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OREGON HEALTH AUTHORITY
HEALTH SYSTEMS DIVISION: MEDICAL ASSISTANCE PROGRAMS

FILING CAPTION: Repeal of Current Rules 3355-4120 Governing Coordinated Care Organizations (CCOs)

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RULES:
410-141-3355, 410-141-3360, 410-141-3365, 410-141-3370, 410-141-3375, 410-141-3380, 410-141-3385, 410-141-3390, 410-141-3395, 410-141-3420, 410-141-3430, 410-141-3435, 410-141-3440, 410-141-3445, 410-141-3450, 410-141-3455, 410-141-3460, 410-141-3465, 410-141-3470, 410-141-3475, 410-141-3480, 410-141-3485, 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

REPEAL: 410-141-3355

RULE TITLE: Restricted Reserves, Capital and Surplus– DCBS Reporting CCOs Only

NOTICE FILED DATE: 09/16/2019

RULE SUMMARY: The agency has completed an exhaustive review and revision of all rules within Chapter 410 Division 141. As part of this process, OHA is renumbering rules within the Chapter and Division. Therefore, all existing rules need to be repealed to avoid redundant or conflicting rules in the oversight of the State's Coordinated Care Organizations (CCOs).

RULE TEXT:
(1) The provisions of OAR 410-141-3355 apply only to DCBS reporting CCOs, and do not apply to Authority reporting CCOs.
(2) A CCO shall:
(a) Establish a restricted reserve account; and
(b) Maintain adequate funds in this account to meet the Authority's primary and secondary restricted reserve requirements. Reserve funds are held for the purpose of making payments to providers in the event of the CCO's insolvency.
(3) A CCO shall establish a restricted reserve account with a third party financial institution for the purpose of holding the CCO's primary and secondary restricted reserve funds. CCOs shall use the model depository agreement to establish a restricted reserve account;
(a) A model depository agreement shall be used by the CCO to establish a restricted reserve account. CCOs shall request the model depository agreement form from the Authority. CCOs shall submit the model depository agreement

to the Authority at the time of application and the model depository agreement shall remain in effect throughout the period of time that the CCO contract is in effect. The model depository agreement cannot be changed without the Authority's written authorization;
(b) The CCO shall not withdraw funds, change third party financial institutions, or change account numbers within the restricted reserve account without the written consent of the Authority;
(c) A CCO shall submit a copy of the model depository agreement at the time of application for certification. If a CCO requests and receives written authorization from the Authority to make a change to their existing restricted reserve account, the CCO shall submit a model depository agreement reflecting the changes to the Authority within 15 days of the date of the change;
(d) The following instruments are considered eligible deposits for the purposes of the Authority's primary and secondary restricted reserves:
(A) Cash;
(B) Certificates of Deposit; or
(C) Amply secured obligations of the United States, a state or a political subdivision thereof as determined by the Authority.
(e) In addition to the instruments allowed in this rule, a CCO may satisfy the primary restricted reserve amount by a surety bond that meets the requirements listed below:
(A) The bond is prepaid at the beginning of the contract year for 18 months;
(B) Evidence of prepayment is provided to the Authority;
(C) The surety bond is purchased by a surety bond company approved by the Oregon Insurance Division;
(D) The surety bond agreement contains a clause stating the payment of the bond will be made to the third party entity holding the restricted reserve account on behalf of the contracting company for deposit into the restricted reserve account;
(E) The surety bond agreement contains a clause that no changes to the surety bond agreement will occur until approved by the Authority; and
(F) The Authority approves the terms of the surety bond agreement.
(4) A CCO's primary and secondary reserve balances are determined by calculating the average monthly medical expense incurred. A CCO that has submitted quarterly financial statements for the current quarter and the prior three quarters, the average monthly medical expense incurred is derived by adding together the "total hospital and medical" expense (NAIC statement of revenue and expenses) for the prior four quarters and dividing by 12. A newly formed CCO will use an average of hospital and medical expense projected for the first four quarters of operation. Each quarter the average expense liability will be recalculated using historical quarter data available. The amount a CCO must deposit into the restricted reserve account shall be:
(a) If a CCO's average monthly medical expense incurred is less than or equal to $250,000, an amount equal to the average monthly medical expense incurred. This amount will be referred to as the CCO's primary reserve and the CCO shall have no secondary reserve, until such time as the average monthly medical expense exceeds $250,000;
(b) If a CCO's average monthly medical expense is greater than $250,000, funds equaling 50 percent of the difference between the average monthly medical expense and the primary reserve balance of $250,000. This amount will be referred to as the CCO's secondary reserve;
(c) Adjusted each quarter after the CCO calculates its average monthly medical expense each quarter.
(5) Working capital or surplus requirements:
(a) As used in this section, "net healthcare revenue" means direct healthcare premium less the following: amounts paid for reinsurance ceded, HRA and GME payments (if any received by a CCO), and MCO taxes. "Net healthcare revenue" includes all healthcare related revenue and fee-for-service revenue adjusted for the change in unearned premium reserves;
(b) Except as provided in Section (8) CCOs shall possess and thereafter maintain capital or surplus, or any combination thereof, equal to the greater of $2.5 million or the amount required from the application of the risk-based capital

standards in OAR 410-141-3360;
(c) A CCO that possesses the amount required in this rule as of the effective date of this rule must thereafter maintain that capital and surplus;
(d) Except as provided in Section (8), if a CCO does not possess the minimum capital and surplus as of the effective date of these rules, the CCO shall possess and thereafter maintain capital or surplus, or any combination thereof as follows:
(A) Five percent of annualized total net healthcare revenue as of August 1, 2012. The CCO shall calculate its authorized control level and file the RBC report in accordance with these rules;
(B) The greater of five percent annualized total net healthcare revenue or its authorized control level risk-based capital as of January 1, 2014;
(C) The greater of six percent of annualized total net healthcare revenue or 125 percent of its authorized control level risk-based capital as of January 1, 2015;
(D) The greater of seven percent of annualized total net healthcare revenue or 150 percent of its authorized control level risk-based capital as of January 1, 2016;
(E) The greater of eight percent of annualized total net healthcare revenue or 175 percent of its authorized control level risk-based capital as of January 1, 2017;
(F) The greater of nine percent of annualized total net healthcare revenue or 200 percent of its authorized control level risk-based capital as of January 1, 2018;
(G) The greater of 10 percent of annualized total net healthcare revenue or 200 percent of its authorized control level risk-based capital as of January 1, 2019.
(e) A CCO may use a subordinated surplus note to meet its minimum capital and surplus requirement provided it meets the standards in Statements of Statutory Accounting Principles #41 and the Authority has given prior approval of the form and content of the surplus note;
(f) A converting CCO will initially be subject to financial responsibility and solvency standards applicable to the Authority reporting CCO. Effective January 1, 2014, the converting CCO shall comply with the minimum capital and surplus set forth in this rule;
(g) The converting CCO shall calculate its authorized control level and file the RBC report in accordance with this rule.
(6) Funds of a CCO at least equal to its required capital and surplus shall be invested and kept invested as follows:
(a) In amply secured obligations of the United States, a state or a political subdivision of this state;
(b) In loans secured by first liens upon improved, unencumbered real property (other than leaseholds) in this state where:
(A) The lien does not exceed 50 percent of the appraised value of the property and the loan is for a term of five years or less;
(B) The lien does not exceed 66-2/3 percent of the appraised value of the property provided there is an amortization plan mortgage, deed of trust or other instrument under the terms of which the installment payments are sufficient to repay the loan within a period of not more than 25 years; or
(C) The investment is insured or guaranteed by the Federal Housing Administration, the United States Department of Veterans Affairs, or under Title I of the Housing Act of 1949 (providing for slum clearance and redevelopment projects) enacted by Congress on July 15, 1949.
(c) In deposits, certificates of deposit, accounts or savings or certificate shares or accounts of or in banks, trust companies, savings and loan associations or building and loan associations to the extent such investments are insured by the Federal Deposit Insurance Corporation.
(7) Investments made pursuant to Section (6) of this rule shall be kept free of any lien or pledge.
(8) A CCO that is not a converting CCO shall possess $500,000 working capital above the minimum capital and surplus requirement upon the CCO contract date sufficient to pay initial expenses without causing the CCO to fall below the minimum capital and surplus required by these rules.

