120-1210: Medical Assistance Benefit Packages and Delivery System

Medical Assistance Benefit Packages and Delivery System

(1) The services clients are eligible to receive are based on their benefit package. Not all packages receive the same benefits.
(2) The Health Systems Division (Division), Medical Assistance Programs benefit package description, codes, eligibility criteria, coverage, limitations, and exclusions are identified in these rules.
(3) The limitations and exclusions listed here are in addition to those described in OAR 410-120-1200 and in any chapter 410 OARs.
(4) Benefit package descriptions:

(a) Oregon Health Plan (OHP) Plus:

(A) Benefit package identifier: BMH;

(B) Eligibility criteria: As defined in federal regulations and in the 1115 OHP waiver demonstration, a client is categorically eligible for medical assistance if they are eligible under a federally defined mandatory, selected, optional Medicaid program or the Children's Health Insurance Program (CHIP) and also meets Oregon Health Authority (Authority) adopted income and other eligibility criteria;

(C) Coverage includes:

(i) Services above the funding line on the Health Evidence Review Commission (HERC) Prioritized List of Health Services (Prioritized List), (OAR 410-141-3820 through 410-141-3830);

(ii) Ancillary services, (OAR 410-141-3820);

(iii) Substance use disorder treatment and recovery services provided through local substance use disorder treatment and recovery providers;

(iv) Mental health services based on the Prioritized List to be provided by Board licensed, certified, or credentialed providers or through Community Mental Health Programs certified and credentialed providers;

(v) Hospice;

(vi) Post-hospital extended care benefit up to a 20-day stay in a nursing facility for non-Medicare Division clients who meet Medicare criteria for a post-hospital skilled nursing placement. This benefit requires prior authorization by pre-admission screening (OAR 411-070-0043) or by the Coordinated Care Organization (CCO) for clients enrolled in a CCO; and

(vii) HRSN Services (OAR 410-120-2000).

(D) Limitations: Except for YSHCN Members, t~~T~~he following services have limited coverage for non-pregnant adults age 21 and older, who are outside of the protected postpartum eligibility period (see OAR 410-200-0135). (Refer to the cited OAR chapters and divisions for details):

(i) Selected dental (OAR chapter 410, division 123 and 200);

(ii) Vision services such as frames, lenses, contacts corrective devices and eye exams for the purpose of prescribing glasses or contacts (OAR chapter 410, division 140 and 200).

(b) OHP with Limited Drugs:

(A) Benefit package identifier: BMM, BMD;

(B) Eligibility criteria: Eligible clients are eligible for Medicare and Medicaid benefits;

(C) Coverage includes: services covered by Medicare and OHP Plus as described in this rule;

(D) Limitations:
(i) The same as OHP Plus as described in this rule;
(ii) Drugs excluded from Medicare Part D coverage that are also covered under the medical assistance programs, subject to applicable limitations for covered prescription drugs (Refer to OAR chapter 410, division 121 for specific limitations). These drugs include but are not limited to:
(I) Over-the-counter (OTC) drugs;
(II) Barbiturates (except for dual eligible individuals when used in the treatment of epilepsy, cancer or a chronic mental health disorder as Part D shall cover those indications).
(E) Exclusions: Drugs or classes of drugs covered by Medicare Part D Prescription Drug;
(F) Payment for services is limited to the Medicaid-allowed payment less the Medicare payment up to the amount of co-insurance and deductible;
(G) Cost sharing related to Medicare Part D is not covered since drugs covered by Part D are excluded from the benefit package.

(c) Qualified Medicare Beneficiary (QMB)-Only:
(A) Benefit Package identifier code MED;
(B) Eligibility criteria: Eligible clients are Medicare Part A and B beneficiaries who have limited income but do not meet the income standard for full medical assistance coverage;
(C) Coverage: Is limited to the co-insurance or deductible for the Medicare service. Payment is based on the Medicaid-allowed payment less the Medicare payment up to the amount of co-insurance and deductible but no more than the Medicare allowable;
(D) Providers may not bill QMB-only clients for the deductible and coinsurance amounts due for services that are covered by Medicare;
(E) Medicare is the source of benefit coverage for service; therefore, an OHP 3165 is not required for this eligibility group. A Medicare Advance Beneficiary Notice of Noncoverage (ABN) may be required by Medicare, refer to Medicare for ABN requirements.

(d) Citizenship Waived Medical (CWM) Benefit Package defined in OAR 410-120-000. Refer to OAR 410-134-0005(2) and 410-134-0005(3) for coverage and billing guidance.

(e) Compact of Free Association (COFA) Dental Program:
(A) Benefit Package identifier code DEN;
(B) Eligibility criteria: Eligible clients are specified in OAR 410-200-0445;
(C) Coverage is state funded and includes the types and extent of Dental services that the Authority determines shall be provided to medical assistance recipients in accordance with OAR Chapter 410 Division 123.

(D) Coverage also includes pharmaceuticals prescribed by a dental health care provider as component of covered dental services.

(E) No copayments, deductibles or cost sharing shall be required for eligible clients.

(f) Veteran Dental Program:

(A) Benefit Package identifier code DEN and DNT;

(B) Eligibility criteria: Eligible clients are specified in OAR 410-200-0445;

(C) Coverage is state funded and includes the types and extent of dental services that the Authority determines shall be provided to medical assistance recipients in accordance with OAR Chapter 410 Division 123.

(D) Coverage also includes pharmaceuticals prescribed by a dental health care provider as component of covered dental services.

(E) No copayments, deductibles or cost sharing shall be required for eligible clients.

(5) Division clients are enrolled for covered health services and HRSN Services to be delivered through one of the following means:

(a) Coordinated Care Organization (CCO):

(A) These clients are enrolled in a CCO that provides integrated and coordinated health care;

(B) CCO services are obtained from the CCO or by referral from the CCO that is responsible for the provision and reimbursement for physical health, substance use disorder treatment and recovery, mental health services, dental care, or HRSN Services.

(b) Fee-for-service (FFS):

(A) These clients are not enrolled in a CCO;

(B) Subject to limitations and restrictions in the Division's individual program rules, the client may receive health care from any Division-enrolled provider that accepts FFS clients. The provider shall bill the Division directly for any covered service and shall receive a fee for the service provided.

(C) Delivery of HRSN Services for members enrolled in FFS shall be provided as set forth in OAR 410-120-2000.

OAR 410-120-2000: HRSN Services Delivery

HRSN Services Delivery

The purpose of this rule is to establish the processes, standards, and obligations required to be followed or met in administering and delivering Health Related Social Needs (HRSN) Services.

(1) HRSN Services General Requirements; Notices of Availability. HRSN Services are similar to Covered Services (as such word is defined in OAR 410-120-0000); however, HRSN Services are not subject to the medically necessary and appropriate standard for coverage under Oregon Health Plan (OHP) but instead are included in and paid for under OHP in accordance with this rule.

(a) Similarities between HRSN Services and Covered Services include the right of Managed Care Entities (MCEs) to be compensated for the provision of HRSN Services (in accordance with the HRSN Services Fee Schedule) and when Members request HRSN Services eligibility and authorization, the MCE's obligation to provide Members with:

(A) Notices outlined in this rule as well as the same notices, in form and content, that are required for Covered Services such as, for example, notices of Adverse Benefit Determinations under 42 CFR 438.404, and that comply with accessibility requirements under OARs 410-141-3580 and 410-141-3585, and 42 CFR 438.10;

(B) Service Authorizations in accordance with OAR 410-141-3835 (7), (8), (9)(d), (10), (11);

(C) Grievance and Appeal rights under OARs 410-141-3875 through OAR 410-14103915, OAR 410-120-1860, and 42 CFR Subpart F; and

(D) HRSN Services delivery that complies with the State 1115 Waiver, and in keeping with National Culturally and Linguistically Appropriate Services (CLAS) Standards at https://thinkculturalhealth.hhs.gov/clas/standards.

(b) MCEs shall notify all Members of the availability of HRSN Services, and the process by which they may obtain an HRSN Eligibility Screening, and the standards for authorization of HRSN Services.

HRSN Service Eligibility.

(2) To receive Housing Related Supports (detailed in Table 1: Housing Related Supports) Members must:

(a) Meet the eligibility criteria as outlined in Table 2: HRSN Housing Eligibility Criteria; and,

(b) Not be eligible for substantially the same Housing Related Supports service through a non-HRSN Medicaid covered service.

(3) To receive Nutrition Related Supports (Table 4: Nutrition Related Supports) Members must:

(a) Meet the eligibility criteria as outlined in Table 5: HRSN Nutrition Eligibility Criteria; and,

(b) Not be eligible for substantially the same Nutrition Related Supports service through a non-HRSN Medicaid covered service.

(4) To receive HRSN Outreach and Engagement Supports (Table 7: HRSN Outreach and Engagement Service) the HRSN Service Provider must have confirmation the individual is enrolled in OHP, and presume that they belong to a HRSN Covered Population and have at least one HRSN Clinical Risk Factor and one HRSN Social Risk Factor, and that they need help connecting to needed HRSN services and other services and supports.

~~(2)~~(5) Identifying Members of HRSN Covered Populations that are likely eligible for HRSN Services. The MCE and the Authority shall ensure multiple pathways for Members to be identified as potentially eligible for HRSN Services.

(a) Pathways for identifying potentially eligible Members for HRSN Services must include:

(A) Proactively identifying Members who are likely eligible for HRSN Services, by first confirming they belong to an HRSN Covered Population and then confirming that they have at least one HRSN Clinical Risk Factor and are confirmed or presumed to have one HRSN Social Risk Factor for an HRSN Service through a review of the MCE or Authority's encounter and claims data;

(B) ~~Engaging~~ contracting with HRSN Service Providers to conduct HRSN Outreach and Engagement to identify Members who belong to an HRSN Covered Population and who are presumed to also have at least one HRSN Clinical Risk Factor and HRSN Social Risk Factor and make HRSN Requests;

(C) Engaging with and r~~R~~eceiving HRSN Requests from other entities and individuals;

~~(C)~~(D) Conducting proactive outreach to HRSN-contracted housing and nutrition providers and housing and nutrition providers who are known to the MCE or the Authority, but not contracted with the MCE or the Authority, to encourage communication with members that may be eligible for and benefit from HRSN Services; and

~~(D)~~(E) Accepting the Members' Self-Attestations or referrals.

(b) The MCE and the Authority shall not require HRSN Connectors or HRSN Service Providers to use the MCE's or the Authority's HRSN Request Form template. Instead, the MCE and the Authority must accept the HRSN Request Form used by HRSN Connectors and HRSN Service Providers so long as the HRSN Request Form includes the information necessary for the MCE or, as applicable, the Authority to contact or otherwise determine whether the individual would like to receive HRSN Services and is interested in participating in an HRSN Eligibility Screening.

~~(3)~~(6) Screening Members for HRSN Eligibility.

(a) The MCE and the Authority shall make good faith efforts to ensure that all Members who have been identified as potentially eligible for HRSN Services are offered an HRSN Eligibility Screening.

(b) When a Member is referred to an MCE or the Authority by an HRSN Service Provider or Connector that has submitted an HRSN Request Form, the MCE, or as applicable, the Authority, shall conduct HRSN Eligibility Screenings of Members who have been identified as potentially eligible for HRSN Services by collecting the information necessary to determine whether the Member:

(A) Is enrolled in OHP except not receiving the BRG service package defined in OAR 410-135-0030,

(B) Would like to receive HRSN Services,

(C) Belongs to an HRSN Covered Population,

(D) ~~Has at least one~~Meets Social Risk Factor criteria applicable to the HRSN Services for which they are being screened,

(E) ~~Has at least one~~Meets Clinical Risk Factor criteria applicable to the HRSN Services for which they are being screened, and

(F) Is not receiving the same or substantially similar service from another state, local, or federally funded program.

(c) If the HRSN Connector does not include information on the recommended service, the MCE or the Authority is required to identify the specific service the individual needs.

~~(c)~~(d) For Members who provide the MCE or the Authority with a Self-Attestation, the MCE and the Authority shall rely on the Self-Attestation to complete the HRSN Eligibility Screening. If the Self-Attestation does not include all the information necessary to complete the HRSN Eligibility Screening the MCE and the Authority shall use good faith efforts to obtain and, as applicable, verify all information necessary to complete the HRSN Eligibility Screening by documenting the Member:

(A) Is enrolled in OHP except not receiving the BRG service package defined in OAR 410-135-0030,

(B) Would like to receive HRSN Services,

(C) Belongs to an HRSN Covered Population,

(D) ~~Has at least one~~Meets Social Risk Factor criteria applicable to the HRSN Services for which they are being screened,

(E) ~~Has at least one~~Meets Clinical Risk Factor criteria applicable to the HRSN Services for which they are being screened, and

(F) Is or is not receiving the same or substantially similar service from another state, local, or federally funded program.

~~(d)~~(e) All efforts to collect information needed to determine HRSN Eligibility must be documented. If the information included in a Member's Self-Attestation cannot, using good faith efforts, be verified within a reasonable period of time the MCE and the Authority shall authorize the identified HRSN Services need(s) if the MCE or, as applicable, the Authority, has a reasonable basis for concluding the Self-Attestation is truthful.

