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

FILING CAPTION: Managed Care Entity (MCE) Assessment Rules and Hospital and Type A-B Hospital Assessment Rules

EFFECTIVE DATE: 01/01/2018

AGENCY APPROVED DATE: 12/22/2017

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RULES:
410-050-0700, 410-050-0730, 410-050-0740, 410-050-0860, 410-050-0861, 410-050-0870, 410-125-0230, 410-141-4000, 410-141-4005, 410-141-4010, 410-141-4020, 410-141-4030, 410-141-4040, 410-141-4050, 410-141-4060, 410-141-4070, 410-141-4080, 410-141-4090, 410-141-4100, 410-141-4110, 410-141-4120

AMEND: 410-050-0700

RULE TITLE: Definitions

NOTICE FILED DATE: 10/13/2017

RULE SUMMARY: The Authority drafted proposed rules to implement provisions of House Bill 2391 from the 2017 Legislative Session. The proposed rules specifically address how the Authority will collect the CCO and hospital assessments as required under the legislation. Details included in the proposed CCO assessment rule include: General program administration; disclosure of information; assessment calculation, reporting, due dates, and verification; authority to audit records; determining assessment liability on failure to file; financial penalties for failure to file a report or failure to pay assessment when due; notice of proposed action; required notices and hearing processes; and final order of payment and remedies available. Adopting rule for Qualified Directive Payments for Rural Type A/B and Public Academic Health Centers for Medicaid members enrolled in Coordinated Care Organizations.

RULE TEXT:
The following definitions apply to OAR 410-050-0700 to 410-050-0870:
(1) “Authority” means the Oregon Health Authority.
(2) "Bad Debt" means the current period charge for actual or expected uncollectible accounts resulting from the extension of credit on inpatient and outpatient hospital services. Bad debt charges shall be offset by any recoveries received on accounts receivable during that current period, subject to final assessment reporting and reconciliation processes required in these rules.
(3) "Charges for Inpatient Care" means gross inpatient charges generated from room, board, general nursing, and ancillary services provided to patients who are expected to remain in the hospital at least overnight and occupy a bed (as distinguished from categories of health care items or services identified in 42 CFR 433.56(a)(2)-(19) that are not

charges for inpatient hospital services). Charges for inpatient care include all payers, and are not limited to Medicaid patients.
(4) "Charges for Outpatient Care" means gross outpatient charges generated from services provided by the hospital to a patient who is not confined overnight. These services include all ancillary and clinic facility charges (as distinguished from categories of health care items or services identified in 42 CFR 433.56(a)(1) and (3)-(19) that are not charges for outpatient hospital services). Charges of outpatient care include all payers and are not limited to Medicaid charges.
(5) "Charity Care" means costs for providing inpatient or outpatient care services free of charge or at a reduced charge because of the indigence or lack of health insurance of the patient receiving the care services. Charity care results from a hospital's policy as reflected in its official financial statements to provide inpatient or outpatient hospital care services free of charge or at a reduced charge to individuals who meet financial criteria. Charity care does not include any amounts above the payments by the Authority that constitute payment in full under ORS 414.065(3), or above the payment rate established by contract with a prepaid managed care health services organization or health insurance entity for inpatient or outpatient care provided pursuant to such contract, or above the payment rate established under ORS 414.743 for inpatient or outpatient care reimbursed under that statute.
(6) "Contractual Adjustments" means the difference between the amounts charged based on the hospital's full, established charges and the amount received or due from the payer.
(7) "Declared Fiscal Year" means the fiscal year declared to the Internal Revenue Service (IRS).
(8) "Deficiency" means the amount by which the assessment, as correctly computed, exceeds the assessment, if any, reported and paid by the hospital. If, after the original deficiency is assessed, subsequent information shows the correct amount of assessment to be greater than previously determined, an additional deficiency arises.
(9) "Delinquency" means the hospital fails to file a report when due as required under these rules or fails to pay the assessment as correctly computed when the assessment was due.
(10) "Director" means the Director of the Authority.
(11) "Hospital" means a hospital licensed under ORS chapter 441. Hospital, as used in this section, does not include special inpatient care facilities as that term is defined in ORS 442.015, hospitals that provide only psychiatric care, pediatric specialty hospitals providing care to children at no charge, and public hospitals other than hospitals created by health districts under ORS 440.315 to 440.410. For purposes of these rules, the hospital shall be identified by using the federal payer identification number for the hospital.
(12) "Net Revenue" means the total amount of charges for inpatient or outpatient care provided by the hospital to patients, less charity care, bad debts, and contractual adjustments. Net revenue does not include revenue derived from sources other than inpatient or outpatient operations including but not limited to interest and guest meals and any revenue that is taken into account in computing a long-term care assessment under the long-term facility assessment.
(13) “Type A Hospital” means a small remote hospital that has 50 or fewer beds and is more than 30 miles from another acute inpatient care facility.
(14) “Type B Hospital” means a small and rural hospital that has 50 or fewer beds and is 30 miles or less from another acute inpatient care facility.
[Note: Publications referenced are available from the agency.]

