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DENNIS RICHARDSON
SECRETARY OF STATE

LESLIE CUMMINGS
DEPUTY SECRETARY OF STATE

ARCHIVES DIVISION
MARY BETH HERKERT
DIRECTOR

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

PERMANENT ADMINISTRATIVE ORDER

FILED
12/26/2018 9:45 AM
ARCHIVES DIVISION
SECRETARY OF STATE
& LEGISLATIVE COUNSEL

DMAP 115-2018

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

FILING CAPTION: Changes in Reporting Requirements for Financial and Claims Information for Coordinated Care Organizations

EFFECTIVE DATE: 01/01/2019

AGENCY APPROVED DATE: 11/30/2018

CONTACT: Sandy Cafourek
503-945-6430
sandy.c.cafourek@dhsoha.state.or.us

500 Summer St. NE
Salem,OR 97301

Filed By:
Sandy Cafourek
Rules Coordinator

RULES:
410-141-0340, 410-141-3015, 410-141-3200, 410-141-3345

AMEND: 410-141-0340

RULE TITLE: Oregon Health Plan Managed Care Entity Financial Solvency

NOTICE FILED DATE: 10/11/2018

RULE SUMMARY: The Division needs to amend these rules to provide direction and clarification to the Coordinated Care Organizations and Prepaid Health Plans. Specifically, these proposed changes will address: (1) CCO financial reporting requirements; (2) CCO reporting of sub-capitated entity financial activity; (3) OHA's right to review financial records; (4) Limitations on combination of asset investments; (5) Health Related Services (HRS) reporting in Medical Loss Rations (MLR) and rate setting; (6) Changes in CCO reporting requirements for the All Payer All Claims (APAC) data reporting system.

RULE TEXT:
(1) Managed Care Entities (MCEs) shall assume the risk for providing capitated services under their contracts and agreements with the Oregon Health Authority (Authority). MCEs shall maintain sound financial management procedures, maintain protections against insolvency, and generate periodic financial reports for submission to the Division:
(a) MCEs shall comply with solvency requirements specified in contracts and agreements with the Authority. Solvency requirements of MCEs shall include the following components:
(A) Maintenance of restricted reserve funds with balances equal to amounts specified in contracts and agreements with the Authority. If the MCE has contracts and agreements with the Authority, separate restricted reserve fund accounts shall be maintained for each contract and agreement. The Authority does not require separate restricted reserve accounts for the Cover All Kids and Oregon Health Plan contracts; however, adequate reserve levels need to be maintained when reviewing both contracts in aggregate;
(B) Protection against catastrophic and unexpected expenses related to capitated services for MCEs. The method of protection may include the purchase of stop loss coverage, reinsurance, self-insurance, or any other alternative