~~(e)~~(f) If the potentially eligible individual is not a Member of the OHP, the MCE or the Authority shall connect individuals to resources to determine OHP Eligibility as requested or consented to by the Member.

~~(4)~~(7) Authorization of HRSN Services.

(a) An MCE shall authorize its own Members, and the Authority shall authorize its Fee-for-Service (FFS) Members, to receive HRSN Services if the MCE or, as appliable, the Authority has completed the HRSN Services Screening and determined and documented that the applicable Member:

(A) Is enrolled in OHP except not receiving the BRG service package defined in OAR 410-135-0030;

(B) Would like to receive HRSN Services;

(C) Belongs to an HRSN Covered Population;

(D) ~~Has~~ Meets ~~determined the HRSN Services are Clinically Appropriate~~a Clinical Risk Factor criteria,

(E) Meets HRSN Social Risk Factor criteria, if distinct from the HRSN Covered Population; and

(F) Meets service-specific eligibility criteria, as required,

~~(D)~~(G) Is not receiving the same or substantially similar service from another state, local, or federally funded program, based on Member attestation.

(b) The Authorization must identify service duration, as appropriate, not to exceed twelve (12) months for an initial authorization, or lesser duration if required according to the HRSN Guidance Document, as well as amount and scope in accordance with 42 CFR §438.210.

(c) MCEs and the Authority shall use reasonable efforts to ensure they do not knowingly authorize an HRSN service that is duplicative of a state or federally funded service or other HRSN Service the Member is already receiving.

(d) MCEs are required to have individuals with appropriate expertise make decisions to deny or reduce HRSN service, in accordance with 42 CFR § 438.210 (b).

(A) Clinical staff are required to review HRSN service denials and reductions based on the following criteria:

(i) HRSN Clinical Risk Factors, including service-specific clinical needs (e.g., health-related condition responsive to medically tailored meals)

(iii) HRSN Climate Device Social Risk Factor

(ii) An individual who requires a Clinically Appropriate home modification/remediation service

(B) Clinical staff are not required to review authorizations, denials, or reductions for HRSN Services in the following scenarios:

(i) All authorizations of amount, duration and scope of HRSN Service requested

(ii) Denials and reductions based on whether the Member is part of an HRSN Covered Population.

(iii) Denials and reductions based on an HRSN Outreach and Engagement Social Risk Factor, HRSN Nutrition-Related Social Risk Factor, and HRSN Housing-Related Social Risk Factor of homelessness as defined by the U.S. Department of Housing and Urban Development (HUD) in 24 CFR 91.5 or at risk of homelessness defined by OAR 410-120-0000.

(e) Document the approval, ~~or~~ denial, or reduction of HRSN Services.

(A) MCEs shall ensure the HRSN Services are furnished to all OHP Members in an amount, duration, and scope that is no less than the amount, duration, and scope for the same HRSN Services furnished to all OHP Members under the Authority's FFS delivery system;

(B) The MCE or, as applicable, the Authority is required to authorize or deny the HRSN Service(s) and notify the Member of the approval or denial of HRSN Services within fourteen (14) days of ~~the completing the HRSN Services Eligibility Screening~~receiving an HRSN Request.

(C) HRSN Services must be denied if the individual does not meet all the HRSN Eligibility Criteria for the HRSN Services for which they are screened.

(D) All notices of Service Authorization and Denials must:

(i) State the basis for the approval along with any utilization limitations based on amount, duration, or scope;

(ii) State the basis for denial;

(iii) Comply with OAR 410-141-3835(7), (8), (10), (11); and

(iv) Inform the Member of their Grievance and Appeal rights under OARs 410-141-3875 through 410-14103915, 410-120-1860, and 42 CFR Subpart F.

(f) The MCE or the Authority must notify the HRSN Connector who submitted the HRSN Request of the authorization or denial of the HRSN Request through a Closed Loop Referral if the HRSN Connector will be or would have been the HRSN Service Provider.

~~(f)~~(g) If an HRSN Eligible Member is authorized for an HRSN Service (HRSN-Authorized Member), then, unless the HRSN-Authorized Member objects to the sharing of their personal information, the MCE or as applicable, the Authority must refer the HRSN-Authorized Member to an HRSN Service Provider that provides the Member's HRSN Service need.

(A) The referral must be made through a Closed Loop

~~(A)~~(B) Referral. If the HRSN-Authorized Member objects to the sharing of their personal information with an HRSN Service Provider, then the HRSN-Authorized Member must be provided with a written referral that they may deliver to the HRSN Service Provider to which they have been referred.

(C) The MCE or, as applicable, the Authority must make a referral to an HRSN Provider that delivers the authorized HRSN Service(s) in accordance with the timeframes specified below, and further specified in the HRSN Guidance Document:

(i) HRSN Services deemed "Urgent Care": Within 72 hours or as indicated in initial screening and in accordance with OAR 410-141-3840

(ii) HRSN Services deemed "Well Care": Within four (4) weeks, or as otherwise required by applicable care coordination rules, including OAR 410-141-3860 through 410-141-3870.

(D) This timeline is not applicable to Members who have not authorized the sharing of their information to an HRSN Service Provider.

(E) In the event that availability and delivery times of HRSN Climate Devices exceed thirty (30) calendar days, Contractor shall notify OHA via Administrative Notice of the delay and allow the State to assist in identifying alternate options to best meet the HRSN Authorized Member's HRSN Service needs.

~~(B) :~~

(i) To the extent capacity permits, support the HRSN-Authorized Member's choice of HRSN Service Provider;

(ii) Identify and refer the HRSN-Authorized Member to alternative HRSN Service Providers if needed and available; [1]

(iii) Inform the HRSN-Authorized Member they have the right to opt out of ~~direct the MCE or, as applicable, the Authority, to use a different means of communicating with HRSN Service Providers other than~~ technology, like CIE, for Closed Loop Referrals and still receive HRSN Services; and

(iv) Ensure and document the Member's HRSN Service needs are being and have been met by the HRSN Service Provider in compliance with the Member's HRSN Person-Centered Service Plan.

~~(5)~~(8) Confirmation of Climate-Related Supports Required (For Climate-Related Supports only). Prior to making a ~~Closed Loop Referral~~referral to authorized Climate-Related Supports, the MCE or, as applicable, the Authority must determine availability of the Climate-Related Supports (either devices or any necessary installation or other related service supports, or both) and notify the HRSN-Authorized Member of the anticipated date or time frame that the Climate-Related Supports shall be available. If for any reason there is limited availability of either devices or necessary installation or other related service supports, the MCE shall notify the State of the following information:

(a) There is a limitation of availability of the Climate-Related Supports,

[1] In accordance with ~~forthcoming~~ Care Coordination requirements outlined in OAR 410-141-3860, 410-141-3865, 410-141-3870.

(b) The reason for the limitation, and

(c) The MCE's plan to obtain additional equivalent devices or related service supports or both.

~~(6)~~(9) ~~No Subcontracting or Delegation of HRSN Service Authorization and Planning. The MCE shall not subcontract or otherwise Delegate the responsibility for HRSN Service authorization or service planning to an HRSN Service Provider or any other third-party that has involvement in, or responsibility for, denying or authorizing HRSN Services, or service planning for Members. However, for HRSN Climate-Related Support Services only,~~ As appropriate, MCEs, the Authority, and Tribal Governments may conduct HRSN Eligibility Screening, HRSN Authorization, and HRSN Service planning and provision so long as there is a documented policy and process for safeguarding against conflicts of interest.

~~(7)~~(10) Person-Centered Service Plan (PCSP). Upon authorization of HRSN Services, the MCE or, as applicable, the Authority and the Member shall update the HRSN-Authorized Member's Care Plan as outlined in OAR 410-141-3870[2] to include an HRSN PCSP for authorized the HRSN Service(s).

(a) The HRSN PCSP shall be a written component of the Member's Care Plan as outlined in OAR 410-141-3870 ~~in writing~~ and developed with and agreed upon by the Member, the Member's guardian, or both, as applicable. The HRSN PCSP must include all of the following:

(A) The recommended HRSN Service(s),

(B) The authorized HRSN Service duration,

~~(B)~~(C) Whether the Member accepts or declines the recommended HRSN Service.

(D) The HRSN Service Provider, supporting Member choice of provider and working to ensure a mutually agreeable option if choices are limited,

~~(C)~~(E) The determination that the recommended service, unit of service, and service duration is clinically appropriate based on HRSN Clinical and Social Risk Factors,

~~(D)~~(F) The goals of the HRSN Service(s) and identifying other HRSN Services and other OHP services the Member may need (if not already included in the Member's Care Plan),~~,~~

(G) The anticipated follow-up and transition plan, including conducting reassessment for HRSN Services prior to the conclusion of the service, or as frequently as required according to the HRSN Guidance Document, and,

~~(E)~~(H) ~~.~~ The MCE, or as applicable, the Authority's care management team responsible for managing the Member's HRSN Services.

(b) The MCE or, as applicable, the Authority, shall, at a minimum, have as many meetings as may be necessary to develop the PCSP, but in no event less than one meeting with the Member (or the Member's guardian, or both, as applicable) during development of the PCSP. The meeting with the Member may be held in person, by telephone, or via videoconference. If efforts to have a meeting are unsuccessful, or if

the Member declines participation, the MCE or, as applicable, the Authority shall document the attempts and barriers to having a meeting, and justification for continued provision of HRSN Services. The MCE or, as applicable, the Authority is not permitted to deny provision of HRSN Services on the basis of a Member not participating in the PCSP.

~~(c)~~ A parent, guardian, or caregiver of a ~~child~~ Member may receive HRSN Service(s) on ~~their child's~~such Member's behalf if the parent, guardian, or caregiver lives with the ~~child~~ Member and it is in the best interest of the ~~child~~ Member as determined through the PSCP.

(11)HRSN Provider Qualifications

(a) MCEs shall ensure that all contracted HRSN Service Providers meet the specific provider qualifications to provide HRSN Services to Members who are authorized by the MCEs to receive HRSN Services (HRSN-Authorized Members). Contracted HRSN Service Providers must:

(a) Be accessible to Members, including having the operating hours and the staff necessary to meet the Members' needs.

(b) Demonstrate their ability or experience to effectively serve at least one of OHA's Priority Populations, as defined in ORS 413.042.

(c) Demonstrate they employ or contract with administrative and service delivery staff, who are, as reasonably determined by the MCE, qualified to perform and fulfill the responsibilities of their jobs.

(d) Demonstrate they provide culturally and linguistically appropriate, responsive and trauma-informed services, which includes the ability to:

(A) Supply (i) language interpretation and translation services to those Members who have limited English proficiency, and (ii) American Sign Language (ASL) services for to those Members who require ASL in order to communicate; and

(B) Respond to the cultural needs of the diverse populations they serve by performing services in accordance with National CLAS Standards.

(e) Documented demonstration of a history of responsible financial administration via recent annual financial reports, an externally conducted audit, or other similar documentation.

(f) Meet readiness standards defined by the Authority, including providing the MCE with an attestation of their agreement or ability (or both agreement and ability) to comply with all of the following:

(A) Reporting and oversight requirements established by the Authority or the MCE or, as applicable, both;

(B) All laws relating to information privacy and security applicable to their business;

(C) Compliance with the credentialing obligations described in OAR 410-141-3510;

(D) All obligations related to participating in the Closed Loop Referral process (acceptance/denial of referrals and confirmation/incomplete services); and

(E) Invoicing for HRSN Services as agreed upon in their contract with the MCE to provide HRSN Services.

(g) Comply with oversight requirements established by the Authority, or the MCE, (or both as applicable), and all laws relating to privacy and security that are applicable to their business.

(h) Agree to be enrolled as a Medicaid HRSN Service Provider in MMIS, OHA's electronic system that processes Medicaid claims. The MCE may enroll their contracted HRSN Service Providers as "encounter only" providers in MMIS.

(i) It is preferred that MCEs contract with HRSN Service Providers providing Climate-Related Supports that are capable of both delivering and installing Climate-Related Devices. In the event an HRSN Service Provider does not provide installation services, MCEs shall ensure installation services are also performed by a different qualified HRSN Services Provider or HRSN vendor(s).

(j) MCEs shall ensure that HRSN Service Providers providing HRSN Outreach and Engagement Services, assign the responsibility for performing HRSN Outreach and Engagement Services to only those staff who have knowledge of principles and methods, as well as the experience and skills that enables them to effectively engage with individuals who are the intended beneficiaries of HRSN Services for the purpose of connecting them to the HRSN Services and other services and supports that meet their needs.

(b) MCEs and the Authority shall ensure that HRSN Service Providers providing Housing Related Supports meet the following domain and service-specific provider qualifications:

(A) Have knowledge of principles, methods and procedures of the housing services covered under the waiver, or comparable services meant to support an individual in meeting their nutritional needs.

(B) Be trained and credentialed, if applicable, to provide the specific service. CCOs may use discretion in determining the appropriate level of training or licensure required for each contracted provider.