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

STATUTES/OTHER IMPLEMENTED: ORS 414.610 - 414.685

REPEAL: 410-141-3360

RULE TITLE: Risk-based capital — DCBS Reporting CCOs Only

NOTICE FILED DATE: 09/16/2019

RULE SUMMARY: The agency has completed an exhaustive review and revision of all rules within Chapter 410 Division 141. As part of this process, OHA is renumbering rules within the Chapter and Division. Therefore, all existing rules need to be repealed to avoid redundant or conflicting rules in the oversight of the State's Coordinated Care Organizations (CCOs).

RULE TEXT:

(1) The provisions of OAR 410-141-3360 shall apply only to DCBS reporting CCOs, and do not apply to OHA reporting CCOs.

(2) As used in this rule:

(a) "Authorized Control Level RBC" means the number determined under the risk-based capital formula in accordance with the RBC Instructions;

(b) "Company Action Level RBC" means, with respect to any CCO, the product of 2.0 and the CCO's Authorized Control Level RBC;

(c) "Mandatory Control Level RBC" means the product of .70 and the CCO's authorized control level RBC;

(d) "RBC Instructions" means the RBC report including risk-based capital instructions adopted by the NAIC, as the RBC instructions may be amended by the NAIC from time to time in accordance with the procedures adopted by the NAIC;

(e) "RBC Level" means a CCO's company action level RBC, regulatory action level RBC, authorized control level RBC or mandatory control level RBC;

(f) "RBC Plan" means a comprehensive financial plan containing the elements specified in this rule. If OHA rejects the RBC plan and it is revised by the CCO with or without OHA's recommendation, the plan shall be called the "revised RBC plan;"

(g) "RBC Report" means the report required in OAR 410-141-3360;

(h) "Regulatory Action Level RBC" means the product of 1.5 and the CCO's authorized control level RBC;

(i) "Total Adjusted Capital" means the sum of:

(A) A CCO's capital and surplus (i.e. net worth) as determined in accordance with the statutory accounting applicable to the annual financial statements required to be filed under these rules; and

(B) Such other items, if any, as the RBC instructions may provide.

(3) For the purpose of determining the reasonableness and adequacy of a CCO's capital and surplus, the Oregon Health Authority must consider at least the following factors, as applicable:

(a) The size of the CCO, as measured by its assets, capital and surplus, reserves, premium writings, insurance in force and other appropriate criteria;

(b) The number of lives insured;

(c) The extent of the geographical dispersion of the lives insured by the CCO;

(d) The nature and extent of the reinsurance program of the CCO;

(e) The quality, diversification and liquidity of the investment portfolio of the CCO;

(f) The recent past and projected future trend in the size of the investment portfolio of the CCO;

(g) The combined capital and surplus maintained by comparable CCOs;

(h) The adequacy of the reserves of the CCO;

(i) The quality and liquidity of investments in affiliates. OHA may treat any such investment as a disallowed asset for purposes of determining the adequacy of combined capital and surplus whenever in the judgment of OHA the investment so warrants; and

(j) The quality of the earnings of the CCO and the extent to which the reported earnings include extraordinary items.

(4) The following pertain to a CCO's RBC levels:

(a) On or before March 1 of each year, a CCO shall prepare and submit to OHA a report of its RBC levels as of the end of

the calendar year just ended, in a form and containing such information as is required by the RBC instructions. In addition, a CCO shall file its RBC report with the NAIC in accordance with the RBC instructions. The CCO shall report in its annual financial statement the authorized control level calculated using its RBC report. A CCO's RBC report will be considered confidential under OAR 410-141-3390;
(b) A CCO's RBC shall be determined in accordance with the formula set forth in the RBC instructions. The formula shall take the following into account (and may adjust for the covariance between) determined in each case by applying the factors in the manner set forth in the RBC instructions:
(A) Asset risk;
(B) Credit risk;
(C) Underwriting risk; and
(D) All other business risks and such other relevant risks as are set forth in the RBC instructions.
(c) An excess of capital (i.e. net worth) over the amount produced by the risk-based capital requirements contained in this rule and the formulas, schedules and instructions referenced in this rule is desirable in the business of a CCO. Accordingly, CCOs should seek to maintain capital above the RBC levels required by this rule. Additional capital is used and useful in the business of a risk-bearing entity and helps to secure a CCO against various risks inherent in, or affecting, the business of a CCO and not accounted for or only partially measured by the risk-based capital requirements contained in this rule;
(d) If a CCO files an RBC report that in the judgment of OHA is inaccurate, then OHA shall adjust the RBC report to correct the inaccuracy and shall notify the CCO of the adjustment. The notice shall contain a statement of the reason for the adjustment. An RBC report as so adjusted is referred to as an "adjusted RBC report."
(5) "Company Action Level Event" means any of the following events:
(a) The filing of an RBC report by a CCO that indicates that the CCO's total adjusted capital is greater than or equal to its regulatory action level RBC but less than its company action level RBC;
(b) If a CCO has total adjusted capital that is greater than or equal to its company action level RBC but less than the product of its authorized control level RBC and 3.0 and triggers the trend test determined in accordance with the trend test calculation included in the health RBC instructions;
(c) Notification by OHA to the CCO of an adjusted RBC report that indicates an event in Section 15 of this section, if the CCO does not challenge the adjusted RBC report in this rule; or
(d) If a CCO challenges an adjusted RBC report that indicates the event in Section (5)(a), the notification by OHA to the CCO that OHA has, after a hearing, rejected the CCO's challenge.
(6) In the event of a company action level event, the CCO shall prepare and submit to OHA an RBC plan that shall:
(a) Identify the conditions that contribute to the company action level event;
(b) Contain proposals of corrective actions that the CCO intends to take and that would be expected to result in the elimination of the company action level event;
(c) Provide projections of the CCO's financial results in the current year and at least the two succeeding years, both in the absence of proposed corrective actions and giving effect to the proposed corrective actions, including projections of statutory balance sheets, operating income, net income, capital and surplus, and RBC levels. The projections for both new and renewal business might include separate projections for each major line of business and separately identify each significant income, expense and benefit component;
(d) Identify the key assumptions impacting the CCO's projections and the sensitivity of the projections to the assumptions; and
(e) Identify the quality of, and problems associated with, the CCO's business, including but not limited to its assets, anticipated business growth and associated surplus strain, extraordinary exposure to risk, mix of business and use of reinsurance, if any, in each case.
(7) The RBC plan shall be submitted:
(a) Within 45 days of the Company Action Level Event; or
(b) Within 45 days after notification to the CCO that OHA has, after a hearing, rejected the CCO's challenge, if the CCO