determined acceptable by the Authority. Self-insurance must be determined appropriate by the Authority;
(C) Maintenance of professional liability coverage of not less than $1,000,000 per person per incident and not less than $1,000,000 in the aggregate either through binder issued by an insurance carrier or by self-insurance with proof of same, except to the extent that the Oregon Tort Claims Act, ORS 30.260 to 30.300 is applicable;
(D) Systems that capture, compile, and evaluate information and data concerning financial operations. Such systems shall provide for the following:
(i) Determination of future budget requirements for the next three quarters;
(ii) Determination of incurred but not reported (IBNR) expenses;
(iii) Tracking additions and deletions of members and accounting for capitation payments;
(iv) Tracking claims payment;
(v) Tracking all monies collected from third party resources on behalf of members; and
(vi) Documentation of and reports on the use of incentive payment mechanisms, risk-sharing, and risk-pooling, if applicable.
(b) MCEs shall submit the following applicable reports as specified in agreements with the Division:
(A) An annual audit performed by an independent accounting firm containing but not limited to:
(i) A written statement of opinion by the independent accounting firm based on the firm's audit regarding the MCE's financial statements;
(ii) A written statement of opinion by an independent actuarial firm about the assumptions and methods used in determining loss reserve, actuarial liabilities, and related items;
(iii) Balance Sheets;
(iv) Statement of Revenue, Expenses and Net Income, and Change in Fund Balance;
(v) Statements of Cash Flows;
(vi) Notes to Financial Statements;
(vii) Health Related Services (as defined by OAR 410-141-3150 and as described in Oregon's Medicaid 1115 Waiver for 2017 – 2022) and additional supplemental information, including care coordination, case management, flexible services, and community benefit expenses;
(viii) Any supplemental information deemed necessary by the independent accounting firm or actuary;
(ix) Certification of compliance with financial and encounter data reporting requirements; and
(x) Any supplemental information deemed necessary by the Authority.
(B) MCE-specific quarterly financial reports. Such quarterly reports shall include but are not limited to:
(i) Statement of Revenue, Expenses and Net Income;
(ii) Balance Sheet;
(iii) Statement of Cash Flows;
(iv) Incurred But Not Reported (IBNR) Expenses;
(v) Fee-for-service liabilities and medical and hospital expenses that are covered by risk-sharing arrangements;
(vi) Restricted reserve documentation;
(vii) Third party resources collections (MCE contractor);
(viii) Certification of compliance with financial and encounter data reporting requirements; and
(ix) Corporate Relationships of Contractors (FCHPs, DCOs, and PCOs) or Incentive Plan Disclosure and Detail (MCEs).
(C) MCE-specific utilization reports;
(D) MCE-specific quarterly documentation of the Restricted Reserve. Restricted reserve funds of FCHPs, PCOs, and DCOs shall be held by a third party. Restricted reserve fund documentation shall include the following:
(i) A copy of the certificate of deposit from the party holding the restricted reserve funds;
(ii) A statement showing the level of funds deposited in the restricted reserve fund accounts;
(iii) Documentation of the liability that would be owed to creditors in the event of MCE insolvency;
(iv) Documentation of the dollar amount of that liability that is covered by any identified risk-adjustment mechanisms.
(c) MCEs that sub-capitate any work described in agreements with the Division shall require subcontractors to report

financial activity at the sub-capitated entity level as specified in agreements with the Division:
(A) “Sub-capitated Entity” means an individual or organization affiliated with the MCE who is authorized to provide services to members or any other risk accepting entity receiving a sub-capitation payment from an MCE as a payment for services provided to members;
(B) MCEs that pay annual sub-capitation payments in the amount greater than 0.5 percent of an MCE’s annual gross revenues shall submit to the division the following sub-capitated entity financial reports on an annual basis including but not limited to:
(i) Statement of Revenue, Expenses and Net Income;
(ii) Restricted reserve documentation;
(iii) Certification of compliance with financial and encounter data reporting requirements;
(iv) Any supplemental information deemed necessary by the Division.
(2) MCEs shall comply with the following additional requirements regarding restricted reserve funds:
(a) MCEs that sub-capitate any work described in agreements with the Authority may require subcontractors to maintain a restricted reserve fund for the subcontractor's portion of the risk assumed or may maintain a restricted reserve fund for all risk assumed under the agreement with the Authority. Regardless of the alternative selected, MCEs shall assure that the combined total restricted reserve fund balance meets the requirements of the agreement with the Authority;
(b) If the restricted reserve fund of the MCE is held in a combined account or pool with other entities, the MCE and its subcontractors, as applicable, shall provide a statement from the pool or account manager that the restricted reserve fund is available to the MCE or its subcontractors, as applicable, and is not obligated elsewhere;
(c) If the MCE must use its restricted reserve fund to cover services under its agreement with the Authority, the MCE shall provide advance notice to the Authority of the amount to be withdrawn, the reason for withdrawal, when and how the restricted reserve fund will be replenished, and steps to be taken to avoid the need for future restricted reserve fund withdrawals;
(d) MCEs shall provide the Authority access to restricted reserve funds if insolvency occurs;
(e) MCEs shall have written policies and procedures to ensure that if insolvency occurs, members and related clinical records are transitioned to other MCEs or providers with minimal disruption.
(3) The Authority may require an MCE to produce books, records, accounts, papers, documents, and computer and other recordings the MCE or the MCE’s affiliates have that are necessary for the Authority to ascertain the MCE’s financial condition or to determine the MCE’s compliance with the contracts and agreements with the Authority.
(4) Funds of an MCE may be invested in a bond, debenture, note, warrant, certificate, or other evidence of indebtedness that are not investment grade as established by these rules, but the funds that a MCE may invest under this section shall not exceed 20 percent of the MCE’s assets. For purposes of this rule, MCEs shall be subject to the requirements of OAR 836-033-0105 through 836-033-0130.
(5) An MCE may not have any combination of investments in or secured by the stocks, obligations, and property of one person, corporation or political subdivision in excess of 10 percent of the MCE’s assets, nor shall it invest more than 10 percent of its assets in a single parcel of real property or in any other single investment. This section does not apply to:
(a) Investments in or loans upon the security of the general obligations of a sovereign; or
(b) Investments by an MCE in all real or personal property used exclusively by such MCE to provide health services or in real property used primarily for its home office.
(6) MCEs shall comply with the following additional requirements regarding Health Related Services (as defined by OAR 410-141-3150 and as described in the CMS section 1115 Waiver):
(a) Health Related Services shall be considered in the rate setting consistent with the current 1115 Waiver.
(b) Health Related Services shall be included as Non-Encounterable Service Costs in the Minimum Medical Loss Rebate Calculation report.