STATUTORY/OTHER AUTHORITY: 413.042

STATUTES/OTHER IMPLEMENTED: 2017 HB 2391

AMEND: 410-050-0730

RULE TITLE: Entities Subject to the Hospital Assessment

NOTICE FILED DATE: 10/13/2017

RULE SUMMARY: The Authority drafted proposed rules to implement provisions of House Bill 2391 from the 2017 Legislative Session. The proposed rules specifically address how the Authority will collect the CCO and hospital assessments as required under the legislation. Details included in the proposed CCO assessment rule include: General program administration; disclosure of information; assessment calculation, reporting, due dates, and verification; authority to audit records; determining assessment liability on failure to file; financial penalties for failure to file a report or failure to pay assessment when due; notice of proposed action; required notices and hearing processes; and final order of payment and remedies available. Adopting rule for Qualified Directive Payments for Rural Type A/B and Public Academic Health Centers for Medicaid members enrolled in Coordinated Care Organizations.

RULE TEXT:

Each hospital in Oregon is subject to the hospital assessment except:

(1) Hospitals operated by the United States Department of Veterans Affairs;

(2) Pediatric specialty hospitals providing care to children at no charge;

(3) Public hospitals other than hospitals created by health districts.

STATUTORY/OTHER AUTHORITY: 413.042, 410.070, 411.060

STATUTES/OTHER IMPLEMENTED: 2017 HB 2391

AMEND: 410-050-0740

RULE TITLE: The Hospital Assessment: Calculation, Report, Due Date

NOTICE FILED DATE: 10/13/2017

RULE SUMMARY: The Authority drafted proposed rules to implement provisions of House Bill 2391 from the 2017 Legislative Session. The proposed rules specifically address how the Authority will collect the CCO and hospital assessments as required under the legislation. Details included in the proposed CCO assessment rule include: General program administration; disclosure of information; assessment calculation, reporting, due dates, and verification; authority to audit records; determining assessment liability on failure to file; financial penalties for failure to file a report or failure to pay assessment when due; notice of proposed action; required notices and hearing processes; and final order of payment and remedies available. Adopting rule for Qualified Directive Payments for Rural Type A/B and Public Academic Health Centers for Medicaid members enrolled in Coordinated Care Organizations.

RULE TEXT:

(1) The amount of the assessment equals the assessment rate multiplied by the hospital's net revenue, consistent with OAR 410-050-0750, 410-050-0860, and 410-050-0861. The assessment shall be imposed on net revenues earned by the hospital on or after January 1, 2004, based on calendar quarters. The first calendar quarter begins on January 1; the second calendar quarter begins on April 1; the third calendar quarter begins on July 1; and the fourth calendar quarter begins on October 1.

(2) The assessment rate shall be determined in accordance with OAR 410-050-0860 and 410-050-0861.

(3) The hospital shall file the quarterly report on a form approved by the Authority on or before the 45th day following the end of the calendar quarter for which an assessment is due. The quarterly payment is due and shall be paid at the same time required for filing the quarterly report. The hospital shall provide all information required on the quarterly report when due. Failure to file or pay when due shall be a delinquency.

(4) The fiscal year reconciliation report, including the financial statement and reconciliation statement, is due and shall be submitted to the Authority no later than the final day of the sixth calendar month after the hospital's declared fiscal year end. The fiscal year reconciliation assessment payment is due and shall be paid at the same time required for filing the fiscal year reconciliation report. The hospital shall provide all information required on the fiscal year reconciliation report when due. Failure to file or pay when due shall be a delinquency.

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

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

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

STATUTORY/OTHER AUTHORITY: 413.042, 410.070, 411.060

STATUTES/OTHER IMPLEMENTED: 2017 HB 2391

AMEND: 410-050-0860

RULE TITLE: Director Determines Assessment Rate

NOTICE FILED DATE: 10/13/2017

RULE SUMMARY: The Authority drafted proposed rules to implement provisions of House Bill 2391 from the 2017 Legislative Session. The proposed rules specifically address how the Authority will collect the CCO and hospital assessments as required under the legislation. Details included in the proposed CCO assessment rule include: General program administration; disclosure of information; assessment calculation, reporting, due dates, and verification; authority to audit records; determining assessment liability on failure to file; financial penalties for failure to file a report or failure to pay assessment when due; notice of proposed action; required notices and hearing processes; and final order of payment and remedies available. Adopting rule for Qualified Directive Payments for Rural Type A/B and Public Academic Health Centers for Medicaid members enrolled in Coordinated Care Organizations.

RULE TEXT:

(1) The Director shall determine the assessment rate.

(2) The rate of assessment shall be imposed on the net revenue of each hospital subject to the assessment. The Director shall consult with representatives of hospitals before setting the rate.

(3) The Director may reduce the rate of assessment to the maximum rate allowed under federal law if the reduction is required to comply with federal law. If the rate is reduced pursuant to this section, the Director shall notify the hospitals as to the effective date of the rate reduction.

(4) The Director may impose a lower rate of assessment on Type A hospitals and Type B hospitals to take into account the hospital's financial position.