challenges an adjusted RBC report;
(c) Within 60 days after the submission by a CCO of an RBC plan to OHA, OHA shall notify the CCO whether the RBC plan shall be implemented or is, in the judgment of OHA, unsatisfactory. If OHA determines the RBC plan is unsatisfactory, the notification to the CCO shall set forth the reasons for the determination and may set forth proposed revisions that will render the RBC plan satisfactory, in the judgment of OHA. Upon notification from OHA, the CCO shall prepare a revised RBC plan, which may incorporate by reference any revisions proposed by OHA, and shall submit the revised RBC plan to OHA:
(A) Within 45 days after the notification from OHA; or
(B) Within 45 days after a notification to the CCO that OHA has, after a hearing, rejected the CCO's challenge, if the CCO challenges the notification from OHA under this rule.
(8) In the event of a notification by OHA to a CCO that the CCO's RBC plan or revised RBC plan is unsatisfactory, OHA may at OHA's discretion, subject to the CCO's right to a hearing under this rule, specify in the notification that the notification constitutes a regulatory action level event.
(9)"Regulatory Action Level Event" means, with respect to a CCO, any of the following events:
(a) The filing of an RBC report by the CCO that indicates that the CCO's total adjusted capital is greater than or equal to its authorized control level RBC but less than its regulatory action level RBC;
(b) Notification by OHA to a CCO of an adjusted RBC report that indicates the event in Section (9)(a), if the CCO does not challenge the adjusted RBC report in this rule;
(c) If the CCO challenges an adjusted RBC report that indicates the event in this rule, the notification by OHA to the CCO that OHA has, after a hearing, rejected the CCO's challenge;
(d) The failure of the CCO to file an RBC report by the filing date, unless the CCO has provided an explanation for the failure that is satisfactory to OHA and has cured the failure within ten days after the filing date;
(e) The failure of the CCO to submit an RBC plan to OHA within the time period set forth in this rule;
(f) Notification by OHA to the CCO that:
(A) The RBC plan or revised RBC plan submitted by the CCO is, in the judgment of OHA, unsatisfactory; and
(B) Notification constitutes a regulatory action level event with respect to the CCO, if the CCO has not challenged the determination in this rule.
(g) If the CCO challenges a determination by OHA, the notification by OHA to the CCO that OHA has, after a hearing, rejected the challenge;
(h) Notification by OHA to the CCO that the CCO has failed to adhere to its RBC plan or revised RBC plan, but only if the failure has a substantial adverse effect on the ability of the CCO to eliminate the company action level event in accordance with its RBC plan or revised RBC plan and OHA has so stated in the notification, if the CCO has not challenged the determination; or
(i) If the CCO challenges a determination by OHA, the notification by OHA to the CCO that OHA has, after a hearing, rejected the challenge.
(10) In the event of a regulatory action level event OHA shall:
(a) Require the CCO to prepare and submit an RBC plan or, if applicable, a revised RBC plan;
(b) Perform such examination or analysis as OHA deems necessary of the assets, liabilities and operations of the CCO including a review of its RBC plan or revised RBC plan; and
(c) Subsequent to the examination or analysis, issue an order specifying such corrective actions as OHA shall determine are required (a "corrective order").
(11) In determining corrective actions, OHA may take into account factors OHA deems relevant with respect to the CCO based upon OHA's examination or analysis of the assets, liabilities and operations of the CCO, including, but not limited to, the results of any sensitivity tests undertaken pursuant to the RBC instructions. The RBC plan or revised RBC plan shall be submitted:
(a) Within 45 days after the occurrence of the regulatory action level event;
(b) Within 45 days after the notification to the CCO that OHA has, after a hearing, rejected the CCO's challenge; if the

CCO challenges an adjusted RBC report, and the challenge is not frivolous in the judgment of OHA; or
(c) Within 45 days after the notification to the CCO that the care service CCO has, after a hearing, rejected the CCO's challenge, if the CCO challenges a revised RBC plan, and the challenge is not frivolous in the judgment of OHA.
(12) OHA may retain actuaries and investment experts and other consultants as may be necessary in the judgment of OHA to review the CCO's RBC plan or revised RBC plan, examine or analyze the assets, liabilities and operations (including contractual relationships) of the CCO and formulate the corrective order with respect to the CCO. The fees, costs and expenses relating to consultants shall be borne by the affected CCO or such other party as directed by OHA.
(13) "Authorized Control Level Event" means any of the following events:
(a) The filing of an RBC report by the CCO that indicates that the CCO's total adjusted capital is greater than or equal to its mandatory control level RBC but less than its authorized control level RBC;
(b) The notification by OHA to the CCO of an adjusted RBC report that indicates the event in this section, if the CCO does not challenge the adjusted RBC report;
(c) If the CCO challenges an adjusted RBC report that indicates the event in this section, notification by OHA to the CCO that OHA has, after a hearing, rejected the CCO's challenge;
(d) The failure of the CCO to respond, in a manner satisfactory to OHA, to a corrective order if the CCO has not challenged the corrective order; or
(e) If the CCO has challenged a corrective order in this rule and OHA has, after a hearing, rejected the challenge or modified the corrective order, the failure of the CCO to respond, in a manner satisfactory to OHA, to the corrective order subsequent to rejection or modification by OHA.
(14) In the event of an authorized control level event with respect to a CCO, OHA shall:
(a) Take such actions as are required by this rule regarding a CCO with respect to which an regulatory action level event has occurred; or
(b) If OHA deems it to be in the best interests of the members and creditors of the CCO and of the public, take such actions as are necessary to work with the Authority, which may terminate the CCO contract and revoke or suspend its certification as a CCO.
(15)"Mandatory Control Level Event" means any of the following events:
(a) The filing of an RBC report that indicates that the CCO's total adjusted capital is less than its mandatory control level RBC;
(b) Notification by OHA to the CCO of an adjusted RBC report that indicates the event in this section, if the CCO does not challenge the adjusted RBC report; or
(c) If the CCO challenges an adjusted RBC report that indicates the event in this section, notification by OHA to the CCO that OHA has, after a hearing, rejected the CCO's challenge.
(16) In the event of a mandatory control level event, OHA shall take such actions as are necessary to work with the Authority, which may to terminate the CCO contract and revoke or suspend its certification as a CCO. Notwithstanding the provisions of this rule, OHA may forego action for up to 90 days after the mandatory control level event if OHA finds there is a reasonable expectation that the mandatory control level event may be eliminated within the 90 day period.
(17) Upon the occurrence of any of the following events, a CCO may request a hearing for the purpose of challenging any determination or action by OHA in connection with any event described in this rule. The CCO shall notify OHA of its request for a hearing not later than the fifth day after notification by OHA under any of the events described in this rule. Upon receipt of the CCO's request for a hearing, OHA shall set a date for the hearing. The date shall be not less than 10 or more than 30 days after the date of the CCO's request. The events to which the opportunity for a hearing under this rule relates are as follows:
(a) Notification to a CCO by OHA of an adjusted RBC report;
(b) Notification to a CCO by OHA that:
(A) The CCO's RBC plan or revised RBC plan is unsatisfactory; and
(B) Notification constitutes a Regulatory Action Level Event with respect to the CCO.

(c) Notification to a CCO by OHA that the CCO has failed to adhere to its RBC plan or revised RBC plan and that the failure has a substantial adverse effect on the ability of the CCO to eliminate the company action level event with respect to the CCO in accordance with its RBC plan or revised RBC plan; or
(d) Notification to a CCO by OHA of a corrective order with respect to the CCO.
(18) OHA may keep confidential a CCO's RBC plan or the results or report of any examination or analysis conducted in this rule if OHA determines that disclosure of such information would jeopardize the CCO's corrective action plan.
(19) This rule shall not preclude or limit any other powers or duties of OHA or OHA under other laws and rules.

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

STATUTES/OTHER IMPLEMENTED: ORS 414.610 - 414.685

REPEAL: 410-141-3365

RULE TITLE: Financial Reporting– DCBS Reporting CCOs Only

NOTICE FILED DATE: 09/16/2019

RULE SUMMARY: The agency has completed an exhaustive review and revision of all rules within Chapter 410 Division 141. As part of this process, OHA is renumbering rules within the Chapter and Division. Therefore, all existing rules need to be repealed to avoid redundant or conflicting rules in the oversight of the State's Coordinated Care Organizations (CCOs).

RULE TEXT:

(1) The provisions of OAR 410-141-3365 shall apply only to DCBS reporting CCOs and do not apply to OHA reporting CCOs.

(2) Every CCO shall file with DCBS, on or before March 1 of each year, a financial statement for the year ending December 31 immediately preceding. The CCO shall also file with DCBS, on or before May 15, August 15, and November 15 of each year, quarterly financial statements for the quarter ending March 31, June 30 and September 30, respectively. All financial statements shall be completed in accordance with NAIC annual statement instructions. OHA may also require additional filings as OHA determines necessary.

(3) The financial statement filed by a CCO under this rule shall be verified by the oaths of the president and secretary of the CCO or, in their absence, by two other principal officers.

(4) Each CCO shall have an annual audit conducted by an independent certified public accountant and shall file an audited financial report annually with DCBS. The annual audited financial report shall be in the form required of insurers by the insurance code, specifically ORS 731.488 and OAR 836-011-0100 through 836-011-0220.

STATUTORY/OTHER AUTHORITY: ORS 414.032, 414.615, 414.625, 414.635, 414.651

STATUTES/OTHER IMPLEMENTED: ORS 414.610 – 685 2011 OL Ch. 602 Sec. 13, 14, 16, 17, 62, 64(2), 65, HB 3650

REPEAL: 410-141-3370

RULE TITLE: Solvency Monitoring and Corrective Actions

NOTICE FILED DATE: 09/16/2019

RULE SUMMARY: The agency has completed an exhaustive review and revision of all rules within Chapter 410 Division 141. As part of this process, OHA is renumbering rules within the Chapter and Division. Therefore, all existing rules need to be repealed to avoid redundant or conflicting rules in the oversight of the State's Coordinated Care Organizations (CCOs).