STATUTORY/OTHER AUTHORITY: ORS 413.042

STATUTES/OTHER IMPLEMENTED: ORS 414.651

AMEND: 410-141-3015

RULE TITLE: Criteria for Coordinated Care Organizations

NOTICE FILED DATE: 10/11/2018

RULE SUMMARY: The Division needs to amend these rules to provide direction and clarification to the Coordinated Care Organizations and Prepaid Health Plans. Specifically, these proposed changes will address: (1) CCO financial reporting requirements; (2) CCO reporting of sub-capitated entity financial activity; (3) OHA's right to review financial records; (4) Limitations on combination of asset investments; (5) Health Related Services (HRS) reporting in Medical Loss Rations (MLR) and rate setting; (6) Changes in CCO reporting requirements for the All Payer All Claims (APAC) data reporting system.

RULE TEXT:

Pursuant to OAR 410-141-3010, the Authority may include a readiness review process as part of the RFA and require successful completion of the readiness review process as a condition to contracting.

(1) Applicants shall submit applications to the Authority describing their capacity and plans for meeting the goals and requirements established for the Oregon Integrated and Coordinated Health Care Delivery System including being prepared to enroll all eligible individuals within the CCO's proposed service area. The Authority shall use the RFA procurement process described in OAR 410-141-3010.

(2) In addition to the requirements for CCOs expressed in the laws establishing Health System Transformation, the Authority interprets the qualifications and expectations for CCO contracting within the context of the Oregon Health Policy Board's adopted reports and policies.

(3) Applicants shall describe their demonstrated experience and capacity for:

(a) Managing financial risk and establishing financial reserves;

(b) Meeting the following minimum financial requirements:

(A) Maintaining restricted reserves of $250,000 plus an amount equal to 50 percent of the entity's total actual or projected liabilities above $250,000;

(B) Maintaining a net worth in an amount equal to at least 5 percent of the average combined revenue in the prior two quarters of the participating health care entities.

(c) Operating within a fixed global budget;

(d) Developing and implementing alternative payment methodologies that are based on health care quality and improved health outcomes;

(e) Coordinating the delivery of physical health care, mental health and Substance Use Disorder (SUD) services, oral health care, and covered long-term care services;

(f) Engaging community members and health care providers in improving the health of the community and addressing regional, cultural, socioeconomic, and racial disparities in health care that exist among the entity's enrollees and in the entity's community.

(4) In selecting one or more CCOs to serve a geographic area, the Authority shall:

(a) For members and potential members, optimize access to care and choice of providers, and where possible choice among CCOs;

(b) For providers, optimize choice in contracting with CCOs; and

(c) Allow more than one CCO to serve the geographic area if desirable to optimize access and choice under this subsection.