(5) A hospital is not guaranteed that any additional moneys paid to the hospital in the form of payments for services will equal or exceed the amount of the assessment paid by the hospital.

STATUTORY/OTHER AUTHORITY: 413.042

STATUTES/OTHER IMPLEMENTED: 2017 HB 2391

AMEND: 410-050-0861

RULE TITLE: Assessment Rate

NOTICE FILED DATE: 10/13/2017

RULE SUMMARY: The Authority drafted proposed rules to implement provisions of House Bill 2391 from the 2017 Legislative Session. The proposed rules specifically address how the Authority will collect the CCO and hospital assessments as required under the legislation. Details included in the proposed CCO assessment rule include: General program administration; disclosure of information; assessment calculation, reporting, due dates, and verification; authority to audit records; determining assessment liability on failure to file; financial penalties for failure to file a report or failure to pay assessment when due; notice of proposed action; required notices and hearing processes; and final order of payment and remedies available. Adopting rule for Qualified Directive Payments for Rural Type A/B and Public Academic Health Centers for Medicaid members enrolled in Coordinated Care Organizations.

RULE TEXT:

(1) The assessment rate for the period beginning January 1, 2005, and ending June 30, 2006, is .68 percent.
(2) The assessment rate for the period beginning July 1, 2006, and ending December 31, 2007, is .82 percent.
(3) The assessment rate for the period beginning January 1, 2008, and ending June 30, 2009, is .63 percent.
(4) The assessment rate for the period of January 1, 2008 through June 30, 2009 does not apply to the period beginning July 1, 2009.
(5) The assessment rate for the period beginning July 1, 2009, and ending September 30, 2009, is .15 percent.
(6) The assessment rate for the period beginning October 1, 2009, and ending June 30, 2010, is 2.8 percent.
(7) The assessment rate for the period beginning July 1, 2010, and ending June 30, 2011, is 2.32 percent.
(8) The assessment rate for the period beginning July 1, 2011, and ending September 30, 2011, is 5.25 percent.
(9) The assessment rate for the period beginning October 1, 2011, and ending December 31, 2011, is 5.08 percent.
(10) The assessment rate for the period beginning January 1, 2012, and ending March 31, 2013, is 4.32 percent.
(11) The assessment rate for the period beginning April 1, 2013, and ending September 30, 2014, is 5.30 percent.
(12) The assessment rate for the period beginning October 1, 2014, and ending March 31, 2016, is 5.80 percent.
(13) The assessment rate for the period beginning April 1, 2016, and ending June 30, 2017, is 5.30 percent.
(14) The assessment rate for the period beginning July 1, 2017, and ending October 4, 2017, is 6.00 percent.
(15) The assessment rate for the period beginning October 5, 2017, and ending December 31, 2017, is 5.30 percent.
(16) The assessment rate for the period beginning January 1, 2018, is 6.0 percent.
(17) For TypeA/B hospitals, the assessment rate for the period beginning January 1, 2018, is 4.00 percent.

STATUTORY/OTHER AUTHORITY: 413.042

STATUTES/OTHER IMPLEMENTED: 2017 HB 2391

AMEND: 410-050-0870

RULE TITLE: Sunset Provisions

NOTICE FILED DATE: 10/13/2017

RULE SUMMARY: The Authority drafted proposed rules to implement provisions of House Bill 2391 from the 2017 Legislative Session. The proposed rules specifically address how the Authority will collect the CCO and hospital assessments as required under the legislation. Details included in the proposed CCO assessment rule include: General program administration; disclosure of information; assessment calculation, reporting, due dates, and verification; authority to audit records; determining assessment liability on failure to file; financial penalties for failure to file a report or failure to pay assessment when due; notice of proposed action; required notices and hearing processes; and final order of payment and remedies available. Adopting rule for Qualified Directive Payments for Rural Type A/B and Public Academic Health Centers for Medicaid members enrolled in Coordinated Care Organizations.

RULE TEXT:

(1) The hospital assessment applies to net revenue received by hospitals on or after January 1, 2004, and before October 1, 2019.

(2) The Type A and B hospital assessment applies to net revenue received by hospitals on or after January 1, 2018, and before October 1, 2021.

STATUTORY/OTHER AUTHORITY: 413.042

STATUTES/OTHER IMPLEMENTED: 2017 HB 2391

ADOPT: 410-125-0230

RULE TITLE: Qualified Directive Payments

NOTICE FILED DATE: 10/13/2017

RULE SUMMARY: The Authority drafted proposed rules to implement provisions of House Bill 2391 from the 2017 Legislative Session. The proposed rules specifically address how the Authority will collect the CCO and hospital assessments as required under the legislation. Details included in the proposed CCO assessment rule include: General program administration; disclosure of information; assessment calculation, reporting, due dates, and verification; authority to audit records; determining assessment liability on failure to file; financial penalties for failure to file a report or failure to pay assessment when due; notice of proposed action; required notices and hearing processes; and final order of payment and remedies available. Adopting rule for Qualified Directive Payments for Rural Type A/B and Public Academic Health Centers for Medicaid members enrolled in Coordinated Care Organizations.