(C) Have the ability to directly meet member's needs for the activities listed in the housing service descriptions or the ability to connect members to the appropriate service provider or vendor. CCOs are expected to develop a broad network of providers to ensure service providers can meet the personal and cultural needs of their communities as appropriate.

(D) Housing Service-Specific Provider Qualifications: See Table 3: Housing Service-Specific Provider Qualifications.

(c) MCEs and the Authority shall ensure that HRSN Service Providers providing Nutrition Related Supports meet the following domain and service-specific provider qualifications:

(A) Have knowledge of principles, methods and procedures of the nutrition services covered under the waiver, or comparable services meant to support an individual in meeting their nutritional needs.

(B) Comply with best practice guidelines, industry standards, and all applicable federal, state, and local laws governing food safety standards.

(C) Be trained and accredited, to the extent appropriate based on nutrition industry standards, to provide the specific service. CCOs may use discretion in determining the appropriate level of training or licensure required for each contracted provider of a HRSN nutrition service, as long as they ensure providers will act in accordance with nutrition-related national guidelines, such as the Dietary Guidelines for Americans, or evidence-based practice guidelines for specific chronic diseases and conditions. Depending on the specific service being provided, appropriate training and credentialing may entail:

(i) Relevant training(s) (e.g., webinar courses provided by SNAP-Ed, CDC-approved training for the National Diabetes Prevention Program Lifestyle Coach position, or other trainings from accredited nutrition organizations); or

(ii) Certification (e.g., Certified Nutrition & Wellness Educator by the American Association of Family & Consumer Sciences); or

(iii) Licensure (e.g., licensed dietitian).

(D) Have the ability to meet the needs of Member's personal and cultural dietary preferences. CCOs are expected to develop a network of HRSN nutrition providers that, together, are able to serve the personal and cultural needs of their communities, though no one provider must be able to meet all Members' personal and cultural dietary preferences.

(E) Have the capacity to provide services on a one-time, daily, weekly, or monthly basis, depending on the specific service's permitted frequency and Member's preference.

(F) If a nutrition service is administered through depositing funds electronically to a debit card to be used by the Member, the HRSN Service Provider must have the ability to administer and coordinate the service, including engaging with Members to explain the service, having relationships with food retailers that will accept payment, and monitoring and overseeing use of the cards.

(G) Nutrition Service-Specific Provider Qualifications: See Table ~~26~~: Nutrition Service-Specific Provider Qualifications.

(2) MCEs and the Authority must ensure that HRSN Outreach and Engagement service providers meet the following domain specific qualifications:

(a) Have knowledge of principles, methods, and procedures of these services or comparable services meant to outreach to and engage the populations covered under the waiver and connect them to benefits and services to meet their needs. and capacity to carry out the responsibilities outlined in the Outreach and Engagement service definition. CCOs may use discretion in determining whether a provider can sufficiently provide this service.

(b) Have knowledge of the following:

(A) Cultural specificity and responsiveness approaches

(B) Community outreach and engagement best practices

(C) Basic eligibility and enrollment policies and practices for OHP, the HRSN program, and Federal and state entitlements and benefits including SNAP, WIC, TANF, Social Security, Social Security Disability, and Veterans Affairs benefits, and federal and state housing programs.

(D) Local community resources for supporting basic needs such as access to shower, laundry, shelter, and food.

(E) Excellent oral communication skills with the ability to explain complex information to individuals—including those in the OHA HRSN Priority Populations — in an understandable, trauma-informed, and culturally responsive way.

(F) Ability to maintain strict confidentiality and handle sensitive information appropriately.

~~(8)~~(12)

~~(a)~~

Table 1: Descriptions of Housing Related Supports	
(1) Rent and Utility Costs	
(a) Service Description	Provision of payment to cover a Member's costs for recurring rent, including: • Rent payment • Renter's insurance if required by the lease • Landlord paid utilities that are not duplicative of the utility payments covered by this service Contractor/FFS TPC is authorized to pay rent to Members who reside in: • Apartment units, single room occupancy units, single or multifamily homes • Mobile home communities • Accessory dwelling units (ADUs) • Co-housing communities • Middle housing types (e.g. duplex, triplex) • Trailers, manufactured homes or manufactured home lots • Permanent supportive housing • Or other housing with a lease or written agreement Provision of payment to cover a Member's cost for the following utilities: • Garbage • Water • Sewage • Recycling • Gas • Electric • Internet • Phone (inclusive of land line phone service and cell phone service) This service may be tailored in amount to account for a member's household size.[2]
(b) Frequency	Payment may occur based on the billing schedule of the provider and/or vendor
(c) Duration	• ***Recurring Rent Payment:*** Presumption of, and no longer than, six months. Payment may be for past due rent up to six months, or forward rent for up to six months, or some combination of past due and forward rent. • ***Recurring Utility Payment:*** Not longer than the duration of any forward rent related to the Rent/ service that the Member is receiving.
(d) Setting	N/A

(e) Additional Service Limitations	• Costs that are not eligible in this service include:
	  ○ Pet fees
	  ○ Parking garage fees
	  ○ Amenity fees
	  ○ Landlord-paid property taxes
	  ○ Any homeowner costs, including mortgage, utilities or other costs
	  ○ Property insurance
	• Any combination of "Hotel/Motel Stays" and "Rent and Utility Costs" may not exceed a total of six months of assistance.

	• Any combination of payment for arrears under "Utilities Arrears" and "Rent Utility Costs" may not exceed a total of six months.

(f) Additional Requirements	• ***Rent Payment:***
	  ○ Member or parent/caregiver must submit either a written lease or the "Oregon Emergency Rental Assistance Program Verification of Landlord/Tenant Relationship And Rent Owed" form.[3]
	  ○ The provider must ensure the residence that a member is remaining in is in a safe and habitable living condition based on maintenance regulation code within the local jurisdiction.[4]
	• ***Utility Payment:*** Member or parent/caregiver must submit the bill(s) from the utility company(ies) to be paid for through this service. The address on the utility bills must be the same as the address on the lease or self-verification form.
	• Members receiving this service must also be considered for Tenancy Services.

(2) Hotel/Motel Stays	
(a) Service Description	Provision of payment to cover a Member's costs for hotel or motel stays. This service may be tailored in amount to account for a Member's household size.[5]
(b) Frequency	Payment may occur based on the billing schedule of the provider and/or vendor
(c) Duration	Up to three months at which time a Member may be reassessed for an additional three months. No longer than a total of six months.
(d) Setting	N/A
(e) Additional Service Limitations	Costs that are not eligible in this service include: • Pet fees • Parking fees • Amenity fees Any combination of "Hotel/Motel Stays" and "Rent and Utility Costs" may not exceed a total of six months of assistance.
(f) Additional Requirements	Members receiving this service must also be receiving Tenancy Services.
(3) Utilities Arrears	
(a) Service Description	This service provides payment for costs related to past-due utility bills for the following types of utility services: • Garbage • Water • Sewage • Recycling • Gas • Electric

[2] Household as defined by "Family Size" in OAR 410-200-0015
[3] Link to Oregon Emergency Rental Assistance Verification of Landlord/Tenant Relationship form: https://oerap.oregon.gov/downloads/programs/orera/04-23-2021-OERAP-no-lease.pdf
Language for safety and habitability drawn from City of Portland Property Maintenance Code https://www.portland.gov/code/29
[5] Household as defined by "Family Size" in OAR 410-200-0015

	• Internet • Phone (inclusive of land line phone service and cell phone service) This service may be tailored in amount to account for a member's household size.[6]
(b) Frequency	As needed at any point at which a member meets service specific eligibility criteria.
(c) Duration	Any combination of payment for arrears under "Utilities Arrears" and "Rent and Utility Costs" may not exceed a total of six months' worth of payments.
(d) Setting	N/A
(e) Additional Service Limitations	N/A
(f) Additional Requirements	• Member or parent/caregiver must submit the bill(s) from the utility company(ies) to be paid for through this service. • If the Member or parent/caregiver's name is not on the utility bill, the member or parent/caregiver must submit documentation to verify that the address for service completion is the Member's primary address or the Member's most recent prior primary address. The following are accepted forms of residency verification: ○ Member's Medicaid address of record; ○ A signed lease or written rental agreement; ○ State issued program ID or license; ○ Official letter from third party showing the member's name and residence address (including a letter from a landlord, governmental agency, financial institution, medical institution, and/or school); or, ○ Government issued library card. • Members receiving this service must also be considered for Tenancy Services.
(4) Utilities Set Up	
(a) Service Description	This service provides payment for non-refundable, non-recurring utility set-up or restart costs, and payment for the first month of the utility payment for the following types of utility services: • Garbage • Water • Sewage • Recycling • Gas • Electric • Internet • Phone (inclusive of land line phone service and cell phone service)
(b) Frequency	As needed at any point at which a Member meets service specific eligibility criteria
(c) Duration	N/A
(d) Setting	N/A
(e) Additional Service Limitations	N/A

[6] Household as defined by "Family Size" in OAR 410-200-0015

(f) Additional Requirements	• Member or parent/caregiver must submit the bill(s) from the utility company(ies) to be paid for through this service.
	• If the Member or parent/caregiver's name is not on the utility bill, the member or parent/caregiver must submit documentation to verify that the address for service completion is the Member's primary address. The following are accepted forms of residency verification:
	  ○ Member's Medicaid address of record
	  ○ A signed lease or written rental agreement
	  ○ State issued program ID or license
	  ○ Official letter from third party showing the member's name and residence address (including a letter from a landlord, governmental agency, financial institution, medical institution, and/or school)
	  ○ Government issued library card
	• Members receiving this service must also be considered for Tenancy Services.

(5) Storage Fees	
(a) Service Description	Storage of personal property to facilitate moving or a transition period so that the Member's belongings may be safely and securely transferred or held until the time at which they are needed. This may include storing the following types of personal property and belongings: • Appliances • Furniture • Bedding • Clothing • Identifying documentation This service may be tailored in amount to account for a Member's household size.[7]
(b) Frequency	Payment may occur based on the billing schedule of the provider and/or vendor
(c) Duration	Not to exceed 6 months each time a Member is eligible for the service
(d) Setting	Commercial storage units, including self-storage and portable moving and storage solutions (e.g. PODS, U-Box)
(e) Additional Service Limitations	This service does not include storage of items that are not permitted according to the storage unit's policies.
(f) Additional Requirements	N/A
(6) Tenancy Services (paid via 15-minute increments)	
(a) Service Description	Tenancy services are flexible supports provided to Members or Members' households to achieve and maintain their housing stability goals. Members may receive support for any of the activities listed below, and providers will bill for these services on a fee-for-service basis. These services include: ***Member Supports Services:*** • Working with the member to develop a housing plan that supports the stated needs of the member and/or household to achieve their stability and housing retention goals

[7] Household as defined by "Family Size" in OAR 410-200-0015

	• Reviewing, updating, and implementing the plan with the member to reflect current needs and preferences and address existing or recurring housing retention barriers • As needed, facilitating enrollment in the local Continuum of Care's Coordinated Entry System (the standard community-wide process by which individuals and families are connected to housing resources and supports) • Assisting in completing housing applications (e.g. rentals, waitlists, housing vouchers, etc.) • Assisting in obtaining identification and other required documentation (e.g., Social Security card, birth certificate, prior rental history) • Providing training and resources to assist the member in complying with the member's lease • Establishing procedures and contacts to retain housing, including developing a housing support crisis plan that includes prevention and early intervention services when housing is jeopardized • Providing supports to assist the member in developing independent living skills needed to remain housed (e.g., skills to maintain a healthy living environment, develop and manage a household budget, interact appropriately with neighbors or roommates, reduce social isolation, utilize local transportation, etc.) • Supporting housing stability by facilitating the enrollment of members of the household in local school and college systems • Coordinating referrals for access to other necessary medical, disability, social, educational, legal, income-related tools and resources for housing, and other services • Coordinating and assuring the delivery of another HRSN housing service ***Landlord Engagement Services:*** • Engaging and communicating with a Member's landlord and, when appropriate and as requested by the Member, advocating on behalf of the Member • Assisting and coaching the Member in communicating with the landlord and property manager ***CCO/FFS TPC Engagement Services:*** • All coordination and information sharing with the CCO/FFS TPC care coordination team • Service planning support and participating in person-centered plan meetings at redetermination and/or revision plan meetings, as needed
(b) Frequency	As needed at any point at which a Member meets service specific eligibility criteria.
(c) Duration	***Member Supports and CCO Engagement:*** On average, individuals require 6-18 months of case management services to become stably housed but Member needs will vary and may continue beyond the 18-month timeframe. Service duration would persist until services are no longer needed, as determined in the Member's person-centered care plan, contingent on determination of continued service eligibility.