(5) Evaluation of CCO applications shall account for the developmental nature of the CCO system. The Authority recognizes that CCOs and partner organizations need time to develop capacity, relationships, systems, and experience to fully realize the goals envisioned by the Oregon Integrated and Coordinated Health Care Delivery System. The Authority shall thoroughly review how the application describes community involvement in the governance of the CCO and the CCO's strategic plan for developing its community health assessment and community health improvement plan:

(a) In all cases, CCOs shall have plans in place to meet the criteria laid out in these rules and the application process and to make sufficient progress in implementing plans and realizing the goals set forth in contract;
(b) Each criterion is listed followed by the elements that are addressed during the initial evaluation described in this rule without limiting the information that is requested in the RFA.
(6) Each CCO shall have a governance structure that meets the requirements of ORS 414.625. The applicant shall:
(a) Clearly describe how it meets governance structure criteria from ORS 414.625, how the governance structure makeup reflects community needs and supports the goals of health care transformation, how the criteria are used to select governance structure members, and how it assures transparency in governance;
(b) Identify key leaders who are responsible for successful implementation and sustainable operation of the CCO;
(c) Describe how its governance structure reflects the needs of members with serious and persistent mental illnesses and members receiving DHS Medicaid-funded, long-term care services and supports.
(7) Each CCO shall convene a community advisory council (CAC) that meets the requirements of ORS 414.625. The applicant shall clearly describe how it meets the requirements for selection and implementation of a CAC consistent with ORS 414.625, how the CAC is administered to achieve the goals of community involvement, and the development, adoption, and updating of the community health assessment and community health improvement plan.
(8) CCOs shall partner with their local public health authority, hospital system, type B AAA, APD field office, and local mental health authority to develop a shared community health assessment that includes a focus on health disparities in the community:
(a) Since community health assessments evolve over time as relationships develop and CCOs learn what information is most useful, initial CCO applicants may not have time to conduct a comprehensive community assessment before operating as a CCO;
(b) The applicant shall describe how it develops its health assessment, meaningfully and systematically engaging representatives of critical populations and community stakeholders and its community advisory council to create a health improvement plan for addressing community needs that builds on community resources and skills and emphasizes innovation.
(9) The CCO shall describe its strategy to adopt and implement a community health improvement plan consistent with OAR 410-141-3145.
(10) Dental care organizations: Each CCO shall have a contractual relationship with any DCO in its service area.
(11) CCOs shall have agreements in place with publicly funded providers to allow payment for point-of-contact services including immunizations, sexually transmitted diseases and other communicable diseases, family planning, and HIV/AIDS prevention services. Applicants shall confirm that these agreements have been developed unless good cause can be shown:
(a) CCOs shall also have agreements in place with the local mental health authority consistent with ORS 414.153. Applicants shall confirm that these agreements have been developed unless good cause can be shown;
(b) The Authority shall review CCO applications to ensure that statutory requirements regarding county agreements are met unless good cause is shown why an agreement is not feasible.
(12) CCOs shall provide integrated, personcentered care and services designed to provide choice, independence, and dignity. The applicant shall describe its strategy:
(a) To assure that each member receives integrated, personcentered care and services designed to provide choice, independence, and dignity;
(b) For providing members the right care at the right place and the right time and to integrate and coordinate care across the delivery system.
(13) CCOs shall develop mechanisms to monitor and protect against underutilization of services and inappropriate denials, provide access to qualified advocates, and promote education and engagement to help members be active partners in their own care. Applicants shall describe:
(a) Planned or established policies and procedures that protect member rights including access to qualified peer wellness specialists, peer-delivered services specialists, personal health navigators, and qualified community health