RULE TEXT:

Qualified Directed Payments (QDP) are payments made by the Oregon Health Authority (Authority) to Coordinated Care Organizations from two Quality and Access pools; one for Rural Type A and Type B hospitals and one for and Public Academic Health Centers. QDPs are tied to inpatient discharges and outpatient encounters by Medicaid members enrolled in a Coordinated Care Organization (CCO).

(1) Type A and Type B rural hospitals:

(a) The Authority shall make a qualified directed payment for each inpatient and outpatient encounter; one encounter per member, per day, per facility;

(b) QDP amounts shall be at two separate rates; one for inpatient encounter and one for outpatient encounters;

(c) Payment rates shall be set by the Authority and may be adjusted based on actual utilization and available Quality and Access Funds;

(d) The Authority shall create a monthly report to assist CCOs in distributing funds to the appropriate hospital. The report shall be redistributed to each CCO and each Type A and Type B hospital;

(e) Within five business days after receipt of the monthly report, the CCO shall submit an electronic payment to an account established by the hospital for the amount indicated on the report;

(f) Adjustments shall be processed weekly through the Medicaid payment system and included in the monthly report.

(2) Public Academic Health Centers:

(a) To receive qualified directed payments, the hospital must have at least two obstetricians with staff privileges at the hospital who have agreed to provide obstetric services to individuals who are entitled to medical assistance for such services; the hospital must be located within the State of Oregon (border hospitals are excluded); and the hospital provides a major medical teaching program, defined as a hospital with more than 200 residents or interns;

(b) The Authority shall make a qualified directed payment for each inpatient and outpatient encounter; one encounter per member, per day, per facility;

(c) QDP amounts shall be at two separate rates; one for inpatient encounters and one for outpatient encounters;

(d) Payment rates shall be set by the Authority and may be adjusted based on actual utilization and available Quality and Access Funds;

(e) The Authority shall combine the weekly encounters into a monthly report to assist CCOs in distributing the funds to the appropriate hospital. The report shall be distributed to each CCO and each public academic health center;

(f) Within five business days after receipt of the monthly report, the CCO shall submit an electronic payment to an account established by each public health center for the amount indicated on the report;

(g) Adjustments shall be processed weekly through the Medicaid payment system and included in the monthly report.

(3) If an error is identified in the monthly report, the CCO shall make the payment based on the original amount provided in the report. The Authority shall identify separately the correction in the following month's report and adjust the total payment amount to account for the error.

STATUTORY/OTHER AUTHORITY: 413.042

STATUTES/OTHER IMPLEMENTED: 2017 HB 2391

ADOPT: 410-141-4000

RULE TITLE: Definitions

NOTICE FILED DATE: 10/13/2017

RULE SUMMARY: The Authority drafted proposed rules to implement provisions of House Bill 2391 from the 2017 Legislative Session. The proposed rules specifically address how the Authority will collect the CCO and hospital assessments as required under the legislation. Details included in the proposed CCO assessment rule include: General program administration; disclosure of information; assessment calculation, reporting, due dates, and verification; authority to audit records; determining assessment liability on failure to file; financial penalties for failure to file a report or failure to pay assessment when due; notice of proposed action; required notices and hearing processes; and final order of payment and remedies available. Adopting rule for Qualified Directive Payments for Rural Type A/B and Public Academic Health Centers for Medicaid members enrolled in Coordinated Care Organizations.

RULE TEXT:

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

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

(3) "Managed Care Premiums" means all capitation payments received by the MCE for the provision of health services and all other payments received by the MCE from the Authority for providing health services under ORS chapter 414, including maternity payments and qualified directed payments as defined in OAR 410-120-120. Managed care premiums do not include Medicare premiums or any form of payment by Oregon Health Plan (OHP) enrollees.

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

STATUTORY/OTHER AUTHORITY: 413.042, 414.025

STATUTES/OTHER IMPLEMENTED: 414.065, 2017 HB 2391

ADOPT: 410-141-4005

RULE TITLE: General Administration

NOTICE FILED DATE: 10/13/2017

RULE SUMMARY: The Authority drafted proposed rules to implement provisions of House Bill 2391 from the 2017 Legislative Session. The proposed rules specifically address how the Authority will collect the CCO and hospital assessments as required under the legislation. Details included in the proposed CCO assessment rule include: General program administration; disclosure of information; assessment calculation, reporting, due dates, and verification; authority to audit records; determining assessment liability on failure to file; financial penalties for failure to file a report or failure to pay assessment when due; notice of proposed action; required notices and hearing processes; and final order of payment and remedies available. Adopting rule for Qualified Directive Payments for Rural Type A/B and Public Academic Health Centers for Medicaid members enrolled in Coordinated Care Organizations.