RULE TEXT:

(1) For purposes of this rule, the CCO shall be monitored in the context of the financial standards applicable to the reporting method described in OAR 410-141-3345. An OHA reporting CCO is accountable under the standards in the CCO contract and this rule. A DCBS reporting CCO or a CCO with a certificate of authority is accountable under DCBS standards.

(2) OHA shall examine every CCO, including an audit of the financial affairs of such CCO, as often as OHA determines an examination to be necessary but generally at least once during the CCO's certification period. An examination shall be conducted for the purpose of determining the financial condition of the CCO, its ability to fulfill its obligations and its manner of fulfillment, the nature of its operations and its compliance with these rules and applicable CCO contract requirements.

(3) The following apply to CCO examinations:

(a) When OHA determines that an examination should be conducted, OHA shall appoint one or more examiners to perform the examination and instruct them as to the scope of the examination. In conducting the examination, each examiner shall consider the guidelines and procedures in the examiner handbook, or its successor publication, adopted by the NAIC. OHA may prescribe the examiner handbook or its successor publication and employ other guidelines and procedures that OHA determines to be appropriate, taking into account whether the CCO is an OHA reporting CCO, is a DCBS reporting CCO, or has a certificate of authority;

(b) When making an examination, OHA may retain appraisers, independent actuaries, independent certified public accountants or other professionals and specialists as needed. The cost of retaining such professionals and specialists shall be borne by the CCO that is the subject of the examination;

(c) At any time during the course of an examination, OHA may take other action pursuant to these rules;

(d) Facts determined and conclusions made pursuant to an examination shall be presumptive evidence of the relevant facts and conclusions in any judicial or administrative action;

(e) Upon an examination or investigation OHA may examine under oath all persons who may have material information regarding the property or business of the person being examined or investigated;

(f) Every person being examined or investigated shall produce all books, records, accounts, papers, documents and computer and other recordings in its possession or control relating to the matter under examination or investigation, including, in the case of an examination, the property, assets, business and affairs of the person; and

(g) The officers, directors and agents of the person being examined shall provide timely, convenient and free access at all reasonable hours at the offices of the person being examined to all books, records, accounts, papers, documents and computer and other recordings. The officers, directors, employees and agents of the person must facilitate the examination.

(4) The following apply to the Authority's report following the examination:

(a) Not later than the 60th day after completion of an examination, the examiner in charge of the examination shall submit to OHA a full and true report of the examination, verified by the oath of the examiner. The report shall comprise only facts appearing upon the books, papers, records, accounts, documents or computer and other recordings of the person, its agents or other persons being examined or facts ascertained from testimony of individuals concerning the affairs of such person, together with such conclusions and recommendations as reasonably may be warranted from such facts;

(b) OHA shall make a copy of the report submitted under this section available to the person who is the subject of the examination and shall give the person an opportunity to review and comment on the report. OHA may request additional information or meet with the person for the purpose of resolving questions or obtaining additional information, and may direct the examiner to consider the additional information for inclusion in the report;
(c) Before OHA files the examination report as a final examination report or makes the report or any matters relating thereto public, the person being examined shall have an opportunity for a hearing. A copy of the report must be mailed by certified mail to the person being examined. The person may request a hearing not later than the 30th day after the date on which the report was mailed. This subsection does not limit the authority of OHA to disclose a preliminary or final examination report as otherwise provided in this section, or to CMS or other federal or state authorities authorized to obtain access to CCO financial records in accordance with the CCO contract;
(d) OHA shall consider comments presented at a hearing requested under paragraph (c) of this section and may direct the examiner to consider the comments or direct that the comments be included in documentation relating to the report, although not as part of the report itself. OHA may file the report as a final examination report at any time after consideration of the comments or at any time after the period for requesting a hearing has passed if a hearing is not requested;
(e) A report filed as a final examination report is subject to public inspection. OHA, after filing any report, if OHA considers it for the interest of the public to do so, may publish any report or the result of any examination as contained therein in one or more newspapers of the state without expense to the person examined; and
(f) OHA may disclose the content of an examination report that has not yet otherwise been disclosed or may disclose any of the materials described in this section as provided in OAR 410-141-3390.
(5) No cause of action may arise and no liability may be imposed against OHA or DCBS, an authorized representative of OHA or DCBS or any examiner appointed by OHA or DCBS for any statements made or conduct performed in good faith pursuant to an examination or investigation. No cause of action may arise and no liability may be imposed against any person for communicating or delivering information or data to OHA or an authorized representative of OHA or examiner pursuant to an examination or investigation if the communication or delivery was performed in good faith and without fraudulent intent or intent to deceive.
(6) Section (5) does not abrogate or modify in any way any common law or statutory privilege or immunity otherwise enjoyed by any person to which this subsection applies.
(7) Any CCO or applicant for CCO certification examined under this rule shall pay to OHA the just and legitimate costs of the examination as determined by OHA, including actual necessary transportation and traveling expenses.
(8) In addition to other powers of OHA under these rules relating to the examination and investigation of CCOs, OHA may also order any CCO to produce such books, records, accounts, papers, documents and computer and other recordings in the possession of the CCO or its affiliates as are necessary to ascertain the financial condition of the CCO or to determine compliance with these rules. If the CCO fails to comply with such an order, OHA may examine the affiliates to obtain such information, in addition to imposing sanctions or other remedies under these OHA rules or the CCO contract. A CCO shall pay the costs of an examination of the CCO.

STATUTORY/OTHER AUTHORITY: 414.625, 414.635, 414.651, ORS 414.032, 414.615

STATUTES/OTHER IMPLEMENTED: ORS 414.610 – 414.685, 2011 OL Ch. 602 Sec. 13, 14, 16, 17, 62, 64(2), 65, HB 3650

REPEAL: 410-141-3375

RULE TITLE: Hazardous Operations

NOTICE FILED DATE: 09/16/2019

RULE SUMMARY: The agency has completed an exhaustive review and revision of all rules within Chapter 410 Division 141. As part of this process, OHA is renumbering rules within the Chapter and Division. Therefore, all existing rules need to be repealed to avoid redundant or conflicting rules in the oversight of the State's Coordinated Care Organizations (CCOs).

RULE TEXT:

(1) For purposes of this rule, the CCO will be held financially responsible in the context of the financial standards applicable to the reporting method described in OAR 410-141-3345. An OHA reporting CCO is accountable under the standards in the CCO contract and this rule. A DCBS reporting CCO or a CCO with a certificate of authority is accountable under the DCBS standards:

(a) Based upon standards established by these rules, if OHA determines that the continued operation of a CCO is hazardous to its members or to the public in general, OHA may order the CCO to take one or more of the following actions:

(A) Reduce the total amount of present and potential liability for policy benefits by reinsurance;

(B) Reduce, suspend or limit the volume of business being accepted or renewed;

(C) Reduce general insurance and commission expenses by methods specified by OHA;

(D) Increase the capital and surplus of the CCO;

(E) Suspend or limit the declaration and payment of dividends by the CCO to its stockholders or members;

(F) Limit or withdraw from certain investments or discontinue certain investment practices to the extent OHA determines such action to be necessary.

(b) OHA may exercise authority under Subsection (a) of this section in addition to or instead of any other authority that OHA may exercise under these rules;

(c) OHA may issue an order with or without a hearing. A CCO subject to an order issued without a hearing may file a written request for a hearing to review the order. Such a request shall not stay the effect of the order. The hearing shall be held within 30 days after the filing of the request. OHA shall complete the review within 30 days after the record for the hearing is closed, and shall discontinue the action taken if OHA determines that none of the conditions giving rise to the action exists.