	Landlord Engagement: Service duration would persist until services are no longer needed, as determined in the Member's person-centered care plan, contingent on determination of continued service eligibility.
(d) Setting	***Member Supports:*** • The majority of sessions with members should be in a setting desired by the member. • Case managers may use telehealth if appropriate and desired by the Member. • Sessions may be "off-site," (e.g., at potential housing locations).
(e) Additional Service Limitations	N/A
(f) Additional Requirements	• This service, or the Tenancy Service (PMPM) must be authorized when any other HRSN Housing Service is authorized to ensure a housing provider may bill for their time coordinating and delivering the other HRSN Housing Service. • Activities listed above may occur with or without the member present.
(7) Tenancy Service (paid per member per month)	
(a) Service Description	Tenancy services are flexible supports provided to members or members' households to achieve and maintain their housing stability goals. Providers will support eligible Members with all of the activities below, as needed or requested by the Member, and will bill for these services on a per member per month basis. These services include: ***Member Supports Services:*** • Working with the Member to develop a housing plan that supports the stated needs of the member and/or household to achieve their stability and housing retention goals • Reviewing, updating, and implementing the plan with the Member to reflect current needs and preferences and address existing or recurring housing retention barriers • As needed, facilitating enrollment in the local Continuum of Care's Coordinated Entry System (the standard community-wide process by which individuals and families are connected to housing resources and supports) • Assisting in completing housing applications (e.g. rentals, waitlists, housing vouchers, etc.) • Assisting in obtaining identification and other required documentation (e.g., Social Security card, birth certificate, prior rental history) • Providing training and resources to assist the Member in complying with the Member's lease • Establishing procedures and contacts to retain housing, including developing a housing support crisis plan that includes prevention and early intervention services when housing is jeopardized • Providing supports to assist the Member in developing independent living skills needed to remain housed (e.g., skills to maintain a healthy living environment, develop and manage a household budget, interact appropriately with neighbors or roommates, reduce social isolation, utilize local transportation, etc.)

	• Supporting housing stability by facilitating the enrollment of Members of the household in local school and college systems • Coordinating referrals for access to other necessary medical, disability, social, educational, legal, income-related tools and resources for housing, and other services • Coordinating and assuring the delivery of another HRSN housing service ***Landlord Engagement Services:*** • Engaging and communicating with the Member's landlord and when appropriate and as requested by the Member, advocating on behalf of the member • Assisting and coaching the Member in communicating with the landlord and property manager ***CCO/FFS TPC Engagement Services:*** • All coordination and information sharing with the CCO care coordination team • Service planning support and participating in person-centered plan meetings at redetermination and/or revision plan meetings, as needed
(b) Frequency	As needed at any point at which a Member meets service specific eligibility criteria.
(c) Duration	***Member Supports and CCO Engagement:*** On average, individuals require 6-18 months of case management services to become stably housed but Member needs will vary and may continue beyond the 18-month timeframe. Service duration would persist until services are no longer needed, as determined in the Member's person-centered care plan, contingent on determination of continued service eligibility. ***Landlord Engagement:*** Service duration would persist until services are no longer needed, as determined in the Member's person-centered care plan, contingent on determination of continued service eligibility.
(d) Setting	***Member Supports:*** • The majority of sessions with Members should be in a setting desired by the Member. • Case managers may use telehealth if appropriate and desired by the Member. • Sessions may be "off-site," (e.g., at potential housing locations).
(e) Additional Service Limitations	N/A
(f) Additional Requirements	• This service, or the Tenancy Service (15 min) must be authorized when any other HRSN Housing Service is authorized to ensure a housing provider may bill for their time coordinating and delivering the other HRSN Housing Service. • Activities listed above may occur with or without the Member present.
(8) Home Modifications	
(a) Service Description	The provision of home modifications to eliminate known home-based health and safety risks and ensure the Member's living environment can accommodate their

	functional, health, or safety needs. These services include installation or execution of: • Ramps, and/or • Grip bars, and/or • Door and cabinet handles for members having difficulty due to dexterity issues.
(b) Frequency	N/A
(c) Duration	N/A
(d) Setting	Home modification services occur in the Member's current place of residence or potential residence.
(e) Additional Service Limitations	The following are excluded from this service: • Accessibility modifications, adaptations, or improvements to the home that are not directly related to the known home-based health and safety risks for the purpose of ensuring the members' health and safety in the living environment and that are completed exclusively for preference, design, or style. Examples of these types of modifications include installations, repairs or updates related to: ○ Roof ○ Appliances ○ Heating and cooling ○ Skylights and windows ○ Hot water tanks • Adaptations that add to the total square footage of the home. • General repair or maintenance and upkeep required for the home. • Modifications that substitute for or duplicate modifications that are the responsibility of a landlord under landlord-tenant laws. • Material upgrades or supplemental payments to the provider by landlords or informal supports.
(f) Additional Requirements	• If the CCO or housing provider is contracting with a vendor to execute the modification, the CCO or housing provider must have a procurement process in place that: ○ Determines the scope of work to meet the Member's need; and, ○ Identifies one or more qualified vendors that can execute the modification timely and at a reasonable cost, meeting the Member's needs and preferences to the maximum extent possible. • Before a home accessibility modification service begins, the landlord must provide written consent to the service. • If the proposed home accessibility modification requires a permit, the proposal must be in compliance with local codes. • Members receiving this service must also be considered for Tenancy Services if they may meet the eligibility for those services.
(9) Home Remediations	
(a) Service Description	The provision of medically necessary home remediation services to eliminate known home-based health and safety risks and ensure the member's health and safety in the living environment. These services include: • Pest eradication, and/or

	• Installation of washable curtains or synthetic blinds to prevent allergens, and/or
	• Chore services, inclusive of the following:
	  ○ Heavy housecleaning to ensure the member can safely navigate in the home, and/or
	  ○ Removal of hazardous waste, debris, or dirt from the home, and/or
	  ○ Removal of yard hazards to ensure the outside of the home is safe for the consumer to enter and exit the home,

(b) Frequency	As often as is medically necessary to eliminate known home-based health and safety risks
(c) Duration	N/A
(d) Setting	Home remediation services occur in the member's current place of residence.

(e) Additional Service Limitations	• The following are excluded from this service:
	  ○ Remediations to the home that are not directly related to eliminating known home-based health and safety risks and ensure the members' health and safety in the living environment.
	  ○ Remediations that add to the total square footage of the home.
	  ○ General repair or maintenance and upkeep required for the home.
	  ○ Remediations that substitute for or duplicate remediations that are the responsibility of a landlord under landlord-tenant laws.
	  ○ Material upgrades or supplemental payments to the provider by landlords or informal supports.
	• Chore services must be intended to ensure the member's home is safe and allows for independent living and may not be provided by homecare workers or in-home agencies. Chore services do not include:
	  ○ General housekeeping
	  ○ Removal of debris that does not impede the member from safely traversing within the home; or entering or exiting the home safely
	  ○ Removing items that do not present a potential fire hazard that would endanger the consumer's health and safety

(f) Additional Requirements	• If the CCO or housing provider is contracting with a vendor to execute the remediation, the CCO or housing provider must have a procurement process in place that:
	  ○ Determines the scope of work to meet the member's need; and,
	  ○ Identifies one or more qualified vendors that can execute the remediation timely and at a reasonable cost, meeting the member's needs and preferences to the maximum extent possible.
	• Before a home remediation service begins, the landlord must provide written consent to the service.
	• If the proposed home remediation requires a permit, the proposal must be in compliance with local codes.
	• Members receiving this service must also be considered for Tenancy Services if they may meet the eligibility for those services.

Table 2: HRSN Housing Eligibility Criteria			
(a) **Service**	(b) **Covered Population & Social Risk Factor**	(c) **Clinical Risk**	(d) **Additional Eligibility Requirements**

(1) Rent and Utility Costs	Member must: • Be currently housed with a written agreement or lease; and, • Need support maintaining current housing; and, • Meet the At-Risk of Homelessness definition in OAR 410-120-0000.	Any HRSN Housing and Nutrition Clinical Risk Factor	Members must be receiving recurring rent to be eligible for recurring utilities.
(2) Hotel/Motel Stays			Members must be receiving the Home Modifications or Home Remediations service and during the delivery of the service the member cannot safely reside in their home.
(3) Utility Arrears			N/A
(4) Utilities Set Up			Members receiving the Rent and Utility Costs service are not eligible for the first month of utility payment under this service.
(5) Storage Fees			Members must be receiving the Rent and Utility Costs service.
(6) Tenancy (15 min)			Members receiving this service may not concurrently receive Tenancy (PMPM).
(7) Tenancy (PMPM)			Members receiving this service may not concurrently receive Tenancy (15 min).

(8) Home Modifications	Member must:
	• Require the clinically appropriate home modification or remediation, and
	• Be in a HRSN Covered Population, including:
	  • Adults and Youth Discharged from an Institution for Mental Diseases (IMD); or,
	  • Adults and Youth Released from Incarceration; or,
	  • Individuals currently or previously involved in Oregon's Child Welfare system; or,
	  • Individuals Transitioning to Dual Medicaid and Medicare Status; or,
			• Member must reside in a housing unit that does not accommodate their functional, health, or safety needs.

(9) Home Remediations			• Member must reside in a housing unit that has mutable conditions that adversely affect their health or safety.

	• Individuals who meet the definition of "HUD Homeless" as defined in OAR 410-120-0000; or • Individuals who meet the At-Risk of Homeless definition in OAR 410-120-0000; or, • Youth with Special Health Care Needs, as defined in OAR 410-120-0000.		

Table 3: Housing Service-Specific Provider Qualifications	
(1) Rent and Utility Costs	HRSN provider must be able to transmit payments to housing and utility vendors in a timely manner.
(2) Hotel/Motel Stays	HRSN provider must be able to transmit payments to housing vendors in a timely manner.
(3) Utility Arrears	HRSN provider must be able to transmit payments to utility vendors in a timely manner.
(4) Utilities Set Up	HRSN provider must be able to transmit payments to utility vendors in a timely manner.
(5) Storage Fees	N/A
(6) Tenancy Service (paid via 15-minute increments)	• Providers that deliver the Tenancy Service via the 15-min payment methodology may not receive reimbursement under the Tenancy Service (PMPM). • Providers must be able to offer any one or more the activities in the service description.
(7) Tenancy Service (paid per member per month)	• Providers that deliver the Tenancy Service via the PMPM methodology may not receive reimbursement under the Tenancy Service (15-min). • Providers receiving a PMPM payment on behalf of a member must be able to provide all services listed within the service description.
(8) Home Modifications	Vendors of home modification services must: • Be state-licensed, and • Have active status and be in good-standing with the State of Oregon Construction Contractors Board.
(9) Home Remediations	Vendors of home remediation services must be state-licensed.

Table 4: Descriptions of Nutrition Related Supports	
(10) Assessment for Medically Tailored Meals	
(a) Service Description	Initial assessment with a Registered Dietitian Nutritionist (RDN) (preferred), or, if not available, a primary care provider, to develop a medically appropriate nutrition care plan specific to the HRSN Medically Tailored Meals service. This service also covers a reassessment, if needed, to understand whether the delivery of the service is meeting the Member's needs.
(b) Frequency	Initial assessment will take place once before the provision of the HRSN service Medically Tailored Meals. A reassessment may take place within a 6 month period.
(c) Duration	Service persists until the Member is no longer receiving the Medically Tailored Meal service.
(d) Setting	Assessments and reassessments may be conducted in-person, via telehealth, or telephonically, at the Member's preference.
(e) Additional Service Limitations	N/A
(11) Medically Tailored Meals	
(a) Service Description	Meals tailored to support Members with health-related condition(s) for which nutrition supports would improve health outcomes. This service includes: 1. The preparation and provision of the prescribed meals consistent with the nutrition care plan; and 2. Delivery of the meal. Each meal must contain sufficient food to support approximately one-third of a Member's daily nutritional need as indicated by the Dietary Reference Intakes and Dietary Guidelines. The meal may also include an accompanying fluid/drink and/or a supplementary food item to support meeting a Member's nutrition needs between meals if medically appropriate (for example, to provide access to fluids and/or support taking medication accompanied by food). Meals may consist of fresh or frozen food. The service must: ——Be provided in accordance with nutrition-related national guidelines, such as the Dietary Guidelines for Americans, or evidence-based practice guidelines for specific chronic diseases and conditions; • ——Follow food safety standards; and • • Consider a Member's personal and cultural dietary preferences.
(b) Frequency	Up to 3 meals per day, for up to 7 days per week, based on the Member's needs and preferences.
(c) Duration	Up to 6 months, at which time the Member may be reassessed for service eligibility.
(d) Setting	Meals must be delivered to the Member's home or private residence.