RULE TEXT:
(1) The purpose of these rules is to govern the administration, enforcement, and collection of the managed care assessment on MCEs.
(2) MCEs shall pay an assessment at a rate of 1.5 percent of the gross amount of managed care premiums received during a calendar quarter.
(3) Assessments imposed are in addition to and not in lieu of any assessment, surcharge, or other assessment imposed on an MCE.
(4) The Authority may develop forms and reporting requirements and change the forms and reporting requirements, as necessary to administer, enforce, and collect the assessments.
(5) The MCE assessment applies to managed care premiums made by the Authority for the period beginning January 1, 2018, and ending December 31, 2019.
(6) Pursuant to Ballot Measure 101 that refers the relevant sections of the enabling legislation for the collection of these assessments for approval to the citizens of Oregon on January 23, 2018, the Division may not collect the managed care assessment between January 1, 2018, and February 22, 2018.
(7) If Ballot Measure 101 is approved by the citizens of Oregon, the managed care assessment shall apply to premium equivalents effective on the original date specified in the enabling legislation, which is January 1, 2018, through December 31, 2019.
(8) If Ballot Measure 101 is not approved by the citizens of Oregon, the managed care assessment may not be effective.
(9) If Ballot Measure 101 is approved by the citizens of Oregon, the managed care assessment provisions of the enabling legislation shall become effective on February 22, 2018; however, the managed care assessments shall be collected based on the effective date of January 1, 2018.

STATUTORY/OTHER AUTHORITY: 413.042, 414.025

STATUTES/OTHER IMPLEMENTED: 414.065, 2017 HB 2391

ADOPT: 410-141-4010

RULE TITLE: Disclosure of Information

NOTICE FILED DATE: 10/13/2017

RULE SUMMARY: The Authority drafted proposed rules to implement provisions of House Bill 2391 from the 2017 Legislative Session. The proposed rules specifically address how the Authority will collect the CCO and hospital assessments as required under the legislation. Details included in the proposed CCO assessment rule include: General program administration; disclosure of information; assessment calculation, reporting, due dates, and verification; authority to audit records; determining assessment liability on failure to file; financial penalties for failure to file a report or failure to pay assessment when due; notice of proposed action; required notices and hearing processes; and final order of payment and remedies available. Adopting rule for Qualified Directive Payments for Rural Type A/B and Public Academic Health Centers for Medicaid members enrolled in Coordinated Care Organizations.

RULE TEXT:

(1) Except as otherwise required by law, the Authority may t not publicly divulge or disclose the amount of income, expense, or other particulars set forth or disclosed in any report or return required in the administration of the assessments. Particulars include but are not limited to social security numbers, employer numbers, or other organization identification numbers, and any business records required to be submitted to or inspected by the Authority to allow it to determine the amount of any assessments, delinquencies, or deficiencies payable or paid, or otherwise administer, enforce, or collect a health care assessment to the extent that the information would be exempt from disclosure under ORS 192.501(5).

(2) The Authority may:

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

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

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

STATUTORY/OTHER AUTHORITY: 413.042, 414.025

STATUTES/OTHER IMPLEMENTED: 414.065, 2017 HB 2391

ADOPT: 410-141-4020

RULE TITLE: The Medicaid Managed Care Assessment: Calculation, Report, Due Date, Verification of Report

NOTICE FILED DATE: 10/13/2017

RULE SUMMARY: The Authority drafted proposed rules to implement provisions of House Bill 2391 from the 2017 Legislative Session. The proposed rules specifically address how the Authority will collect the CCO and hospital assessments as required under the legislation. Details included in the proposed CCO assessment rule include: General program administration; disclosure of information; assessment calculation, reporting, due dates, and verification; authority to audit records; determining assessment liability on failure to file; financial penalties for failure to file a report or failure to pay assessment when due; notice of proposed action; required notices and hearing processes; and final order of payment and remedies available. Adopting rule for Qualified Directive Payments for Rural Type A/B and Public Academic Health Centers for Medicaid members enrolled in Coordinated Care Organizations.

RULE TEXT:

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

(2) Adjustments to the managed care premium subject to assessment shall be determined as follows:

(a) Managed care premiums attributable to periods prior to January 1, 2018, are not subject to the assessment and shall be deducted from the assessable managed care premiums when calculating the assessment due;

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

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

(d) If both an overpayment and recoupment occurs, the MCE shall be subject to the assessment on the managed care premiums received in the calendar quarter; and

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

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

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

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

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

STATUTORY/OTHER AUTHORITY: 413.042, 414.025

STATUTES/OTHER IMPLEMENTED: 414.065, 2017 HB 2391

ADOPT: 410-141-4030

RULE TITLE: Filing an Amended Report

NOTICE FILED DATE: 10/13/2017

RULE SUMMARY: The Authority drafted proposed rules to implement provisions of House Bill 2391 from the 2017 Legislative Session. The proposed rules specifically address how the Authority will collect the CCO and hospital assessments as required under the legislation. Details included in the proposed CCO assessment rule include: General program administration; disclosure of information; assessment calculation, reporting, due dates, and verification; authority to audit records; determining assessment liability on failure to file; financial penalties for failure to file a report or failure to pay assessment when due; notice of proposed action; required notices and hearing processes; and final order of payment and remedies available. Adopting rule for Qualified Directive Payments for Rural Type A/B and Public Academic Health Centers for Medicaid members enrolled in Coordinated Care Organizations.