(2) OHA may consider the following standards, either singly or in combination of two or more, to determine whether the continued operation of any CCO might be determined to be hazardous to the CCO's members, its creditors or the general public:

(a) Adverse findings reported in financial condition examination reports, audit reports, and actuarial opinions, reports or summaries;

(b) Whether the CCO has made adequate provision, according to presently accepted actuarial standards of practice, for the anticipated cash flows required by the contractual obligations and related expenses of the CCO, when considered in light of the assets held by the CCO with respect to such reserves and related actuarial items including but not limited the investment earnings on such assets, and the considerations anticipated to be received and retained under such contracts;

(c) The ability of an assuming reinsurer to perform and whether the CCO's reinsurance program provides sufficient protection for the CCO's remaining capital and surplus after taking into account the CCO's cash flow and the classes of business written as well as the financial condition of the assuming reinsurer;

(d) Whether the CCO's operating loss in the last 12-month period or any shorter period of time is greater than 50 percent of the CCO's remaining capital and surplus in excess of the minimum required;

(e) Whether the CCO's operating loss in the last 12-month period or any shorter period of time, excluding net capital gains, is greater than 20 percent of the CCO's remaining surplus in excess of the minimum required;

(f) Whether a reinsurer or obligor, or any entity within the CCO's system is insolvent, threatened with insolvency or delinquent in payment of its monetary or other obligations and which, in the opinion of OHA may affect the solvency of the CCO;
(g) Contingent liabilities, pledges or guaranties that either individually or collectively involves a total amount that in the opinion of OHA may affect the solvency of the CCO;
(h) Whether any "controlling person" of a CCO is delinquent in the transmitting to, or payment of, net premiums to the CCO;
(i) The age and collectability of receivables;
(j) Whether the management of a CCO, including officers, directors or any other person who directly or indirectly controls the operation of the CCO, fails to possess and demonstrate the competence, fitness and reputation determined by OHA to be necessary to serve the CCO in such position;
(k) Whether management of a CCO has failed to respond to inquiries relating to the condition of the CCO or has furnished false and misleading information concerning an inquiry;
(l) Whether the CCO has failed to meet financial responsibility, accountability or filing requirements in the absence of a reason satisfactory to OHA;
(m) Whether management of a CCO either has filed a false or misleading sworn financial statement or has released a false or misleading financial statement to lending institutions or to the general public, or has made a false or misleading entry, or has omitted an entry of material amount in the books of the CCO;
(n) Whether the CCO has grown so rapidly and to such an extent that it lacks adequate financial and administrative capacity to meet its obligations in a timely manner;
(o) Whether the CCO has experienced or will experience in the foreseeable future cash flow or liquidity problems, or both;
(p) Whether management has established reserves that do not comply with minimum standards established by the CCO contract or regulations, accounting standards, sound actuarial principles and standards of practice;
(q) Whether management persistently engages in material under reserving that results in adverse development;
(r) Whether transactions among affiliates, subsidiaries or controlling persons for which the CCO receives assets or capital gains, or both, do not provide sufficient value, liquidity or diversity to assure the CCO's ability to meet its outstanding obligations as they mature; and
(s) Any other finding determined by OHA to be hazardous to the CCO's members, creditors or general public.
(3) For the purposes of making a determination of the financial condition of a CCO under these rules or the CCO contract, OHA may do one or more of the following:
(a) Disregard any credit or amount receivable resulting from transactions with a reinsurer that is insolvent, impaired or otherwise subject to a delinquency proceeding;
(b) Make appropriate adjustments to asset values attributable to investments in or transactions with parents, subsidiaries or affiliates;
(c) Refuse to recognize the stated value of accounts receivable if the ability to collect receivables is highly speculative in view of the age of the account or the financial condition of the debtor; or
(d) Increase the CCO's liability in an amount equal to any contingent liability, pledge, or guarantee not otherwise included if there is a substantial risk that the CCO will be called upon to meet the obligation undertaken within the next 12-month period.
(4) In addition to the requirements OHA may impose, if OHA determines that the continued operation of the CCO may be hazardous to OHA, the members or the general public, OHA may require the CCO to:
(a) File reports in a form acceptable to OHA concerning the market value of the CCO's assets;
(b) In addition to regular annual statements, file interim financial reports on the form specified by OHA;
(c) Correct corporate governance practice deficiencies, and adopt and utilize the governance practices acceptable to OHA; or
(d) Provide a business plan to OHA demonstrating corrective action the CCO will take to improve its financial condition.

(5) No CCO shall reduce its combined capital and surplus by partial distribution of its assets, by payment in the form of a dividend to stockholders or otherwise, below:
(a) Its required capitalization; or
(b) A greater amount which OHA, by rule or by order after hearing upon the motion of OHA or the petition of any interested person, finds necessary to avoid injury or prejudice to the interest of OHA, members or creditors.
(6) Whenever OHA determines from any showing or statement made to OHA or from any examination made by OHA that the assets of a CCO are less than its liabilities plus required capitalization, OHA may proceed immediately to terminate the CCO contract and revoke or suspend its certification as a CCO, or OHA may allow the CCO a period of time, not to exceed 90 days, in which to make correct the amount of the impairment with cash or authorized investments. If the amount of any such impairment is not corrected within the time prescribed by OHA, OHA shall proceed immediately to terminate the CCO contract and revoke or suspend its certification as a CCO.

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

STATUTES/OTHER IMPLEMENTED: ORS 414.610 - 414.685

REPEAL: 410-141-3380

RULE TITLE: Disallowance of Transactions — DCBS Reporting CCOs Only

NOTICE FILED DATE: 09/16/2019

RULE SUMMARY: The agency has completed an exhaustive review and revision of all rules within Chapter 410 Division 141. As part of this process, OHA is renumbering rules within the Chapter and Division. Therefore, all existing rules need to be repealed to avoid redundant or conflicting rules in the oversight of the State's Coordinated Care Organizations (CCOs).

RULE TEXT:

(1)The provisions of OAR 410-141-3380 apply only to DCBS reporting CCOs, and do not apply to OHA reporting CCOs.
(2) OHA shall disallow as an asset or as a credit against liabilities any reinsurance found by OHA after a hearing thereon to have been arranged for the purpose principally of deception as to the ceding CCO's financial condition as of the date of any financial statement of the CCO. Without limiting the general purport of the foregoing provision, reinsurance of any substantial part of the CCO's outstanding risks contracted for in fact within four months prior to the date of any such financial statement and canceled in fact within four months after the date of such statement, or reinsurance under which the reinsurer bears no substantial insurance risk or substantial risk of net loss to itself, shall prima facie be deemed to have been arranged for the purpose principally of deception.
(3) OHA shall disallow as an asset any deposit, funds or other assets of the CCO found by OHA after a hearing thereon:
(a) Not to be in good faith the property of the CCO;
(b) Not freely subject to withdrawal or liquidation by the CCO at any time for the payment or discharge of claims or other obligations arising under its policies; and
(c) To be resulting from arrangements made principally for the purpose of deception as to the CCO's financial condition as of the date of any financial statement of the CCO.

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

STATUTES/OTHER IMPLEMENTED: ORS 414.610 - 414.685

REPEAL: 410-141-3385

RULE TITLE: Holding Company

NOTICE FILED DATE: 09/16/2019

RULE SUMMARY: The agency has completed an exhaustive review and revision of all rules within Chapter 410 Division 141. As part of this process, OHA is renumbering rules within the Chapter and Division. Therefore, all existing rules need to be repealed to avoid redundant or conflicting rules in the oversight of the State's Coordinated Care Organizations (CCOs).

RULE TEXT:

(1) As used in this rule, "Holding Company System" as it applies to a CCO means two or more affiliated persons, one or more of which is a CCO, and includes a financial holding company as referred to in section 103 of the federal Gramm-Leach-Bliley Act (P.L. 106-102). Such CCO shall also be subject to OAR 836-027-0001 through 836-027-0050 to the extent those rules relate to the filing of a registration statement (Form B filing).

(2) Every CCO that is a member of a holding company system shall be subject to ORS 732.551 to 732.572, except ORS 732.554.

(3) A transaction within a holding company system to which a CCO subject to registration is a party is subject to the following standards:

(a) The terms must be fair and reasonable;

(b) Charges or fees for services performed must be reasonable;

(c) Expenses incurred and payment received must be allocated to the CCO in conformity with customary insurance accounting practices consistently applied;

(d) The books, accounts and records of each party to the transaction must be so maintained as to disclose clearly and accurately the nature and details of the transaction, including accounting information necessary to support the reasonableness of the charges or fees to the respective parties; and

(e) The combined capital and surplus of the CCO following any transaction with an affiliate or any shareholder dividend must be reasonable in relation to the CCO's outstanding liabilities and adequate to its financial needs.