(e) Additional Service Limitations	Frozen meals may only be authorized for Members with appropriate storage capabilities that will keep meals frozen until they are ready for consumption.
(12) Pantry Stocking	
(a) Service Description	This service allows a Member to purchase an assortment of foods aimed at promoting improved nutrition for the Member. Examples of allowable foods include: • Fruits and vegetables; • Meat, poultry, fish, and other proteins; • Legumes; • Dairy products; • Breads and cereals; • Cooking oils, spices and herbs; • Other foods such as snack foods and non-alcoholic beverages; and • Seeds and plants, which produce food for the household to eat. This service may be: • Tailored in size/amount to account for a Member's household size;[8] • Administered through, for example, a voucher or prepaid card to be used only with a food retailer for allowable purchases; and • Provided in conjunction with resources on the Dietary Guidelines for Americans to encourage healthy food selection. This service must: • Be provided in accordance with evidence-based nutrition guidelines; • Follow food safety standards; and • Be person-centered, consider dietary preferences, and be culturally appropriate.
(b) Frequency	Funds to support the food purchases may be provided to the Member on a recurring weekly or monthly basis depending on the provider's offering and Member's preference. If provided on a weekly basis, funds may be provided a maximum of four times per month. If provided monthly, funds may be provided a maximum of once per month.
(c) Duration	Up to 6 months, at which time the Member may be reassessed for service eligibility.
(d) Setting	• Members may purchase food with standard food retailers, which may include but are not limited to grocery stores, convenience stores, farmers markets, mobile markets, and community-supported agriculture (CSA) programs. • Member may pick up food from food retailer or have food delivered to the Member's home or private residence, if delivery service is available.

[8] The State is adhering to the SNAP definition of a household as defined in OAR 461-110-0210.

(e) Additional Service Limitations	• Service cannot be used to purchase the following items: ○ Beer, wine, liquor, cigarettes, or tobacco; ○ Vitamins, medicines, and supplements. If an item has a Supplement Facts label, it is considered a supplement and is not eligible for HRSN purchase; ○ Live animals (except shellfish, fish removed from water, and animals slaughtered prior to pick-up from the store); ○ Foods that are hot at the point of sale; ○ Any nonfood items such as: ▪ Pet foods; ▪ Cleaning supplies, paper products, and other household supplies; and ▪ Hygiene items or cosmetics. • This service is intended to wrap around existing nutrition assistance programs at the local, state, and federal level (e.g., SNAP or WIC) that Members may already be receiving and should be tailored to address any remaining gap in need. For Members not receiving any other nutrition assistance, this service is intended to cover up to approximately 80% of a Member's dietary intake as based on the USDA Thrifty Food Plan.
(13) Meals	
(a) Service Description	This service allows for the purchase of prepared hot foods, meal kits, or restaurant meals in supplement to HRSN Pantry Stocking for Members who require additional food supports, in particular for but not limited to supporting Members' engagement with healthcare or other supportive services. This service may also be provided in place of HRSN Pantry Stocking for Members who do not have the means to prepare or store groceries (e.g., Members who are unhoused). This service may be: • Tailored in size/amount to account for a Member's household size;[9] • Administered through, for example, a voucher or prepaid card to be used only with a food retailer for allowable purchases; and • Provided in conjunction with resources on the Dietary Guidelines for Americans to encourage healthy food selection. This service must: • Be provided in accordance with evidence-based nutrition guidelines; • Follow food safety standards; and • Be person-centered, consider dietary preferences, and be culturally appropriate.
(b) Frequency	• When service is provided in place of HRSN Pantry Stocking, Members may receive up to 3 meals per day. • When service is provided as a supplement to HRSN Pantry Stocking, Members may receive up to 2 meals per day.
(c) Duration	Up to 6 months, at which time the Member may be reassessed for service eligibility.

[9] The State is adhering to the SNAP definition of a household as defined in OAR 461-110-0210.

(d) Setting	• Service may be provided by any restaurant, prepared hot food retailer (for example, a grocery store with a prepared hot food bar), or meal kit service provider. • Member may pick up food from food retailer or have food delivered to the Member's home or private residence, if delivery service is available.
(e) Additional Service Limitations	• Service cannot be used to purchase the following items: ○ Permitted foods as defined under the HRSN Pantry Stocking service; ○ Beer, wine, liquor, cigarettes, or tobacco; ○ Vitamins, medicines, and supplements. If an item has a Supplement Facts label, it is considered a supplement and is not eligible for HRSN purchase; ○ Live animals (except shellfish, fish removed from water, and animals slaughtered prior to pick-up from the store); ○ Any nonfood items such as: ▪ Pet foods; ▪ Cleaning supplies, paper products, and other household supplies; and ▪ Hygiene items or cosmetics. • This service is intended to wrap around existing nutrition assistance programs at the local, state, and federal level (e.g., SNAP or WIC) that Members may already be receiving and should be tailored to address any remaining gap in need. For Members not receiving any other nutrition assistance, this service is intended to support coverage of up to approximately 80% of a Member's dietary intake as based on the USDA Thrifty Food Plan.
(14) Fruit and Vegetable Benefit	
(a) Service Description	This service allows a Member to purchase fruits and vegetables from participating food retailers and farms. Fruits and vegetables available for purchase through this service may be fresh, frozen, dried, or canned. Herbs are also included. This service may be: • Tailored in size/amount to account for a Member's household size[10] if the Member is a child under 21, YSHCN, or pregnant; • Administered through, for example, a voucher or prepaid card to be used only at a food retailer for allowable purchases; and • Provided in conjunction with resources on the Dietary Guidelines for Americans to encourage healthy food selection. This service must: • Be tailored to health risk, certain nutrition-sensitive health conditions, and or/demonstrated outcome improvement; • Be provided in accordance with evidence-based nutrition guidelines; • Follow food safety standards; and

[10] The State is adhering to the SNAP definition of a household as defined in OAR 461-110-0210.

	• Be person-centered, consider dietary preferences, and be culturally appropriate.
(b) Frequency	Funds to support the food purchases may be provided to the Member on a recurring weekly or monthly basis depending on the provider's offering and Member's preference. If provided on a weekly basis, funds may be provided a maximum of four times per month. If provided monthly, funds may be provided a maximum of once per month.
(c) Duration	Up to 6 months, at which time the Member may be reassessed for service eligibility.
(d) Setting	• This service can be used to purchase eligible items from food retailers including but not limited to grocery stores, farmers markets, farm stands, mobile markets, and community-supported agriculture (CSA) programs. • Member may pick up food from food retailer or have food delivered to where the Member resides, if delivery service is available.
(e) Additional Service Limitations	• This service is limited solely to the purchase of qualifying fruits, vegetables, and culinary herbs as outlined in the service description. It does not cover any foods that are not commonly understood to fall within these food categories (e.g., meat, poultry, and fish; dairy products; breads and cereals). • This service is intended to wrap around existing nutrition assistance programs at the local, state, and federal level (e.g., SNAP or WIC) that Members may already be receiving and should be tailored to address any remaining gap in need. For Members not receiving any other nutrition assistance, this service is intended to cover up to approximately 80% of a Member's fruit and vegetable intake.
(15) Nutrition Education	
(a) Service Description	Any combination of educational strategies designed to motivate and facilitate voluntary adoption of food choices and other food- and nutrition-related behaviors conducive to health and well-being. This service may consist of the following: 1. Provision of nutrition education or information to an individual or group that offers evidence-based or evidence-informed strategies on adoption of food choices and other food- and nutrition-related behaviors conducive to health and well-being and guidance on food and nutrition resources; 2. Meal preparation education in an individual or group setting. Nutrition education services may be supplemented with handouts, take-home materials, and other informational resources that support nutritional health and well-being. Distribution of these paper and electronic handouts, materials and products, by themselves, does not constitute nutrition education. This service must:

	• Be provided in accordance with evidence-based nutrition guidelines; • Follow food safety standards; and • Be person-centered, consider dietary preferences, and be culturally appropriate.
(b) Frequency	Variable – may be provided one-time or on a recurring weekly or monthly basis dependent on the specific service, provider's offering, and Member's preference.
(c) Duration	Service duration would persist until services are no longer needed.
(d) Setting	Service may be offered: • In-person, virtually, or telephonically dependent on the specific service and Member's preference; • Where the Member resides; or • In community settings, e.g., YMCAs, schools, health clinics, transitional housing shelters, emergency housing shelters, and community kitchens.
(e) Additional Service Limitations	Members receiving any other HRSN nutrition service must also be offered Nutrition Education, and receipt of Nutrition Education shall not be conditioned on engagement in other HRSN nutrition services.

Table 5: HRSN Nutrition Eligibility Criteria

(a) Service	(b) Covered Population	~~(a)~~(c) Clinical Risk	(d) Social Risk	(e) Additional Eligibility Requirements
(1) Assessment for Medically Tailored Meals	Member must be in a HRSN Covered Population (OAR 410-120-0000), including: • Adults and Youth Discharged from an Institution for Mental Diseases (IMD); or, • Adults and Youth Released from Incarceration; or, • Individuals currently or previously involved in Oregon's Child Welfare system; or, • Individuals Transitioning to Dual Medicaid	Any HRSN Housing and Nutrition Clinical Risk Factor as defined in OAR 410-120-0000	Low Food Security as defined in OAR 410-120-0000	• Member must be eligible for the HRSN Medically Tailored Meals service.
(2) Medically Tailored Meals				• Member must first be assessed through the HRSN Assessment for Medically Tailored Meals service to develop a medically appropriate nutrition care plan for this service. • Members may receive more than one HRSN Nutrition Support service as long as services are not duplicative and, when combined, do not provide services beyond addressing a member's unique needs; however: ○ Members receiving 3 HRSN Medically Tailored Meals per day

	and Medicare Status; or, • Individuals who meet the definition of "HUD Homeless" as defined in OAR 410-120-0000; or, • Individuals who meet the "At-Risk of Homeless" definition in OAR 410-120-0000; or • Individuals identified as Young Adults with Special Health Care Needs (YSHCN).			may not concurrently receive HRSN: ▪ Pantry Stocking; ▪ Meals; or ▪ Fruit and Vegetable Benefit. ○ Members receiving 3 HRSN Meals per day may not concurrently receive HRSN Medically Tailored Meals. • Members that reside in an institutional setting that is obligated to provide its residents with meals are not eligible for this service.
(3) Pantry Stocking				• Member must be: ○ Child under 21; ○ YSHCN (OAR 410-120-0000); or ○ Pregnant Member. • Members may receive more than one HRSN Nutrition Support service as long as services are not duplicative and, when combined, do not provide services beyond addressing a Member's unique needs; however: ○ Members may not concurrently receive the HRSN Pantry Stocking service and: ▪ Fruit and Vegetable Benefit; ▪ 3 HRSN Medically Tailored Meals per day; or — 3 HRSN Meals per day. • Members that reside in an institutional setting that is obligated to provide its residents with meals are

				not eligible for this service.
(4) Meals				• Member must be: ○ Child under 21; ○ YSHCN (OAR 410-120-0000); or ○ Pregnant Member. • Members may receive more than one HRSN Nutrition Support service as long as services are not duplicative and, when combined, do not provide services beyond addressing a Member's unique needs; however: ○ Members receiving 3 HRSN Meals per day may not concurrently receive HRSN: ▪ Medically Tailored Meals; ▪ Pantry Stocking; or ▪ Fruit and Vegetable Benefit. ○ Members receiving 3 HRSN Medically Tailored Meals per day may not concurrently receive HRSN Meals. • Members that reside in an institutional setting that is obligated to provide its residents with meals are not eligible for this service.
(5) Fruit and Vegetable Benefit				• Members may receive more than one HRSN Nutrition Support service as long as services are not duplicative and, when combined, do not provide services beyond addressing a Member's unique needs; however: ○ Members may not concurrently receive

				the HRSN Fruit and Vegetable Benefit service and: ▪ Pantry Stocking; ▪ 3 HRSN Medically Tailored Meals per day; or ▪ 3 HRSN Meals per day. • Members that reside in an institutional setting that is obligated to provide its residents with meals are not eligible for this service.
(6) Nutrition Education				N/A

Table 6: Nutrition Service-Specific Provider Qualifications	
(1) Assessment for Medically Tailored Meals	HRSN provider must be licensed as a: • Licensed dietitian (ORS 691.405) who has received licensure through one of the pathways described in OAR 834-030-0000; or • Primary care provider (OAR 410-141-3500).
(2) Medically Tailored Meals	• HRSN provider must be able to provide one meal per day, for five or more days per week, except in rural areas where such frequency is not feasible and a lesser frequency is approved by the MCE or Authority. ○ MCE or Authority must ensure sufficient HRSN providers to meet all enrolled Members' needs, including those that are authorized for more frequent service delivery than the minimum requirements.
(3) Pantry Stocking	HRSN provider must have the ability to administer and coordinate the service, including engaging with Members to explain the service, having relationships with food retailers that will accept payment, and monitoring and overseeing use of the cards.
(4) Meals	• Restaurant meal providers must be licensed by the appropriate city or county jurisdiction and maintain health and safety permits as required by state law. • HRSN provider must have the ability to administer and coordinate the service, including engaging with members to explain the service, having relationships with food retailers that will accept payment, and monitoring and overseeing use of the cards.