RULE TEXT:

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

(2) Claim for refund:

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

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

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

(3) Payment of deficiency:

(a) If the amount of the assessment is more than the amount paid by the MCE, the MCE may file a corrected report and pay the deficiency at any time. The penalty under OAR 410-141-4070 shall stop accruing after the Authority receives full payment of the total deficiency for the calendar quarter;

(b) If there is an error in the determination of the assessment due, the MCE may describe the circumstances of the late additional payment with the late filing of the amended report. The Authority, in its sole discretion, shall determine the penalty for such late additional payments pursuant to OAR 410-141-4070.

(4) If the Authority discovers or identifies information that it determines could give rise to the issuance of a notice of proposed action or the issuance of a refund, the Authority shall issue notification pursuant to OAR 410-141-4080.

STATUTORY/OTHER AUTHORITY: 413.042, 414.025

STATUTES/OTHER IMPLEMENTED: 2017 HB 2391

ADOPT: 410-141-4040

RULE TITLE: Determining the Date Filed

NOTICE FILED DATE: 10/13/2017

RULE SUMMARY: The Authority drafted proposed rules to implement provisions of House Bill 2391 from the 2017 Legislative Session. The proposed rules specifically address how the Authority will collect the CCO and hospital assessments as required under the legislation. Details included in the proposed CCO assessment rule include: General program administration; disclosure of information; assessment calculation, reporting, due dates, and verification; authority to audit records; determining assessment liability on failure to file; financial penalties for failure to file a report or failure to pay assessment when due; notice of proposed action; required notices and hearing processes; and final order of payment and remedies available. Adopting rule for Qualified Directive Payments for Rural Type A/B and Public Academic Health Centers for Medicaid members enrolled in Coordinated Care Organizations.

RULE TEXT:

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

(1) Before the close of business on the date due; or

(2) If mailed, postmarked before midnight of the due date. When the due date falls on a Saturday, Sunday, or legal holiday, the response is due on the next business day.

STATUTORY/OTHER AUTHORITY: 413.042, 414.025

STATUTES/OTHER IMPLEMENTED: 414.065

ADOPT: 410-141-4050

RULE TITLE: Authority to Audit Records

NOTICE FILED DATE: 10/13/2017

RULE SUMMARY: The Authority drafted proposed rules to implement provisions of House Bill 2391 from the 2017 Legislative Session. The proposed rules specifically address how the Authority will collect the CCO and hospital assessments as required under the legislation. Details included in the proposed CCO assessment rule include: General program administration; disclosure of information; assessment calculation, reporting, due dates, and verification; authority to audit records; determining assessment liability on failure to file; financial penalties for failure to file a report or failure to pay assessment when due; notice of proposed action; required notices and hearing processes; and final order of payment and remedies available. Adopting rule for Qualified Directive Payments for Rural Type A/B and Public Academic Health Centers for Medicaid members enrolled in Coordinated Care Organizations.

RULE TEXT:

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

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

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

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

STATUTORY/OTHER AUTHORITY: 413.042, 414.025

STATUTES/OTHER IMPLEMENTED: 414.065, 2017 HB 2391

ADOPT: 410-141-4060

RULE TITLE: Determining Assessment Liability on Failure to File

NOTICE FILED DATE: 10/13/2017

RULE SUMMARY: The Authority drafted proposed rules to implement provisions of House Bill 2391 from the 2017 Legislative Session. The proposed rules specifically address how the Authority will collect the CCO and hospital assessments as required under the legislation. Details included in the proposed CCO assessment rule include: General program administration; disclosure of information; assessment calculation, reporting, due dates, and verification; authority to audit records; determining assessment liability on failure to file; financial penalties for failure to file a report or failure to pay assessment when due; notice of proposed action; required notices and hearing processes; and final order of payment and remedies available. Adopting rule for Qualified Directive Payments for Rural Type A/B and Public Academic Health Centers for Medicaid members enrolled in Coordinated Care Organizations.

RULE TEXT:

In the case of a failure by the MCE to file a report or to maintain necessary and adequate records, the Authority shall determine the MCE's assessment liability according to the best of its information and belief. Best of its information and belief means the Authority shall use evidence available to the Authority at the time of the determination on which a reasonable person would rely on to determine the assessment. The Authority's determination of assessment liability shall be the basis for the assessment due in any notice of proposed action.

STATUTORY/OTHER AUTHORITY: 413.042, 414.025

STATUTES/OTHER IMPLEMENTED: 414.065, 2017 HB 2391

ADOPT: 410-141-4070

RULE TITLE: Financial Penalty for Failure to File a Report or Failure to Pay Assessment When Due

NOTICE FILED DATE: 10/13/2017

RULE SUMMARY: The Authority drafted proposed rules to implement provisions of House Bill 2391 from the 2017 Legislative Session. The proposed rules specifically address how the Authority will collect the CCO and hospital assessments as required under the legislation. Details included in the proposed CCO assessment rule include: General program administration; disclosure of information; assessment calculation, reporting, due dates, and verification; authority to audit records; determining assessment liability on failure to file; financial penalties for failure to file a report or failure to pay assessment when due; notice of proposed action; required notices and hearing processes; and final order of payment and remedies available. Adopting rule for Qualified Directive Payments for Rural Type A/B and Public Academic Health Centers for Medicaid members enrolled in Coordinated Care Organizations.