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

STATUTES/OTHER IMPLEMENTED: ORS 414.610 - 414.685

REPEAL: 410-141-3390

RULE TITLE: Transparency

NOTICE FILED DATE: 09/16/2019

RULE SUMMARY: The agency has completed an exhaustive review and revision of all rules within Chapter 410 Division 141. As part of this process, OHA is renumbering rules within the Chapter and Division. Therefore, all existing rules need to be repealed to avoid redundant or conflicting rules in the oversight of the State's Coordinated Care Organizations (CCOs).

RULE TEXT:

(1) Pursuant to ORS 414.018, interactions between OHA or DCBS and CCOs shall be done in a transparent and public manner. Without limitation of the preceding sentence, OHA or DCBS shall publicly disclose all information pertaining to CCOs of a character that DCBS publicly discloses pertaining to CCOs that are licensed health entities.

(2) Certain documents pertaining to a CCO's financial condition may be considered confidential, when so described in these rules. financial analysis solvency tools and analytical reports developed by the NAIC, and comparable reports developed or used by DCBS or OHA, are confidential. In addition, any work papers, recorded information, documents and copies thereof that are produced or obtained by or disclosed to OHA or DCBS, or any other person in the course of an examination or in the course of analysis by OHA or DCBS of the financial condition or market conduct of a CCO may be considered confidential, if the CCO specifically designates the confidential portions and cites an exemption from public disclosure under the Oregon Public Records Law, ORS 192.410 to 192.505. If OHA, in its sole discretion, determines that the cited exemption does not apply or disclosure is necessary to protect the public interest, OHA may make available work papers, recorded information, documents and copies thereof produced by, obtained by or disclosed to OHA or any other person in the course of the examination.

(3) The OHA or DCBS may use a confidential document, material or other information in administering these rules and in furthering a regulatory or legal action brought as a part of the OHA's duties. In order to assist in the performance of OHA's duties, OHA may:

(a) Authorize sharing a confidential document, material or other information as appropriate among the administrative divisions and staff offices of the OHA or DCBS for the purpose of administering and enforcing the statutes within the authority of OHA, in order to enable the administrative divisions and staff offices to carry out their functions and responsibilities;

(b) Share a document, material or other information, including a confidential document, material or other information that is subject to this rule or that is otherwise exempt from disclosure under ORS 192.501 or ORS 192.502, with other state, federal, foreign and international regulatory and law enforcement agencies and with the NAIC and affiliates or subsidiaries of the NAIC, if the recipient agrees to maintain the confidentiality of the document, material or other information; and

(c) Receive a document, material or other information, including an otherwise confidential document, material or other information, from state, federal, foreign and international regulatory and law enforcement agencies and from the NAIC and affiliates or subsidiaries of the NAIC. As provided in this section, the OHA shall maintain the confidentiality of documents, materials or other information received upon notice or with an understanding that the document, material or other information is confidential or privileged under the laws of the jurisdiction that is the source of the document, material or other information.

(4) Disclosing a document, material or other information to the OHA, sharing a document, material or other information does not waive an applicable privilege or claim of confidentiality in the document, material or other information.

(5) OHA may release a final, adjudicated action, including a suspension or revocation of a CCO's certification, if the action is otherwise open to public inspection, to a database or other clearinghouse service maintained by the NAIC or affiliates or subsidiaries of the NAIC.

(6) All information, documents and copies thereof obtained by or disclosed to OHA, DCBS or any other person in the course of an examination or investigation made pursuant to OAR 410-141-3365 are subject to the provisions of ORS

731.312.

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

STATUTES/OTHER IMPLEMENTED: ORS 414.610 - 414.685

REPEAL: 410-141-3395

RULE TITLE: Member Protection Provisions

NOTICE FILED DATE: 09/16/2019

RULE SUMMARY: The agency has completed an exhaustive review and revision of all rules within Chapter 410 Division 141. As part of this process, OHA is renumbering rules within the Chapter and Division. Therefore, all existing rules need to be repealed to avoid redundant or conflicting rules in the oversight of the State's Coordinated Care Organizations (CCOs).

RULE TEXT:

(1) In the event of a finding of impairment by OHA or of a termination of certification as a CCO or of the CCO contract, members of the CCO shall be offered disenrollment from the CCO and enrollment in accordance with OHA rule.

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

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

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

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

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

(a) Deductible or coinsurance amounts;

(b) Health services not covered by the CCO, if a valid OHP 3165, or facsimile, signed by the client, has been completed as described in OAR 410-120-1280; or

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

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

STATUTES/OTHER IMPLEMENTED: ORS 414.610 - 414.685

REPEAL: 410-141-3420

RULE TITLE: Managed Care Entity (MCE) Billing

NOTICE FILED DATE: 09/16/2019

RULE SUMMARY: The agency has completed an exhaustive review and revision of all rules within Chapter 410 Division 141. As part of this process, OHA is renumbering rules within the Chapter and Division. Therefore, all existing rules need to be repealed to avoid redundant or conflicting rules in the oversight of the State's Coordinated Care Organizations (CCOs).

RULE TEXT:

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

(a) Submit billings within no more than four months of the date of service for all cases, except as provided for in section (1) (b) of this rule. MCEs may negotiate terms within this timeframe agreeable to both parties;

(b) Submit billings within 12 months of the date of service in the following cases:

(A) Pregnancy;

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

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

(D) Other cases that delay the initial billing to the MCE, not including failure of the provider to verify the member's eligibility; or

(E) Third Party Liability (TPL). Pursuant to 42 CFR 136.61, subpart G: Indian Health Services and the amended Public Law 93-638 under the Memorandum of Agreement that Indian Health Service and 638 Tribal Facilities are the payers of last resort and are not considered an alternative liability or TPL;

(F) MCE's shall engage in collaborative efforts with the Authority to develop a Value-based Purchasing Roadmap.

(2) Providers shall be enrolled with the Division to be eligible for fee-for-service (FFS) payments. Mental health providers, except Federally Qualified Health Centers (FQHC), shall be approved by the Local Mental Health Authority (LMHA) and the Division before enrollment with the Authority or to be eligible for MCE payment for services. FFS providers may be retroactively enrolled in accordance with OAR 410-120-1260 Provider Enrollment.

(3) Providers, including mental health providers, shall be enrolled with the Authority as a Medicaid FFS provider or an MCE encounter-only provider prior to submission of encounter claims to ensure the encounter claim is accepted.

(4) Providers shall verify before providing services that the client is:

(a) Eligible for Division programs and;

(b) Whether the client is assigned to an MCE on the date of service.

(5) Providers shall use the Authority's and MCE's tools to determine if the service to be provided is covered under the member's OHP benefit package. Providers shall also identify the party responsible for covering the intended service and seek prior authorizations from the appropriate payer before providing services. Before providing a non-covered service, the provider shall complete an OHP 3165 "OHP Client Agreement to Pay for Health Services," or facsimile signed by the client as described in OAR 141-120-1280.

(6) If a member has other insurance coverage available for payment of covered services, the insurance must be exhausted prior to payment for the covered services. Member cost-sharing incurred as part of other coverage shall be paid to the insurer by the contractor.

(7) MCEs shall pay for all covered capitated and coordinated care services. These services shall be billed directly to the MCE, unless the MCE or the Authority specifies otherwise.