workers where appropriate;
(b) Planned or established mechanisms for a complaint, grievance, and appeals resolution process, including how that process shall be communicated to members and providers.
(14) CCOs shall operate in a manner that encourages patient engagement, activation, and accountability for the member's own health. Applicants shall describe how they plan to:
(a) Actively engage members in the design and, where applicable, implementation of their treatment and care plans;
(b) Ensure that member choices are reflected in the development of treatment plans, and member dignity is respected.
(15) CCOs shall assure that members have a choice of providers within the CCO's network, including providers of culturally and linguistically appropriate services and their providers participating in the CCO and shall:
(a) Work together to develop best practices for care and service delivery to reduce waste and improve health and wellbeing of all members;
(b) Be educated about the integrated approach and how to access and communicate within the integrated system about a member's treatment plan and health history;
(c) Emphasize prevention, healthy lifestyle choices, evidence-based practices, shared decision-making, and communication;
(d) Be permitted to participate in the networks of multiple CCOs;
(e) Include providers of specialty care;
(f) Be selected by the CCO using universal application and credentialing procedures, objective quality information, and are removed if the providers fail to meet objective quality standards;
(g) Establish and demonstrate compliance with 42 CFR part 438, subpart K regarding parity in mental health and substance use disorder benefits in alignment with contractual requirements;
(h) Describe how they will work with their providers to develop the partnerships necessary to allow for access to and coordination with medical, mental health and mobile crisis services, Substance Use Disorder (SUD) service providers, and dental care when the CCO includes a dental care organization, and facilitate access to community social and support services including DHS Medicaid-funded long-term care services, mental health crisis services, and culturally and linguistically appropriate services;
(i) Describe their planned or established tools for provider use to assist in the education of members about care coordination and the responsibilities of both parties in the process of communication.
(16) CCOs shall assure that each member has a consistent and stable relationship with a care team that is responsible for providing preventive and primary care and for comprehensive care management in all settings. The applicant shall demonstrate how it will support the flow of information, identify a lead provider or care team to confer with all providers responsible for a member's care, and use a standardized patient follow-up approach.
(17) CCOs shall address the supportive and therapeutic needs of each member in a holistic fashion using patientcentered primary care homes and individualized care:
(a) Applicants shall describe their model of care or other models that support patient-centered primary care, adhere to ORS 414.625 requirements regarding individualized care plans particularly for members with intensive care coordination needs, and screen for all other issues including mental health;
(b) Applicants shall describe how its implementation of individualized care plans reflects member or family and caregiver preferences and goals to ensure engagement and satisfaction.
(18) CCOs shall assure that members receive comprehensive transitional health care including appropriate followup care when entering or leaving an acute care facility or long-term care setting to include warm handoffs as appropriate based on requirements in OAR 309-032-0860 through 0870. Applicants shall:
(a) Describe their strategy for improved transitions in care so that members receive comprehensive transitional care, and members' experience of care and outcomes are improved;
(b) Demonstrate how hospitals and specialty services are accountable to achieve successful transitions of care and establish service agreements that include the role of patient-centered primary care homes;
(c) Describe their arrangements, including memorandum of understanding, with Type B Area Agencies on Aging or the

Department's offices of Aging and People with Disabilities concerning care coordination and transition strategies for members.
(19) CCOs shall provide members with assistance in navigating the health care delivery system and accessing community and social support services and statewide resources including the use of certified or qualified health care interpreters, community health workers, and personal health navigators. The applicant shall describe its planned policies for informing members about access to personal health navigators, peer wellness specialists, peer-delivered services specialists, and community health workers.
(20) Services and supports shall be geographically located as close to where members reside as possible and are, when available, offered in non-traditional settings that are accessible to families, diverse communities, and underserved populations. Applicants shall describe:
(a) Delivery system elements that respond to member needs for access to coordinated care services and supports;
(b) Planned or established policies for the delivery of coordinated health care services for members in long-term care settings;
(c) Planned or established policies for the delivery of coordinated health care services for members in residential treatment settings or long term psychiatric care settings.
(21) CCOs shall prioritize working with members who have high health care needs, multiple chronic conditions, mental illness, or Substance Use Disorder (SUD) services including members with serious and persistent mental illness covered under the state's 1915(i) State Plan Amendment. The CCO shall involve those members in accessing and managing appropriate preventive, health, remedial, and supportive care and services to reduce the use of avoidable emergency department visits and hospital admissions. The applicant shall describe how it will:
(a) Use individualized care plans to address the supportive and therapeutic needs of each member, particularly those with intensive care coordination needs;
(b) Reflect member or family and caregiver preferences and goals to ensure engagement and satisfaction.
(22) CCOs shall participate in the learning collaborative described in ORS 442.210. Applicants shall confirm their intent to participate.
(23) CCOs shall implement to the maximum extent feasible patientcentered primary care homes including developing capacity for services in settings that are accessible to families, diverse communities, and underserved populations:
(a) The applicant shall describe its plan to develop and expand capacity to use patient-centered primary care homes to ensure that members receive integrated, person-centered care and services and that members are fully informed partners in transitioning to this model of care;
(b) The applicant shall require its other health and services providers to communicate and coordinate care with patientcentered primary care homes in a timely manner using health information technology.
(24) CCOs' health care services shall focus on achieving health equity and eliminating health disparities. Applicants shall:
(a) Describe its strategy for ensuring health equity (including interpretation and cultural competence) and elimination of avoidable gaps in health care quality and outcomes, as measured by gender identity, race, ethnicity, language, disability, sexual orientation, age, mental health and addictions status, geography, and other cultural and socioeconomic factors;
(b) Engage in a process that identifies health disparities associated with race, ethnicity, language, health literacy, age, disability (including mental illness and substance use disorders), gender identity, sexual orientation, geography, or other factors through community health assessment;
(c) Collect and maintain race, ethnicity, and primary language data for all members on an ongoing basis in accordance with standards jointly established by the Authority and the Division.
(25) CCOs are required to use alternative payment methodologies consistent with ORS 414.653. The applicant shall describe its plan to implement alternative payment methods alone or in combination with delivery system changes to achieve better care, controlled costs, and better health for members. Use of alternative payment methodologies shall be reported through the All Payer All Claims (APAC) data reporting system annually as prescribed in OAR 409-025-0120 and 409-025-0130.