RULE TEXT:

(1) An MCE that fails to file a report or pay an assessment in full when due is subject to a penalty of up to $500 per day of delinquency. The penalty accrues from the date of delinquency, notwithstanding the date of any notice under these rules.

(2) The total amount of penalty imposed under this section for each reporting period may not exceed five percent of the assessment for the reporting period for which the penalty is being imposed.

(3) In determining the amount of the penalty, the Authority shall consider evidence, such as:

(a) The MCE's history of prior late payments and prior penalties;

(b) The MCE's actions to come into compliance;

(c) The occurrence of unforeseeable circumstances against which it would have been unreasonable for the MCE to take precautions and which the MCE cannot avoid even by using its best efforts. Such circumstances include, but are not limited to, a natural disaster (e.g., earthquakes, floods, tornadoes), fires, an act of war (e.g., hostilities, invasion, terrorism, civil disorder), or other circumstances not within the reasonable control of the MCE.

(d) In the case of a deficiency due to an error when the MCE files a timely original return and pays the assessment identified in the return, the nature and extent of the error, evidence of prior errors, and the MCE's explanation of the circumstances related to the error.

(4) The Authority shall collect any penalties imposed under this section and deposit the funds in the Health System Fund.

(5) Penalties paid under this section are in addition to the Medicaid managed care assessment.

(6) If the Authority determines that an MCE is subject to a penalty under this section, the Authority shall issue a notice of proposed action as described in OAR 410-141-4080.

(7) If an MCE requests a contested case hearing, the Director, at the Director's sole discretion, may reduce the amount of penalty assessed.

STATUTORY/OTHER AUTHORITY: 413.042, 414.025

STATUTES/OTHER IMPLEMENTED: 414.065, 2017 HB 2391

ADOPT: 410-141-4080

RULE TITLE: Notice of Proposed Action

NOTICE FILED DATE: 10/13/2017

RULE SUMMARY: The Authority drafted proposed rules to implement provisions of House Bill 2391 from the 2017 Legislative Session. The proposed rules specifically address how the Authority will collect the CCO and hospital assessments as required under the legislation. Details included in the proposed CCO assessment rule include: General program administration; disclosure of information; assessment calculation, reporting, due dates, and verification; authority to audit records; determining assessment liability on failure to file; financial penalties for failure to file a report or failure to pay assessment when due; notice of proposed action; required notices and hearing processes; and final order of payment and remedies available. Adopting rule for Qualified Directive Payments for Rural Type A/B and Public Academic Health Centers for Medicaid members enrolled in Coordinated Care Organizations.

RULE TEXT:

(1) Prior to issuing a notice of proposed action, the Authority shall notify the MCE of a potential deficiency or failure to report that could give rise to the imposition of a penalty. The Authority shall issue a 30 day notification letter within 30 calendar days of the report or payment due date. The MCE shall have 30 calendar days from the date of the notice to respond. The Authority may consider the response, if any, and any amended report under OAR 410-141- 4030 in its notice of proposed action. In all cases that the Authority has determined that a MCE has an assessment deficiency or failure to report, the Authority shall issue a notice of proposed action. The Authority may not issue a notice of proposed action if the issue is resolved satisfactorily within 59 days from the date of mailing the 30 day notification letter.

(2) The Authority shall issue a notice of proposed action within 60 calendar days from the date of mailing the 30 day notification letter.

(3) Contents of the notice of proposed action must include:

(a) The applicable calendar quarter;

(b) The basis for determining the corrected amount of assessment for the quarter;

(c) The corrected assessment due for the quarter as determined by the Authority;

(d) The amount of assessment paid for the quarter by the MCE;

(e) The resulting deficiency, which is the difference between the amount received by the Authority for the calendar quarter and the corrected amount due as determined by the Authority;

(f) Statutory basis for the penalty;

(g) Amount of penalty per day of delinquency;

(h) Date upon which the penalty began to accrue;

(i) Date the penalty stopped accruing or circumstances under which the penalty will stop accruing;

(j) The total penalty accrued up to the date of the notice;

(k) Instructions for responding to the notice; and

(L) A statement of the MCE's right to a hearing.

STATUTORY/OTHER AUTHORITY: 413.042, 414.025

STATUTES/OTHER IMPLEMENTED: 414.065, 2017 HB 2391

ADOPT: 410-141-4090

RULE TITLE: Required Notice

NOTICE FILED DATE: 10/13/2017

RULE SUMMARY: The Authority drafted proposed rules to implement provisions of House Bill 2391 from the 2017 Legislative Session. The proposed rules specifically address how the Authority will collect the CCO and hospital assessments as required under the legislation. Details included in the proposed CCO assessment rule include: General program administration; disclosure of information; assessment calculation, reporting, due dates, and verification; authority to audit records; determining assessment liability on failure to file; financial penalties for failure to file a report or failure to pay assessment when due; notice of proposed action; required notices and hearing processes; and final order of payment and remedies available. Adopting rule for Qualified Directive Payments for Rural Type A/B and Public Academic Health Centers for Medicaid members enrolled in Coordinated Care Organizations.