(8) Payment by the MCE to participating providers for capitated or coordinated care services is a matter between the MCE and the participating provider:

(a) MCEs shall have written policies and procedures for processing claims submitted from any source. The policies and procedures shall specify time frames for:

(A) Date stamping claims when received;

(B) Determining within a specific number of days from receipt whether a claim is valid or non-valid;

(C) The specific number of days allowed for follow-up on pended claims to obtain additional information;
(D) Sending written notice of the decision with appeal rights to the member when the determination is a denial of the requested service as specified in OAR 410-141-3240.
(b) MCEs shall pay or deny at least 90 percent of valid claims within 30 days of receipt and at least 99 percent of valid claims within 90 days of receipt. MCEs shall make an initial determination on 99 percent of all claims submitted within 60 days of receipt;
(c) MCEs shall provide written notification of MCE determinations when the determinations result in a denial of payment for services as outlined in OAR 410-141-3240;
(d) MCEs may not require providers to delay billing to the MCE;
(e) MCEs may not require Medicare be billed as the primary insurer for services or items not covered by Medicare or require non-Medicare approved providers to bill Medicare;
(f) MCEs may not deny payment of valid claims when the potential TPR is based only on a diagnosis, and no potential TPR has been documented in the member's clinical record;
(g) MCEs may not delay or deny payments because a co-payment was not collected at the time of service;
(h) MCEs may not delay or deny payments for occupational therapy, physical therapy, speech therapy, nurse services, etc., when a child is receiving such services as school-based health services (SBHS) through either an Individual Educational Plan (IEP) or an Individualized Family Service Plan (IFSP). These services are supplemental to other health plan covered therapy services and are not considered duplicative services. Individuals with Disabilities Education Act (IDEA) mandated school sponsored SBHS will not apply toward the member's therapy allowances. SBHS Medicaid covered IDEA services are provided to eligible children in their education program settings by public education enrolled providers billing MMIS for these services to Medicaid through the Authority for reimbursement under Federal Financial Participation (FFP) as part of cost sharing on a fee-for-service basis.
(9) MCEs shall pay for Medicare coinsurances and deductibles up to the Medicare or MCE's allowable for covered services the member receives within the MCE participating provider network for authorized referral care and urgent care services or emergency services the member receives from non-participating providers. MCEs may not pay for Medicare coinsurances and deductibles for non-urgent or non-emergent care members receive from non-participating providers.
(10) MCEs shall pay transportation, meals, and lodging costs for the member and any required attendant for services that the MCE has arranged and authorized when those services are not available within the state, unless otherwise approved by the Authority.
(11) MCEs shall pay for ancillary covered services provided by a non-participating provider that are not prior authorized if all of the following conditions exist:
(a) It can be verified that a participating provider ordered or directed the covered services to be delivered by a non-participating provider; and
(b) The ancillary covered service was delivered in good faith without the prior authorization; and
(c) It was an ancillary covered service that would have been prior authorized with a participating provider if the MCE's referral procedures had been followed;
(d) The MCE shall pay non-participating providers (providers enrolled with the Authority that do not have a contract with the MCE) for ancillary covered services that are subject to reimbursement from the MCE in the amount specified in OAR 410-120-1295. This rule does not apply to providers that are Type A or Type B hospitals, as they are paid in accordance with ORS 414.727;
(e) Except as specified in OAR 410-141-3140 Emergency and Urgent Care Services, MCEs shall not be required to pay for covered treatment services provided by a non-participating provider, unless:
(A) The MCE does not have a participating provider that will meet the member's medical need; and
(B) The MCE has authorized care to a non-participating provider.
(f) Notwithstanding OAR 410-120-1280, non-participating providers may not attempt to bill the member for services rendered;

(g) MCEs shall reimburse hospitals for services provided on or after January 1, 2012, using Medicare Severity DRG for inpatient services and Ambulatory Payment Classification (APC) for outpatient services or other alternative payment methods that incorporate the most recent Medicare payment methodologies for both inpatient and outpatient services established by CMS for hospital services and alternative payment methodologies including but not limited to pay-for-performance, bundled payments, and capitation. An alternative payment methodology does not include reimbursement payment based on percentage of billed charges. This requirement does not apply to Type A or Type B hospitals. MCEs shall attest annually to the Authority in a manner to be prescribed to MCE's compliance with these requirements.
(12) For Type A or Type B hospitals transitioning from Cost-Based Reimbursement (CBR) to an Alternative Payment Methodology (APM):
(a) Sections (11)–(13) only apply to services provided by Type A or Type B hospitals to members that are enrolled in an MCE;
(b) The Authority may upon evaluation by an actuary retained by the Authority, on a case-by-case basis, require MCEs to continue to reimburse fully a rural Type A or Type B hospital determined to be at financial risk for the cost of covered services based on a cost-to-charge ratio;
(c) For those Type A or Type B hospitals that transitioned from CBR to an APM, the Authority shall require hospitals and MCEs to enter into good faith negotiations for contracts. Dispute resolution during the contracting process shall be subject to OAR 410-141-3268 and 410-141-3269;
(d) For monitoring purposes, MCEs shall submit to the Authority no later than November 30 of each year a list of those hospitals with which they have contracted for these purposes.
(13) Determination of which Type A or Type B hospitals shall stay on CBR or transition from CBR:
(a) No later than June 30 of the odd numbered years, the Authority shall update the algorithm for calculation of the CBR determination methodology with the most recent data available;
(b) After determination for each Type A and Type B hospital, any changes in a hospital's status from CBR to APM or from APM to CBR shall be effective January 1 of the following (even numbered) year;
(c) Type A and Type B hospitals located in a county that is designated as "Frontier" are not subject to determination via the algorithm and shall remain on CBR.
(14) Non-contracted Type A or Type B hospital rates for those transitioning or transitioned from CBR:
(a) Reimbursement rates under this section shall be based on discounted hospital charges for both inpatient and outpatient services;
(b) Reimbursement rates effective for the initial year of a hospital transitioning from CBR shall be based on that hospital's most recently filed Medicare cost report adjusted to reflect the hospital's Medicaid/OHP mix of services;
(c) Subsequent year reimbursement rates for hospitals transitioned from CBR shall be calculated by the Authority based on the individual hospital's annual price increase and the Authority's global budget rate increase as defined by the CMS 1115 waiver using the following formula: Current Reimbursement Rate x (1+Global Budget Increase) / (1+Hospital Price Increase);
(d) On an annual basis, each Type A or Type B hospital that has transitioned from CBR shall complete a template provided by the Authority that calculates the hospital's change in prices for their MCE population;
(e) Inpatient and outpatient reimbursement rates shall be calculated separately;
(f) Non-contracted Type A or Type B hospital reimbursement rates can be found in the Rate Table section at the following: http://www.oregon.gov/oha/healthplan/Pages/hospital.aspx.
(15) Members may receive certain services on a Fee-for-Service (FFS) basis:
(a) Certain services shall be authorized by the MCE or the Community Mental Health Program (CMHP) for some mental health services, even though the services are then paid by the Authority on a FFS basis. Before providing services, providers shall verify a member's eligibility and MCE assignment as provided for in this rule;
(b) Services authorized by the MCE or CMHP are subject to the Authority's administrative rules and supplemental information including rates and billing instructions;
(c) Providers shall bill the Authority directly for FFS services in accordance with billing instructions contained in the

Authority administrative rules and supplemental information;
(d) The Authority shall pay at the Medicaid FFS rate in effect on the date the service is provided subject to the Authority's administrative rules, contracts, and billing instructions;
(e) The Authority may not pay a provider for providing services for which an MCE has received an MCE payment unless otherwise provided for in rule;
(f) When an item or service is included in the rate paid to a medical institution, a residential facility, or foster home, provision of that item or service is not the responsibility of the Authority or an MCE except as provided in Authority administrative rules and supplemental information (e.g., coordinated care and capitated services that are not included in the nursing facility all-inclusive rate);
(g) MCE's that contract with FQHCs and RHCs shall negotiate a rate of reimbursement that is not less than the level and amount of payment that the MCE would pay for the same service furnished by a provider who is not an FQHC nor RHC, consistent with the requirements of BBA 4712(b)(2).
(16) MCEs shall maintain a Coordination of Benefits Agreement that allows participation in the automated claims crossover process with Medicare for those members dually eligible for Medicaid and Medicare services.
(17) MCEs shall ensure providers under the MCE contract are notified of billing processes for crossover claims processing, as described in OAR 410-120-1280.
(18) Coverage of services through the OHP benefit package of covered services is limited by OAR 410-141-0500 Excluded Services and Limitations for OHP Clients.

STATUTORY/OTHER AUTHORITY: 413.042, 414.065, 414.615, 414.625, 414.635, 414.651

STATUTES/OTHER IMPLEMENTED: 414.065, 414.610 - 414.685

REPEAL: 410-141-3430

RULE TITLE: Coordinated Care Organization Encounter Claims Data Reporting

NOTICE FILED DATE: 09/16/2019

RULE SUMMARY: The agency has completed an exhaustive review and revision of all rules within Chapter 410 Division 141. As part of this process, OHA is renumbering rules within the Chapter and Division. Therefore, all existing rules need to be repealed to avoid redundant or conflicting rules in the oversight of the State's Coordinated Care Organizations (CCOs).