(5) Fruit and Vegetable Benefit	HRSN provider must have the ability to administer and coordinate the service, including engaging with members to explain the service, having relationships with food retailers that will accept payment, and monitoring and overseeing use of the cards.
(6) Nutrition Education	MCE and the Authority may contract with HRSN providers to provide this service and are also encouraged to support their existing network of providers (including peer support specialists, traditional health workers, case managers, primary care providers, dental providers, and other individuals with regular Member touchpoints) to receive appropriate training and credentialing to provide this service to Members. Depending on the specific component of this service being provided, appropriate training and credentialing may entail: • Relevant training(s) (e.g., webinar courses provided by SNAP-Ed, CDC-approved training for the National Diabetes Prevention Program Lifestyle Coach position, or other trainings from accredited nutrition organizations); • Certification (e.g., Certified Nutrition & Wellness Educator by the American Association of Family & Consumer Sciences); or • Licensure (e.g., licensed dietitian). MCE may use discretion in determining the appropriate level of training or licensure required for each contracted provider of this service.

Table 7: Description of HRSN Outreach and Engagement Service	
(a) Service Description	HRSN Outreach and Engagement Services means the activities performed by HRSN Service Providers or Contractor for the purpose of identifying OHP enrolled individuals in HRSN Covered Populations who are presumed to have a qualifying HRSN Clinical Risk Factor and HRSN Social Risk Factor for the purpose of helping them connect to needed HRSN Services and other social services and supports. Payment for HRSN Outreach and Engagement Services, are conditioned on the MCE, the Authority , as applicable, HRSN Service Providers performing and documenting at a minimum, all of the activities specified in (a) –(c) below and may also include the activities specified in. (d)-(j) below, as follows: a. Engaging individuals who belong to one or more HRSN Covered Populations who may be eligible for HRSN Services. Engagement activities may use multiple strategies, , including, without limitation, meeting Members in person where they live, seek care, or are otherwise accessible; b. Identifying and verifying the individual's CCO enrollment. c. Transmitting HRSN Requests to the applicable CCO for eligibility determination and service authorization. d. Working with Members to obtain the information necessary for assessment of HRSN service need, including through multiple engagements. e. Helping Members maintain enrollment in Medicaid. f. Helping Members, with securing and maintaining entitlements and benefits, such as TANF, WIC, SNAP, and other federal and state housing programs including through application assistance and providing support in identifying coverage for application fees, as necessary. g. Assisting Members, with obtaining identification and other required documentation needed to receive benefits and other supports, e.g., Social Security card, birth certificate, prior rental history. h. Connecting Members, to settings where basic needs can be met, such as access to shower, laundry, shelter, and food. i. Providing Members, who may have a need for medical, peer, social, educational, legal, and other related services with information and logistical support necessary to connect to resources.
(b) Frequency	HRSN Service Providers contracted to provide HRSN Outreach and Engagement, can be compensated for conducting HRSN Outreach and Engagement Services to Members up to a maximum of twenty (20) hours per Member per year starting in 2025 in accordance with the HRSN Fee Schedule. There must be an exceptions process to allow Members to receive additional hours of HRSN Outreach and Engagement.
(c) Duration	N/A
(d) Setting	N/A

(e) Additional Service Limitations	N/A
(f) Additional Requirements	N/A

Table 8: HRSN Outreach and Engagement Eligibility Criteria		
(a) Covered Population	**(b) Clinical Risk**	**(c) Social Risk**
Individual must be presumed to be in a HRSN Covered Population (OAR 410-120-0000), including: • Adults and Youth Discharged from an Institution for Mental Diseases (IMD); or, • Adults and Youth Released from Incarceration; or, • Individuals currently or previously involved in Oregon's Child Welfare system; or, • Individuals Transitioning to Dual Medicaid and Medicare Status; or, • Individuals who meet the definition of "HUD Homeless" as defined in OAR 410-120-0000; or, • Individuals who meet the "At-Risk of Homeless" definition in OAR 410-120-0000; or • Individuals identified as Young Adults with Special Health Care Needs (YSHCN).	Individual must be presumed to have any HRSN Clinical Risk Factor as defined in OAR 410-120-0000	Individual must be presumed to have any HRSN Social Risk Factor, as defined in OAR 410-120-0000

OAR 410-141-3510: Provider Contracting and Credentialing

Provider Contracting and Credentialing

~~(1)~~(3) Managed Care Entity's (MCEs) shall develop policies and procedures for credentialing providers to include quality standards and a process to remove providers from their provider network if they fail to meet the objective quality standards.

(a) MCEs shall ensure that all participating providers as defined in OAR 410-141-3500 providing coordinated care services to members are credentialed upon initial contract with the MCE and re-credentialed no less frequently than every three (3) years. The credentialing and re-credentialing process shall include review of any information in the National Practitioners Databank. MCEs shall accept both the Oregon Practitioner Credentialing Application and the Oregon Practitioner Recredentialing Application;

(b) MCEs shall screen their participating providers to be in compliance with 42 CFR 455 Subpart E (42 CFR 455.410 through 42 CFR 455.470) and retain all resulting documentation for audit purposes, except in the following circumstances for credentialing COVID-19 vaccine administration providers for the sole purpose of administering COVID-19 vaccines or the administration of the flu vaccine when administered in conjunction with the COVID-19 vaccination. For the purpose of this rule, COVID-19 vaccination administration provider means a healthcare provider that has successfully enrolled with the Authority's Public Health Division to be a COVID-19 vaccination administration provider, completed all required training, and has agreed to all terms of program participation.

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

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

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

(c) MCEs shall screen their contracted HRSN Service Providers to be in compliance with 42 CFR §§ 455.410 through 455.436, 455.450, 455.452, and 455.470, and retain all resulting documentation for audit purposes.

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

(A) Ensure that coordinated care services are provided within the scope of license or certification of the participating provider or facility and within the scope of the participating provider's contracted services. They shall ensure participating providers are appropriately supervised according to their scope of practice;

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

(e) The MCE shall provide accurate and timely information to the Authority about:

(A) License or certification expiration and renewal dates;

(B) Whether a provider's license or certification is expired or not renewed or is subject to licensing termination, suspension, or certification sanction;

(C) If an MCE knows or has reason to know that a provider has been convicted of a felony or misdemeanor related to a crime or violation of federal or state laws under Medicare, Medicaid, or Title XIX (including a plea of "nolo contendere");

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

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

(A) Have been terminated from Medicaid;

(B) Have been excluded as a Medicaid provider by another state;

(C) Have been excluded as Medicare/Medicaid providers by CMS; or

(D) Are subject to exclusion for any lawful conviction by a court for which the provider may be excluded under 42 CFR 1001.101.

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

(h) MCEs shall require each atypical provider to be enrolled with the Authority. MCEs shall also require each atypical provider, except HRSN Service Providers, unless that HRSN Service Provider is a licensed and credentialed and Medicaid billable professional, to obtain and use registered National Provider Identifiers (NPIs), and taxonomy codes reported to the Authority in the Provider Capacity Report for purposes of encounter data submission prior to submitting encounter data in connection with services by the provider. MCEs shall require each qualified provider, except HRSN Service Providers, to have and use an NPI as enumerated by the National Plan and Provider Enumeration System (NPPES),;

(i) The provider enrollment request (for encounter purposes) and credentialing documents require the disclosure of taxpayer identification numbers. The Authority shall use taxpayer identification numbers for the administration of this program including provider enrollment, internal verification, and administrative purposes for

the medical assistance program for administration of tax laws. The Authority may use taxpayer identification numbers to confirm whether the individual or entity is subject to exclusion from participation in the medical assistance program. Taxpayer identification number includes Employer Identification Number (EIN), Social Security Number (SSN), and Individual Tax Identification Number (ITIN) used to identify the individual or entity on the enrollment request form or disclosure statement. Disclosure of all tax identification numbers for these purposes is mandatory. Failure to submit the requested taxpayer identification numbers may result in denial of enrollment as a provider and denial of a provider number for encounter purposes or denial of continued enrollment as a provider and deactivation of all provider numbers used by the provider for encounters.

~~(2)~~(4) An MCE may not discriminate with respect to participation in the MCE against any health care provider who is acting within the scope of the provider's license or certification under applicable state law on the basis of that license or certification. If an MCE declines to include individual or groups of providers in its network, it shall give the affected providers written notice of the reason for its decision. This rule may not be construed to:

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

(b) Preclude the MCE from establishing varying reimbursement rates based on quality or performance measures. For purposes of this section, quality and performance measures include all factors that advance the goals of health system transformation including:

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

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

(c) The requirements in subsection (2)(b) of this rule do not apply to reimbursement rate variations between providers with the same license or certification or between specialists and non-specialty providers.

~~(3)~~(5) An MCE shall establish an internal review process for a provider aggrieved by a decision under section (2) of this rule including an alternative dispute resolution or peer review process. An aggrieved provider may appeal the determination of the internal review to the Authority.

~~(4)~~(6) To resolve appeals made to the Authority under sections (2) and (3) of this rule, the Authority shall provide administrative review of the provider's appeal using the administrative review process established in OAR 410-120-1580. The Authority shall invite the aggrieved provider and the MCE to participate in the administrative review. In making a determination of whether there has been discrimination, the Authority shall consider the MCE's:

(a) Network adequacy;

(b) Provider types and qualifications;

(c) Provider disciplines; and

(d) Provider reimbursement rates.

~~(5)~~(7) A prevailing party in an appeal under sections (3) through (4) of this rule shall be awarded the costs of the appeal.

~~(6)~~(8) MCEs shall not apply any requirement that any entity operated by the IHS, an Indian tribe, tribal organization or urban Indian organization be licensed or recognized under the State or local law where the entity is located to furnish health care services, if the entity meets all the applicable standards for such licensure or recognition. This requirement is pursuant to 25 USC 1621t and 1647a.

~~(7)~~(9) MCEs shall not require the licensure of a health professional employed by such an entity under the State or local law where the entity is located, if the professional is licensed in another State.

~~(8)~~(10) MCEs shall offer contracts to all Medicaid eligible IHCPs and to provide timely access to specialty and primary care within their networks to MCE enrolled IHS beneficiaries seen and referred by IHCPs, regardless of the IHCPs status as contracted provider within the MCE network.

~~(9) MCEs shall ensure that all contracted HRSN Service Providers meet the specific provider qualifications to provide HRSN Services to Members who are authorized by the MCEs to receive HRSN Services (HRSN-Authorized Members). Contracted HRSN Service Providers must:~~

~~(a) Be accessible to Members, including having the operating hours and the staff necessary to meet the Members' needs.~~

~~(b) Demonstrate their ability or experience to effectively serve at least one of OHA's Priority Populations, as defined in ORS 413.042.~~

~~(c) Demonstrate they employ or contract with administrative and service delivery staff, who are, as reasonably determined by the MCE, qualified to perform and fulfill the responsibilities of their jobs.~~

~~(d) Demonstrate they provide culturally and linguistically appropriate, responsive and trauma-informed services, which includes the ability to:~~

~~(A) Supply (i) language interpretation and translation services to those Members who have limited English proficiency, and (ii) American Sign Language (ASL) services for to those Members who require ASL in order to communicate; and~~

~~(B) Respond to the cultural needs of the diverse populations they serve by performing services in accordance with National CLAS Standards.~~

~~(e) Documented demonstration of a history of responsible financial administration via recent annual financial reports, an externally conducted audit, or other similar documentation.~~

~~(f) Meet readiness standards defined by the Authority, including providing the MCE with an attestation of their agreement or ability (or both agreement and ability) to comply with all of the following:~~

(A) Reporting and oversight requirements established by the Authority or the MCE or, as applicable, both;

(B) All laws relating to information privacy and security applicable to their business;

(C) Compliance with the credentialing obligations under section (1)(c) of this rule;

(D) All obligations related to participating in the Closed Loop Referral process (acceptance/denial of referrals and confirmation/incomplete services); and

(E) Invoicing for HRSN Services as agreed upon in their contract with the MCE to provide HRSN Services.

(g) Comply with oversight requirements established by the Authority, or the MCE, (or both as applicable), and all laws relating to privacy and security that are applicable to their business.

(h) Agree to be enrolled as a Medicaid HRSN Service Provider in MMIS, OHA's electronic system that processes Medicaid claims. The MCE may enroll their contracted HRSN Service Providers as "encounter only" providers in MMIS.

(10) It is preferred that MCEs contract with HRSN Service Providers providing Climate-Related Supports that are capable of both delivering and installing Climate-Related Devices. In the event an HRSN Service Provider does not provide installation services, MCEs shall ensure installation services are also performed by a different qualified HRSN Services Provider or HRSN vendor(s).

Outreach and engagement, MCEs shall, and shall ensure that HRSN Service Providers providing HRSN Outreach and Engagement Services, assign the responsibility for performing HRSN Outreach and Engagement Services to only those staff who have knowledge of principles and methods, as well as the experience and skills that enables them to effectively engage with individuals who are the intended beneficiaries of HRSN Services for the purpose of connecting them to the HRSN Services and other benefits and services that shall meet their needs.

(A) Service Provider must have the ability to administer and coordinate the service, including engaging with Members to explain the service, having relationships with food retailers that will accept payment, and monitoring and overseeing use of the cards.