RULE TEXT:

(1) Any notice required to be sent under these rules to the MCE shall be sent to the individual and address identified as the point of contact for the MCE in its contract with the Authority.

(2) Any notice required to be sent to the Authority shall be sent to the contact point identified on the Authority's notice.

STATUTORY/OTHER AUTHORITY: 413.042, 414.025

STATUTES/OTHER IMPLEMENTED: 414.065, 2017 HB 2391

ADOPT: 410-141-4100

RULE TITLE: Hearing Process

NOTICE FILED DATE: 10/13/2017

RULE SUMMARY: The Authority drafted proposed rules to implement provisions of House Bill 2391 from the 2017 Legislative Session. The proposed rules specifically address how the Authority will collect the CCO and hospital assessments as required under the legislation. Details included in the proposed CCO assessment rule include: General program administration; disclosure of information; assessment calculation, reporting, due dates, and verification; authority to audit records; determining assessment liability on failure to file; financial penalties for failure to file a report or failure to pay assessment when due; notice of proposed action; required notices and hearing processes; and final order of payment and remedies available. Adopting rule for Qualified Directive Payments for Rural Type A/B and Public Academic Health Centers for Medicaid members enrolled in Coordinated Care Organizations.

RULE TEXT:

(1) Any MCE that receives a notice of proposed action may request a contested case hearing pursuant to ORS 183.411 through 183.500.

(2) The MCE may request a hearing by submitting a written request within 20 days of the date of the notice of proposed action.

(3) Prior to the hearing, the MCE shall meet with the Authority for an informal conference:

(a) The informal conference may be used to negotiate a written settlement agreement;

(b) If the settlement agreement includes a reduction or waiver of penalties, the agreement must be approved and signed by the Director.

(4) Except as provided in section (5) of this rule, if the case proceeds to a hearing, the administrative law judge shall issue a proposed order with respect to the notice of proposed action. The Authority shall issue a final order.

(5) Nothing in this section shall preclude the Authority and the MCE from agreeing to informal disposition of the contested case at any time.

STATUTORY/OTHER AUTHORITY: 413.042, 414.025

STATUTES/OTHER IMPLEMENTED: 414.065, 2017 HB 2391

ADOPT: 410-141-4110

RULE TITLE: Final Order of Payment

NOTICE FILED DATE: 10/13/2017

RULE SUMMARY: The Authority drafted proposed rules to implement provisions of House Bill 2391 from the 2017 Legislative Session. The proposed rules specifically address how the Authority will collect the CCO and hospital assessments as required under the legislation. Details included in the proposed CCO assessment rule include: General program administration; disclosure of information; assessment calculation, reporting, due dates, and verification; authority to audit records; determining assessment liability on failure to file; financial penalties for failure to file a report or failure to pay assessment when due; notice of proposed action; required notices and hearing processes; and final order of payment and remedies available. Adopting rule for Qualified Directive Payments for Rural Type A/B and Public Academic Health Centers for Medicaid members enrolled in Coordinated Care Organizations.

RULE TEXT:

The Authority shall issue a final order of payment for deficiencies or penalties when:

(1) The MCE did not make a timely request for a hearing.

(2) Any part of the deficiency or penalty was upheld after a hearing.

(3) Upon agreement of the MCE and the Authority.

STATUTORY/OTHER AUTHORITY: 413.042, 414.025

STATUTES/OTHER IMPLEMENTED: 414.065, 2017 HB 2391

ADOPT: 410-141-4120

RULE TITLE: Remedies Available after Final Order of Payment

NOTICE FILED DATE: 10/13/2017

RULE SUMMARY: The Authority drafted proposed rules to implement provisions of House Bill 2391 from the 2017 Legislative Session. The proposed rules specifically address how the Authority will collect the CCO and hospital assessments as required under the legislation. Details included in the proposed CCO assessment rule include: General program administration; disclosure of information; assessment calculation, reporting, due dates, and verification; authority to audit records; determining assessment liability on failure to file; financial penalties for failure to file a report or failure to pay assessment when due; notice of proposed action; required notices and hearing processes; and final order of payment and remedies available. Adopting rule for Qualified Directive Payments for Rural Type A/B and Public Academic Health Centers for Medicaid members enrolled in Coordinated Care Organizations.

RULE TEXT:

Any amounts due and owing under the final order of payment and any interest thereon may be recovered by Oregon as a debt to the state, using any available legal and equitable remedies which include but are not limited to:

(1) Collection activities including but not limited to deducting the amount of the final deficiency or penalty from any sum then or later owed to the MCE by the Authority.

(2) Every payment obligation shall bear interest at the statutory rate of interest in ORS 82.010 accruing from the date of the final order of payment and continuing until the payment obligation, including interest, has been discharged.

STATUTORY/OTHER AUTHORITY: 413.042, 414.025

STATUTES/OTHER IMPLEMENTED: 414.065, 2017 HB 2391