(26) CCOs shall use health information technology (HIT) to link services and care providers across the continuum of care to the greatest extent practicable. The applicant shall describe:
(a) Its initial and anticipated levels of electronic health record adoption and health information exchange infrastructure and capacity for collecting and sharing patient information electronically and its HIT improvement plan for meeting transformation expectations;
(b) Its plan to ensure that each network provider participates in a health information organization (HIO) or is registered with a statewide or local direct-enabled health information service provider.
(27) CCOs shall report on outcome and quality measures identified by the Authority under ORS 414.638, participate in the APAC data reporting system, and follow expectations for participation in annual TQS reporting to the Authority as detailed in the MCE contract and external quality review with the Authority contracted External Quality Review Organization as outlined in CFR 42 §438.350, §438.358, and §438.364. The applicant shall provide assurances that:
(a) It has the capacity to report and demonstrate an acceptable level of performance with respect to Authority-identified metrics;
(b) It submits APAC data in a timely manner pursuant to OAR 409-025-0130.
(28) CCOs shall be transparent in reporting progress and outcomes. Applicants shall:
(a) Describe how it assures transparency in governance;
(b) Agree to provide timely access to certain financial, outcomes, quality, and efficiency metrics that are transparent and publicly reported and available on the Internet.
(29) CCOs shall use best practices in the management of finances, contracts, claims processing, payment functions, and provider networks. The applicant shall describe:
(a) Its planned or established policies for ensuring best practices in areas identified by ORS 414.625;
(b) Whether the CCO uses a clinical advisory panel (CAP) or other means to ensure clinical best practices;
(c) Plans for an internal quality improvement committee that develops and operates under an annual quality strategy and work plan that incorporates implementation of system improvements and an internal utilization review oversight committee that monitors utilization against practice guidelines and treatment planning protocols and policies.
(30) CCOs shall demonstrate sound fiscal practices and financial solvency and shall possess and maintain resources needed to meet their obligations:
(a) Initially, the financial applicant shall submit required financial information that allows the DCBS Division of Financial Regulation on behalf of the Authority to confirm financial solvency and assess fiscal soundness;
(b) The applicant shall provide information relating to assets and financial and risk management capabilities.
(31) CCOs may provide coordinated care services within a global budget. Applicants shall submit budget cost information consistent with its proposal for providing coordinated care services within the global budget.
(32) CCOs shall operate, administer, and provide for integrated and coordinated care services within the requirements of the medical assistance program in accordance with the terms of the contract and rule. The applicant shall provide assurances about compliance with requirements applicable to the administration of the medical assistance program.
(33) CCOs shall provide covered Medicaid services other than Department of Human Services Medicaid-funded long-term care services to members who are dually eligible for Medicare and Medicaid.