OAR 410-141-3515: Network Adequacy

Network Adequacy

(1) Managed Care Entities (MCEs) shall maintain and monitor a network of participating providers that is sufficient in number, provider type, and geographic distribution to ensure adequate service capacity and availability to provide available and timely access to medically appropriate and culturally responsive covered services to both current members and those the MCE anticipate shall become enrolled as members.
(2) The MCE shall develop a provider network that enables members to access services within the standards defined in this rule.
(3) The MCE shall meet access-to-care standards that allow for appropriate choice for members. Services and supports shall be as close as possible to where members reside and, to the extent necessary, offered in nontraditional settings that are accessible to families, diverse communities, and underserved populations.
(4) MCEs shall meet quantitative network access standards defined in rule and contract.
(5) MCEs shall ensure access to integrated and coordinated care as outlined in OAR 410-141-3860, which includes access to a primary care provider or primary care team that is responsible for coordination of care and transitions.
(6) In developing its provider network, the MCEs shall anticipate access needs so that the members receive the right care at the right time and place, using a patient-centered, trauma informed approach. The provider network shall support members, especially those with behavioral health conditions, in the most appropriate and independent setting, including in their own home or independent supported living.
(7) In assessing the capacity and adequacy of its provider network, MCEs shall consider, in conjunction with the quantitative standards set forth in this rule, the variety of provider and facility types with the demonstrated ability and expertise to render specific medically or dentally appropriate covered services within the scope of applicable licensing and credentialling. This includes, but is not limited to, the prescribing of Medication-Assisted Treatment and more specialized oral health care services.
(8) All MCEs shall ensure 95% of members can access the following provider and facility types, further defined by the Authority in guidance made available on the CCO Contracts Forms webpage https://www.oregon.gov/oha/HSD/OHP/Pages/CCO-Contract-Forms.aspx, within acceptable travel time or distance standards set forth this rule:
    (a) Tier one:
        (A) Primary care providers serving adults and those serving pediatrics;
        (B) Primary care dentists serving adults and those serving pediatrics;
        (C) Mental health providers serving adults and those serving pediatrics;
        (D) Substance use disorder providers serving adults and those serving pediatrics
        (E) Pharmacy;

(F) Additional provider types when it promotes the objectives of the Authority or as required by legislation.

(b) Tier two:

(A) Obstetric and gynecological service providers;

(B) The following specialty providers, serving adults and those serving pediatrics;

(i) Cardiology;

(ii) Neurology;

(iii) Occupational Therapy;

(iv) Medical Oncology;

(v) Radiation Oncology;

(vi) Ophthalmology;

(vii) Optometry;

(viii) Physical Therapy;

(ix) Podiatry;

(x) Psychiatry;

(xi) Speech Language Pathology.

(C) Hospital;

(D) Durable medical equipment;

(E) Methadone Clinic;

(F) Additional provider types when it promotes the objectives of the Authority or as required by legislation.

(c) Tier three:

(A) The following specialty providers, serving adults and those serving pediatrics;

(i) Allergy & Immunology;

(ii) Dermatology;

(iii) Endocrinology;

(iv) Gastroenterology;

(v) Hematology;

(vi) Nephrology;

(vii) Otolaryngology;

(viii) Pulmonology;

(ix) Rheumatology;

(x) Urology.

(B) Post-hospital skilled nursing facilities;

(C) Additional provider types when it promotes the objectives of the Authority or as required by legislation.

(9) All MCE acceptable travel time and distance monitoring must assess the geographic distribution of providers relative to members and calculate driving time and distance from the member's physical address to the provider's location through the use of geocoding software or other mapping applications. The Authority shall provide tools and additional guidance specific to time

and distance monitoring on the CCO Contracts Forms webpage https://www.oregon.gov/oha/HSD/OHP/Pages/CCO-Contract-Forms.aspx.

(a) A CCO service area may contain multiple geographic designations. When calculating travel time and distance, geographic designations shall not overlap and the following definitions of geographic designations shall apply:

(A) Large urban area: Conjoined urban areas with a total population of at least 1 million people or with a population density greater than 1,000 people per square mile.

(B) Urban area: An area with greater than 40,000 people within a 10 mile radius of a city center.

(C) Rural area: An area greater than 10 miles from the center of an urban area.

(D) County with extreme access considerations: County with a population density of 10 or fewer people per square mile.

(b) When calculating travel time and distance, MCEs shall use the following standards:

(A) Large Urban Area:

(i) Tier one: 10 minutes or 5 miles;

(ii) Tier two: 20 minutes or 10 miles;

(iii) Tier three: 30 minutes or 15 miles.

(B) Urban Area:

(i) Tier one: 25 minutes or 15 miles;

(ii) Tier two: 30 minutes or 20 miles;

(iii) Tier three: 45 minutes or 30 miles.

(C) Rural Area:

(i) Tier one: 30 minutes or 20 miles;

(ii) Tier two: 75 minutes or 60 miles;

(iii) Tier three: 110 minutes or 90 miles.

(D) County with Extreme Access Considerations:

(i) Tier one: 40 minutes or 30 miles;

(ii) Tier two: 95 minutes or 85 miles;

(iii) Tier three: 140 minutes or 125 miles.

(10) MCEs may request an exception to a standard set above. MCEs may request multiple exceptions.

(a) Exception requests must be submitted in a format provided by the Authority and made available on the CCO Contract Forms webpage https://www.oregon.gov/oha/HSD/OHP/Pages/CCO-Contract-Forms.aspx.

(b) The Authority shall review and approve or deny exception requests based on criteria made available on the CCO Contracts Forms webpage. Approved exceptions must be reviewed at least annually.

(11) MCEs shall have an access plan that establishes a protocol for monitoring and ensuring access, outlines how provider capacity is determined, and establishes procedures for monthly monitoring of capacity and access and for improving access and managing access in times of

reduced participating provider capacity. The access plan and associated monitoring protocol shall address the following:

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

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

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

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

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

(13) MCEs shall have policies and procedures and a monitoring system to ensure that members who are aged, blind, or disabled, or who have complex or high health care needs, multiple chronic conditions, or have behavioral health conditions, or who are children receiving Department or Oregon Youth Authority (OYA) services have access to primary care, oral care (when the MCE is responsible for oral care), behavioral health providers, and referral, and involve those members in accessing and managing appropriate preventive, health, remedial, and supportive care and services. MCEs shall monitor and have policies and procedures to ensure:

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

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

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

(a) Physical health:

(A) Emergency care: Immediately or referred to an emergency department depending on the member's condition;

(B) Urgent care: Within 72 hours or as indicated in initial screening and in accordance with OAR 410-141-3840;

(C) Well care: Within four (4) weeks, or as otherwise required by applicable care coordination rules, including OAR 410-141-3860 through 410-141-3870.

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

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

(B) Urgent dental l care: Within two (2) weeks;

(C) Routine oral care: Within eight (8) weeks, unless there is a documented special clinical reason that makes a period of longer than eight (8) weeks appropriate.

(c) Oral and Dental care for pregnant individuals:

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

(B) Urgent dental care, within one (1) week;

(C) Routine oral care: Within four (4) weeks, unless there is a documented special clinical reason that would make access longer than four (4) weeks appropriate.

(d) Behavioral health:

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

(B) Specialty behavioral health care for priority populations:

(i) In accordance with the timeframes listed in this rule for assessment and entry, terms are defined in OAR 309-019-0105, with access prioritized per OAR 309-019-0135. If a timeframe cannot be met due to lack of capacity, the member must be placed on a waitlist and provided interim services within 72 hours of being put on a waitlist. Interim services must be comparable to the original services requested based on the level of care and may include referrals, methadone maintenance, HIV/AIDS testing, outpatient services for substance use disorder, risk reduction, residential services for substance use disorder, withdrawal management, and assessments or other services described in OAR 309-019-0135;

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

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

(iv) Opioid use disorder: Assessment and entry within 72 hours;
(v) Medication assisted treatment: As quickly as possible, not to exceed 72 hours for assessment and entry;
(vi) Children with serious emotional disturbance as defined in OAR 410-141-3500: Any limits that the Authority may specify in the contract or in sub regulatory guidance.

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

(15) MCEs shall implement procedures for communicating with and providing care to members who have difficulty communicating due to a medical condition, who need accommodation due to a disability, or, as detailed in OAR Chapter 950, Division 050 for those who have Limited English Proficiency, prefer to communicate in a language other than English or who communicates in signed language.

(a) The policies and procedures shall ensure the provision of Oregon certified or Oregon qualified interpreter services by phone or in person anywhere the member is attempting to access care or communicate with the MCE or its representatives;
(b) MCEs shall ensure the provision of certified or qualified interpreter services for all covered services to interpret for members with hearing impairment or in the primary language of non-English-speaking members;
(c) All interpreters must be linguistically appropriate and capable of communicating in both English and the member's primary language and be able to translate clinical information effectively. Interpreter services must enable the provider to understand the member's complaint, make a diagnosis, respond to the member's questions and concerns, and communicate instructions to the member;
(d) MCEs shall ensure the provision of services that are culturally appropriate as described in National CLAS Standards, demonstrating both awareness for and sensitivity to cultural differences and similarities and the effect on the member's care. MCEs shall ensure the provision of Oregon certified or Oregon qualified interpreters.
(e) MCEs shall comply with requirements of the Americans with Disabilities Act of 1990, as amended via the ADA Amendments Act of 2008, in providing access to covered services for all members and shall arrange for services to be provided by non-participating providers when necessary;
(f) MCEs shall collect and actively monitor data on language accessibility to ensure compliance with these language access requirements;
(g) MCEs shall report to the Authority such language access data and other language access related analyses in the form and manner set forth in this rule and as may otherwise be required in the MCE contract. The Authority shall provide supplemental instructions about the use of any required forms:

(A) Using the interpreter services self-assessment reporting template provided by the Authority, MCEs shall conduct an annual language access self-assessment

and submit the completed language access self-assessment to the Authority on or before the third Monday of each January;

(B) MCEs shall collect and report language access and interpreter services to the Authority quarterly using the report form provided by the Authority. The quarterly due date for each Report is the first day of each calendar quarter, reporting data for the twelve (12) months ending one quarter before the due date.

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

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

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

(a) Behavioral health access;

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

(c) Behavioral health provider network.

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

(19) MCEs shall implement and require its providers to adhere to the following appointment and wait time requirements:

(a) A member may request to reschedule an appointment if the wait time for a scheduled appointment exceeds 30 minutes. If the member requests to reschedule, they shall not be penalized for failing to keep the appointment;

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

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

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

(C) Recall or notification efforts; and

(D) Method of member follow-up.

(c) If failure to keep a scheduled appointment is a symptom of the member's diagnosis or disability or is due to lack of transportation to the MCE's participating provider office or clinic, or lack of interpreter services, MCEs shall provide outreach services and offer

Care Coordination as medically appropriate to make a plan with the member to resolve barriers;

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

(20) MCEs shall assess the needs of their membership and make available supported employment and Assertive Community Treatment services when members are referred and eligible:

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

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

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

(B) Adding additional Assertive Community Treatment teams; or

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

(21) HRSN Service Provider Minimum Network Requirements.

(a) An MCE must offer HRSN Services in all service areas in which the MCE operates.

(b) The MCE must ensure that HRSN Services are delivered to Members ~~in a reasonable amount of time.~~within the timelines outlined in OAR 410-120-2000 and further specified in the HRSN Guidance Document.

OAR 410-141-3820: Covered Services

Covered Services

(1) General standard. The OHP Benefit Package includes treatments and health services which pair together with a condition on the same line of the Health Evidence Review Commission (HERC) Prioritized List of Health Services adopted under OAR 410-141-3830, to the extent that such line appears in the funded portion of the Prioritized List of Health Services. Coverage of these services is included in the benefit package when provided as specified in any relevant Statements of Intent and Guideline Notes of the Prioritized List of Health Services. The Benefit Package also covers the additional services described in this rule.
    (a) As used in OAR 410-141-3820 and OAR 410-141-3825, the word "health services" has the meaning given in ORS 414.025(13);
    (b) Services are covered with respect to an individual member only when the services are medically or orally necessary and appropriate as defined in OAR 410-120-0000 and at the time they are provided, except that services shall also meet the prudent layperson standard defined in ORS 743A.012.
    (c) HRSN Services are covered with respect to an individual member only when the Member belongs to an HRSN Covered Population and meets other service-specific eligibility criteria as needed, as defined in OAR 410-120-0000, and the HRSN Services are Clinically Appropriate as defined in OAR 410-120-0000;
    (d) Benefit Package coverage of prescription drugs is discussed in OAR 410-141-3855;
    (e) The Benefit Package is subject to the exclusions and limitations described in OAR 410-141-3825.
(2) MCE service offerings:
    (a) MCEs shall offer their members, at a minimum:
        (A) The physical, behavioral and/or oral health services covered under the member's benefit package, as appropriate for the MCE's mandatory scope of services; and
        (B) Any additional services required in OAR chapter 410, or in the MCE contract.
    (b) CCOs shall coordinate physical health, behavioral health, oral health care benefits, and HRSN benefits;
    (c) With respect to members who are dually eligible for Medicare and Medicaid, MCEs shall provide:
        (A) OHP Benefit Package services except for Medicaid-funded long-term care, services, and supports; and
        (B) Secondary payment for services covered by Medicare but not otherwise covered under the Oregon Health Plan as specified in OAR 410-141-3565 and specific to benefit packages in OAR 410-120-1210.
(3) Diagnostic services. Diagnostic services that are medically or orally appropriate and medically or orally necessary to diagnose the member's presenting condition (signs and symptoms) or guide

management of a member's condition, regardless of whether the condition appears above or below the funded line on the Prioritized List of Health Services. Coverage of diagnostic services is subject to any applicable Diagnostic Guidelines on the Prioritized List of Health Services.