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

STATUTES/OTHER IMPLEMENTED: ORS 414.610 - 414.685

AMEND: 410-141-3200

RULE TITLE: Outcome and Quality Measures

NOTICE FILED DATE: 10/11/2018

RULE SUMMARY: The Division needs to amend these rules to provide direction and clarification to the Coordinated Care Organizations and Prepaid Health Plans. Specifically, these proposed changes will address: (1) CCO financial reporting requirements; (2) CCO reporting of sub-capitated entity financial activity; (3) OHA's right to review financial records; (4) Limitations on combination of asset investments; (5) Health Related Services (HRS) reporting in Medical Loss Rations (MLR) and rate setting; (6) Changes in CCO reporting requirements for the All Payer All Claims (APAC) data reporting system.

RULE TEXT:

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

(2) The contractor shall inform the Authority if it has been accredited by a private independent accrediting entity. If the contractor has been so accredited, the contractor shall authorize the private independent accrediting entity to provide the Authority a copy of its most recent accreditation review.

(3) As required by Health System Transformation, CCOs shall be accountable for performance on outcomes, quality, and efficiency measures incorporated into the CCO's contract with the Authority. The measures are adopted by the Metrics and Scoring Committee using a public process. Information can be requested from the Authority or viewed online at http://www.oregon.gov/oha/HPA/ANALYTICS/Pages/Metrics-Scoring-Committee.aspx.

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

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

(a) Detect both underutilization and overutilization of services;

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

(c) Evaluate grievance, appeals, and contested case hearings consistent with OAR 410-141-3245 through 410-141-3248; and

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

(6) CCOs shall implement policies and procedures that assure it collects timely data including health disparities and other data required by rule or contract that allows the CCO to conduct and report on its outcome and quality measures and report its performance. CCOs shall submit to the Authority the CCO's annual written evaluation of outcome and quality measures established for the CCO or other reports as the Authority may require in response to the measures adopted by the Metrics and Scoring Committee.

(7) CCOs shall adopt practice guidelines consistent with 42 CFR 438.236 and the CCO contract that addresses assigned contractual responsibilities for physical health care, behavioral healthcare, or oral health care; goals to increase care

coordination with other MCEs, the state, or other providers as outlined in OAR 410-141-0160 and 410-141-3160; and concerns identified by members or their representatives and to implement changes that have a favorable impact on health outcomes and member satisfaction in consultation with its community advisory council or clinical review panel.
(8) CCOs shall be accountable for both core and transformational measures of quality and outcomes:
(a) Core measures will be triple-aim oriented measures that gauge CCO performance against key expectations for care coordination, consumer satisfaction, quality, and outcomes. The measures shall be uniform across CCOs and shall encompass the range of services included in CCO global budgets (e.g., behavioral health, hospital care, women's health) or MHO and DCO contracts;
(b) Transformational metrics shall assess CCO progress toward the broad goals of health systems transformation. This subset may include newer kinds of indicators (for which CCOs have less measurement experience) or indicators that entail collaboration with other care partners.
(9) CCOs shall provide the required data to the All Payer All Claims data system established in ORS 442.464 and 442.466 and the CCO agreement in the manner authorized by OAR 409-025-0130.

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

STATUTES/OTHER IMPLEMENTED: ORS 414.610 - 414.685

AMEND: 410-141-3345

RULE TITLE: General Financial Reporting and Financial Solvency Matters; CCO Reporting Method

NOTICE FILED DATE: 10/11/2018

RULE SUMMARY: The Division needs to amend these rules to provide direction and clarification to the Coordinated Care Organizations and Prepaid Health Plans. Specifically, these proposed changes will address: (1) CCO financial reporting requirements; (2) CCO reporting of sub-capitated entity financial activity; (3) OHA's right to review financial records; (4) Limitations on combination of asset investments; (5) Health Related Services (HRS) reporting in Medical Loss Rations (MLR) and rate setting; (6) Changes in CCO reporting requirements for the All Payer All Claims (APAC) data reporting system.

RULE TEXT:

(1) Each MCE must demonstrate that it is able to provide coordinated care services efficiently, effectively, and economically. MCEs shall maintain sound financial management procedures, maintain protections against insolvency, and generate periodic financial reports as provided in these rules.

(2) The Authority shall collaborate with the Department of Consumer and Business Services (DCBS) to review MCE financial reports and evaluate financial solvency. MCEs are not required to file financial reports with both the Authority and DCBS except as provided in this section or as outlined in the MCE contract:

(a) Initial applicants for certification as an MCE shall submit all required information to the Authority as part of the application process, and the Authority shall transmit that information to DCBS for its review. In making its determination about the qualifications of the applicant, the Authority shall consult with DCBS about the financial materials and reports submitted with the application;

(b) For purposes of these financial reporting and solvency rules, DCBS is authorized to make recommendations to the Authority and to act in conjunction with the Authority in accordance with these rules. If quarterly reports or other evidence suggest that an MCE's financial solvency is in jeopardy, the Authority shall act as necessary to protect the public interest.

(3) The Authority may address any proper inquiries to any MCE or its officers in relation to the activities or condition of the MCE or any other matter connected with its transactions. The person shall promptly and truthfully reply to the inquiries using the form of communication requested by the Authority. The reply shall be timely, accurate, and complete and, if the Authority requires, verified by an officer of the MCE. A reply is subject to the provisions of ORS 731.260.

(4) MCEs shall follow reporting and documentation requirements found in OAR 410-141-0340 MCE Financial Solvency.

(5) OAR 410-141-3345 through 410-141-3395 provide for three alternative methods for an MCE's solvency plan and financial reporting requirements, depending on the status of the CCO as described in this rule:

(a) The Authority reporting MCE: The CCO complies with restricted reserve and net worth requirements the Authority used to regulate financial solvency of MCEs on July 1, 2012, submitting financial information and reports to the Authority as detailed in the MCE contract. Under this approach, the Authority shall monitor the MCE's financial solvency utilizing the same reporting format and financial standards that the Authority used for MCEs on July 1, 2012;

(b) DCBS reporting MCE: The MCE complies with financial requirements as detailed in the MCE contract and in OAR 410-141-3345 through 410-141-3395, including risk-based capital and NAIC reporting requirements. These requirements shall be monitored by DCBS;

(c) Certificate of Authority: The MCE has a certificate of authority and complies with financial reporting and solvency requirements applicable to licensed health entities pursuant to applicable DCBS requirements under the Oregon insurance code and DCBS rules. In addition, the MCE shall report to the Authority the schedules outlined in the MCE contract.

(6) MCE Status. The method described in this rule that applies to an MCE is determined as follows:

(a) If the MCE is a licensed health entity, the MCE shall use the method described in this rule for certificate of authority. The MCE shall submit a copy of its certificate of authority to the Authority not later than the readiness review document submission date under the initial MCE contract and annually thereafter, not later than August 31. The MCE

shall report to the Authority immediately at any time that this certificate of authority is suspended or terminated;
(b) If the MCE is neither a converting MCO nor a licensed health entity, the MCE shall use the method described in this rule for DCBS reporting MCE;
(c) If the MCE is a converting MCO and is not a licensed health entity, the MCE shall elect either the method described in this rule for the Authority reporting MCE or the method described in this rule for DCBS reporting MCE. The MCE shall notify the Authority of its election no later than the readiness review document submission date under the initial MCE contract. The MCE shall comply with the requirements applicable to its elected method until it notifies the Authority of its intent to change its election. If the MCE expects to change its election, any elements of the solvency plan, or solvency protection arrangements, the MCE shall provide written advance notice to the Authority at least 90-calendar days before the proposed effective date of change. Such changes are subject to written approval from the Authority.
(7) MCE may be required to use specific required reporting forms or items in order to supply information related to financial responsibility, financial solvency, and financial management. The Authority or DCBS, as applicable, shall provide supplemental instructions about the use of these forms.
(8) The standards established in OAR 410-141-3350 through 410-141-3395 are intended to be consistent with and may utilize procedures and standards common to insurers and to DCBS in its administration of financial reporting and solvency requirements. Any reference in these rules to the insurance code or to rules adopted by DCBS under the insurance code may not be deemed to require an MCE to be an insurer but is adopted and incorporated by reference as the Authority standard.

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

STATUTES/OTHER IMPLEMENTED: ORS 414.610 - 414.685