(4) Comfort care. Comfort care is a covered service for a member with a terminal illness.

(5) Preventive services. Preventive Services are included in the OHP benefit package as described in the funded portion of the Prioritized List of Health Services, as specified in related guideline notes. These services include, but are not limited to, periodic medical and dental exams based on age, sex, and other risk factors; screening tests; immunizations; and counseling regarding behavioral risk factors.

(6) Ancillary services. Ancillary services are covered subject to the service limitations of the Oregon Health Plan (OHP) program rules when:
    (a) The services are medically or orally necessary and appropriate in order to provide a funded service; or
    (b) The provision of ancillary services shall enable the member to retain or attain the capability for independence or self-care;
    (c) Coverage of ancillary services is subject to any applicable Ancillary Guidelines on the Prioritized List of Health Services.

(7) SUD services. The provision of SUD services shall comply with OAR 410-141-3545.

(8) Services necessary for compliance with the requirements for parity in mental health and substance use disorder benefits in 42 CFR part 438, subpart k.

(9) Services necessary for compliance with the requirements for Early and Periodic Screening, Diagnosis and Treatment as specified in the Oregon Health Plan 1115 Demonstration Project (waiver) and meeting requirements for individualized determination of medical necessity as specified in OAR 410-130-0245.

(10) Services necessary for compliance with the requirements for HRSN Services (as described in Oregon's Medicaid 1115 Waiver for 2022-2027) and meeting requirements for individualized determination of Service authorization as specified in OAR 410-141-3835.

(11) Coverage of services for unfunded conditions based on effect on funded comorbid conditions:
    (a) The OHP Benefit Package includes coverage in addition to that available under subsection (1). Specifically, it includes coverage of certain medically necessary and appropriate services for conditions which appear below the funding line in the Prioritized List of Health Services if it can be shown that:
        (A) The member has a funded condition for which documented clinical evidence shows that the funded treatments are not working or are contraindicated; and
        (B) The member concurrently has a medically related unfunded condition that is causing or exacerbating the funded condition; and
        (C) Treating the unfunded medically related condition would significantly improve the outcome of treating the funded condition.
    (b) Services that are expressly excluded from coverage as described in OAR 410-141-3825 are not subject to consideration for coverage under subsection (11);

(c) Any co-morbid conditions or disability shall be represented by an ICD diagnosis code or, when the condition is a mental disorder, represented by a DSM diagnosis;

(d) In order for the services to be covered, there shall be a medical determination and finding by the Authority (for fee-for-service OHP clients) or by the MCE (for MCE members) that the terms of subsection (a) of this rule have been met based upon the applicable:

(A) Treating health care provider opinion;

(B) Medical research; and

(C) Current peer review.

(12) Ensuring that all coverage options are considered:

(a) When a provider receives a denial for a non-covered service for any member, especially a member with a disability or with a co-morbid condition, the provider shall determine whether there may be a medically appropriate covered service to address the member's condition or clinical situation, before declining to provide the non-covered service. The provider's determination shall include consideration of whether a service for an unfunded condition may improve a funded comorbid condition under subsection (11);

(b) If a member seeks, or is recommended, a non-covered service, providers shall ensure that the member is informed of:

(A) Clinically appropriate treatment that may exist, whether covered or not;

(B) Community resources that may be willing to provide the relevant non-covered service;

(C) If appropriate, future health indicators that would warrant a repeat evaluation visit.

(c) Before an MCE denies coverage for an unfunded service for any member, especially a member with a disability or with a co-morbid condition, the MCE shall determine whether the member has a funded condition or condition/treatment pair that would entitle the member to coverage under the program.

(13)Assistance to providers. The Authority shall maintain a telephone information line for the purpose of assisting practitioners in determining coverage under the OHP Benefit Package. The telephone information line shall be staffed by registered nurses who shall be available during regular business hours. If an emergency need arises outside of regular business hours, the Authority shall make a retrospective determination under this section, provided the Authority is notified of the emergency situation during the next business day. If the Authority denies a requested service, the Authority shall provide written notification and a notice of the right to an administrative hearing to both the OHP member and the treating physician within five (5) working days of making the decision.

(14) Ad hoc coverage determinations.

(a) When a member requests a hearing pertaining to a funded condition and a funded or unfunded treatment that does not pair on the HERC Prioritized List of Health Services, and the treatment is not included in guideline note 172 or 173 of the prioritized list,

before the hearing the Division shall determine if the requested treatment is appropriate and necessary for the member.

(b) For treatments determined to be appropriate and necessary under (a) in this section, the Division determines whether the HERC has considered the funded condition/treatment pair for inclusion on the Prioritized List within the last five (5) years. If the HERC has not considered the pair for inclusion within the last five (5) years, the Division shall make an ad hoc coverage determination in consultation with the HERC.

(c) For treatments determined to not be appropriate and necessary under (a) in this section the hearing process shall proceed.

(15) General anesthesia for oral procedures. General anesthesia for oral procedures that are medically and orally necessary and appropriate to be performed in a hospital or ambulatory surgical setting may be used only for those members as detailed in OAR 410-123-1490.

OAR 410-141-3920: Transportation: NEMT General Requirements

(1) A Coordinated Care Organization (CCO) shall provide all non-emergency medical transportation (NEMT) services for its members. For purposes of OAR 410-141-3920 to 410-141-3965, references to a "member" include any individual eligible for NEMT services under section (1) of this rule unless context dictates otherwise:

(a) The CCO is responsible for NEMT services for all of its members' health care services consistent with the covered services described in OAR 410-141-3820 and the excluded services and limitations described in 410-141-3825 and (1)(b) and (1)(c) of this rule;

(b) NEMT services for those health care services that, based on the member's plan type, are paid by the Authority's fee-for-service program and that, based on rule or contract, are carved-out from or otherwise not covered by the CCO and provided by the Authority. NEMT is not provided for HRSN services;

(c) For members enrolled in the Compact of Free Association (COFA) Dental Program or the Veteran Dental Program, both of which are defined in OAR chapter 410, division 200, the CCO is responsible only for NEMT services related to the member's dental services.

(2) A CCO shall provide a toll-free call center for members to request rides.

(a) The CCO shall ensure that its call center operates, at a minimum, Monday through Friday from 9:00 a.m. to 5:00 p.m. The CCO may close its call center on New Year's Day, Memorial Day, July 4th, Labor Day, Thanksgiving, and Christmas. The Authority may approve, in writing, additional days of closure if the CCO requests the closure at least 30 days in advance.

(A) Consistent with OAR 410-141-3505, a CCO may subcontract the operation of its call center. If the CCO's subcontractor is also contracted by the Authority as an NEMT brokerage for FFS members, the CCO remains fully accountable for the performance of the subcontracted work related to the CCO contract.

(3) Neither a CCO nor any of its Subcontracted transportation providers may bill a member for transport to or from covered medical services, even if the CCO or its contracted transportation provider denied reimbursement for the transportation services.

(4) Transportation providers shall be considered "participating providers" for the purposes of OAR 410-141-3520 (Record Keeping and Use of Health Information Technology).

(5) A CCO shall have written policies and procedures regarding its NEMT services. All policies and procedures must be provided to all Members either in Contractor's Member Handbook or in a stand-alone document referred to as a "NEMT rider guide" that meets the delivery and content specifications as defined by the Authority. The CCO's written policies and procedures regarding NEMT services shall provide, without limitation, for the following:

(a) Allow members or their representatives to schedule:

(A) NEMT services up to 90 days in advance;

(B) Multiple NEMT services at one time for recurring appointments up to 90 days in advance; and

(C) Same-day NEMT services.

(b) Comply with the following criteria for member drop-offs and pick-up protocols. Drivers are not permitted to:

(A) Drop Members off at an appointment more than 15 minutes prior to the office or other facility opening for business unless requested by the member or, as applicable, the Member's guardian, parent, or representative; and

(B) Pick up Members from an appointment more than 15 minutes after the office or facility closes for business unless the appointment is not reasonably expected to end within 15 minutes after closing, or as requested by the member, or as applicable, the Member's guardian, parent, or representative.

(c) Describe passenger rights and responsibilities as set forth in 42 CFR §438.210, and as set forth in OARs 410-141-3920 through 410-141-3960, and other state and federal administrative statutes and rules relating to the rights and responsibilities of Medicaid recipients such as the right to file a grievance and request an appeal or reconsideration.

(6) A CCO must review a NEMT ride service authorization request with the following modifications:

(a) Approving and scheduling, or denying, a request for NEMT ride services (including all legs of the trip) within twenty-four (24) hours of receiving the request. This timeframe shall be reduced as necessary to ensure the member arrives in time for their appointment:

(A) If approved, notify members by their preferred method of contact of the applicable arrangements prior to the date of the NEMT service;

(B) If intending to deny the NEMT ride, the CCO must provide a secondary review by another employee with knowledge of NEMT service requirements and mail the NOABD within 72 hours of denial determination.

(b) Adhering to the grievance and appeal processes and rights specified in OAR 410-141-3835 through 410-141-3915 available with respect to NEMT services; and

(c) The CCO shall mail, within 72 hours of denial, a notice of adverse benefit determination to:

(A) A member denied a ride; and

(B) CCOs shall provide a copy of the NOABD to the provider with which the affected member was scheduled for an appointment, when the provider is part of the CCO's provider network and requested the transportation on the member's behalf, in a format that is agreeable to the provider and provides sufficient documentation of notification.

(7) This rule applies only to the Authority's pilot project in effect for 2/16/2024 through 2/15/2025, which allows a CCO to utilize a Transportation Network Company (TNC) to provide NEMT services to the CCO's members.

(a) Transportation network company (TNC) has the meaning found in ORS 742.520.

(b) A TNC must obtain a certification from the Oregon Health Authority to participate in the TNC Pilot Program as an NEMT provider. Certification for the TNC pilot program is obtained by submitting to HSD.QualityAssurance@odhsoha.oregon.gov the following documents:

(A) A document that identifies the process or policies the TNC follows and documents its compliance with the requirement that each driver has a valid driver license. The TNC must maintain records of their drivers participating in the TNC Pilot and share relevant information with OHA when requested;

(B) A document that identifies the processes or policies the TNC follows and documents its compliance with the processes and policies, to ensure that proposed TNC pilot program drivers, employees, agents and contractors are not, as described in 42 CFR §438.610 (a) or (b): Excluded, suspended, or debarred, or otherwise excluded from participating in procurement or non-procurement activities under the Federal Acquisition Regulations or federal Executive Order No. 12549 or the implementation guidelines for federal Executive Order No. 12549; or Excluded from participation in any federal health care program under section 1128 or 1128A of the Social Security Act as described in 42 CFR 438.610;

(C) A document that identifies the process or policies that the TNC follows and documents its compliance with the processes and policies, to ensure that all TNC proposed pilot program drivers have not: Committed more than tree (3) traffic violations under ORS 801.557 in the past three(3) years; or Committed one (1) or more traffic crimes under ORS 801.545 within the past seven (7) years; or Have been convicted of Driving Under the Influence of Intoxicants under ORS 813.010 within the last seven (7) years;

(D) The TNC's policy for monitoring the driving records and criminal records of all of its proposed TNC pilot program drivers, employees, agents, and contractors;

(E) The TNC's policy for compliance with federal and state regulatory requirements to ensure all OHP member information is protected in accordance with OAR 410-136-3280;

(F) Proof of insurance and policy compliant with ORS 742.520(1)(b).

(c) Upon receipt of the documents identified in subsection (b) of this rule, the application shall be reviewed and if all requirements are met, then the Authority shall issue a certificate of approval to participate in the TNC Pilot Program.

(A) Once certification is issued, a TNC certified to participate in the TNC Pilot Program shall be eligible to provide rides to OHP Members upon request from the Authority or a CCO;

(B) Rides authorized to be provided by a driver employed by or contracted with a certified TNC Pilot Program may only be utilized by a CCO or the Authority if:

(i) No NEMT driver who meets the requirements identified in OAR 410-136-3040 (NEMT Driver) accepts an NEMT brokerage request within twenty-four (24) hours of the scheduled ride time; or

(ii) A previously scheduled NEMT Driver cancels the assigned ride within twenty-four (24) hours of the scheduled ride time and no other NEMT Driver accepts, within a reasonable period of time, the brokerage's new request for another NEMT Driver; or

(iii) The previously scheduled NEMT Driver does not arrive at the pick-up location within fifteen (15) minutes after the scheduled pick-up time.