RULE TEXT:

(1) CCOs must meet the data content and submission standards as required by HIPAA 45 CFR Part 162, the Authority's electronic data transaction rules (OAR 943-120-0100 through 943-120-0200), the Division's 837 technical specifications for encounter data, and the Division's encounter data submission guidelines that are subject to periodic revisions and available on the Authority's web site.

(2) CCOs must collect service information in standardized formats to the extent feasible and appropriate; if HIPAA standard, the CCO must utilize the HIPAA standards:

(a) CCOs shall submit encounter claims for all services, whether they are other health- related services or covered services, provided to members as defined in OAR 410-120-0000 and 410-141-3000.

(b) CCOs shall submit encounter claims data including encounters for services where the CCO determined that:

(A) Liability exists;

(B) No liability exists even if the CCO did not make any payment for a claim;

(C) Including claims for services to members provided by a provider under a subcontract, capitation, or special arrangement with another facility or program; and

(D) Including paid amounts regardless of whether the servicing provider is paid on a fee for service basis, on a capitated basis by the CCO, or the CCO's subcontractor.

(c) CCOs shall submit encounter claims data for all services to members who also have Medicare coverage, if a claim has been submitted to the CCO;

(d) Contractors shall obtain a Coordination of Benefits Agreement (COBA) number and coordinate with COBA to receive direct crossover claims for dually eligible members with traditional Medicare pursuant to 42 CFR 438.3(t);

(e) CCOs shall report encounter claims data whether the provider is an in-network participating or out-of-network, non-participating provider.

(3) CCOs must follow the DCBS standards for electronic data exchange as described in the Oregon Companion Guides available on the DCBS website.

(4) CCOs must submit encounter claims in the time frames as described below for the following claim types:

(a) Non-pharmacy encounter claims; professional, dental, and institutional:

(A) CCOs must submit encounter claims at least once per month for no less than 50 percent of all claim types received and adjudicated that month;

(B) CCOs must submit all remaining unreported encounter claims for services received and adjudicated within 180 days of the date of service except as may be applicable in paragraph (C) below;

(C) CCOs may only delay submission of encounter claims within 180 days from the date of service with prior notification to the Authority and only for any of the following reasons:

(i) Member's failure to give the provider necessary claim information;

(ii) Resolving local or out-of-area provider claims;

(iii) Third-Party Resource liability or Medicare coordination;

(iv) Member's pregnancy;

(v) Hardware or software modifications to CCO's health information system, or;

(vi) Authority recognized system issues preventing timely submission or correction of encounter claims data.

(b) Pharmacy claims:

(A) CCOs must ensure all pharmacy encounter claims data meet the data content standards as required by the National Council for Prescription Drug Programs (NCPDP) as available on their web site http://www.ncpdp.org/ or by contacting the National Council for Prescription Drug Programs organization;
(B) All pharmacy encounter claims data must be submitted by the CCO whether by the CCO's pharmacy benefit manager or the CCO's subcontractor at least once a month for all services received and adjudicated that month and must submit all remaining unreported CCO pharmacy encounter claims within 60 days from the date of service.
(c) Submission Standards and Data Availability:
(A) CCOs must only use the two types of provider identifiers, as allowed by HIPAA NPI standards 45 CFR 160.103 and as provided to the CCO by the Authority in encounter claims:
(i) The National Provider Identifiers (NPI) for a provider covered entity enrolled with the Authority; or
(ii) The Oregon Medicaid proprietary provider numbers for the Authority enrolled non-covered atypical provider entities.
(B) CCOs must make an adjustment to any encounter claim when the CCO discovers the data is incorrect, no longer valid, or some element of the claim not identified as part of the original claim needs to be changed;
(C) If the Authority discovers errors or a conflict with a previously adjudicated encounter claim except as specified in paragraph (E) below, the CCO must adjust or void the encounter claim within 14 days of notification by the Authority of the required action or as identified in paragraph (E) below;
(D) If the Authority discovers errors with a previously adjudicated encounter claim resulting from a federal or state mandate or request that requires the completeness and accuracy of the encounter data, the CCO must correct the errors within a time frame specified by the Authority;
(E) If circumstances prevent the CCO from meeting requested time frames for correction, the CCO may contact the Authority to determine an agreed upon specified date except as required in subsection (d) below;
(F) CCOs must ensure claims data received from providers, either directly or through a third party submitter, is accurate, truthful, and complete by:
(i) Verifying accuracy and timeliness of reported data;
(ii) Screening data for completeness, logic, and consistency;
(iii) Submitting a complete and accurate Encounter Data Certification and Validation Report available on the Authority's website.
(G) CCOs must make all collected and reported data available upon request to the Authority and CMS as described in 42 CFR 438.242.
(d) Encounter Claims Data Corrections for "must correct" Encounter Claims:
(A) The Authority shall notify the CCO of the status of all encounter claims processed;
(B) Notification of all encounter claims processed that are in a "must correct" status shall be provided by the Authority to the CCO each week and for each subsequent week the encounter claim remains in a "must correct" status;
(C) The Authority may not necessarily notify the CCO of other errors; however, this information is available in the CCO's electronic remittance advice supplied by the Authority;
(D) CCOs shall submit corrections to all encounter claims within 63 days from the date the Authority sends the CCO notice that the encounter claim remains in a "must correct" status.
(E) CCOs may not delete encounter claims with a "must correct" status as specified in section (3)(d) except when the Authority has determined the encounter claim cannot be corrected or for other reasons.
(5) Enrollment of providers included on an encounter claim:
(a) CCOs shall ensure that all providers are enrolled with the Authority prior to submission of the encounter claim as either:
(A) An Oregon Medicaid fee for service provider; or
(B) A provider that is not a fee for service provider but does provide services to the CCO's enrolled members.
(b) CCOs must ensure the provider is not excluded per federal and state standards as set forth in OAR 943-120-0100 through 943-120-0200 and as specified in 42 CFR 455.400 through 455.400.

(6) Electronic Health Records (EHR) Systems OAR 410-165-0000 to 410-165-0140. In support of an eligible provider's ability to demonstrate meaningful use as an EHR user, as described by 42 CFR 495.4 and 42 CFR 495.8, the CCO must:
(a) Submit encounter data in support of a qualified EHR user's meaningful use data report to the Authority for validation as set forth in OAR 410-165-0080;
(b) CCOs must respond within the time frame determined by the Authority to any request for:
(A) Any suspected missing CCO encounter claims, or;
(B) CCO submitted encounter claims found to be unmatched to an EHR user's meaningful use report.
(7) CCOs must comply with the following hysterectomy and sterilization standards as described in 42 CFR 441.250 to 441.259 and the requirements of OAR 410-130-0580:
(a) CCOs shall submit a signed informed consent form to the Authority for each member that received either a hysterectomy or sterilization service within 30 days of the date of service; or
(b) Immediately upon notification by the Authority that a qualifying encounter claim has been identified;
(c) The Authority in collaboration and cooperation with the CCO shall reconcile all hysterectomy or sterilization services with informed consents with the associated encounter claims by either:
(A) Confirming the validity of the consent and notifying the CCO that no further action is needed;
(B) Requesting a corrected informed consent form, or;
(C) Informing the CCO the informed consent is missing or invalid and the payment must be recouped and the associated encounter claim must be changed to reflect no payment made for services within the time frame set by the Authority.
(8) Upon request by the Authority, CCOs must furnish information regarding rebates for any covered outpatient drug provided by the CCO as follows:
(a) The Authority is eligible for the rebates authorized under Section 1927 of the Social Security Act (42 USC 1396r-8) as amended by section 2501 of the Patient Protection and Affordable Care Act (P.L. 111-148) and section 1206 of the Health Care and Education Reconciliation Act of 2010 (P.L. 111-152) for any covered outpatient drug provided by the CCO, unless the drug is subject to discounts under Section 340B of the Public Health Service Act;
(b) CCOs shall report prescription drug data as specified in section (3)(b).
(9) Encounter Pharmacy Data Rebate Dispute Resolution as governed by SSA Section 1927 42 U.S.C. 1396r-8 and as required by OAR 410-121-0000 through 410-121-0625. When the Authority receives an Invoiced Rebate Dispute from a drug manufacturer, the Authority shall send the Invoiced Rebate Dispute to the CCO for review and resolution within 15 days of receipt:
(a) The CCO shall assist in the dispute process as follows:
(A) By notifying the Authority that the CCO agrees an error has been made; and
(B) By correcting and re-submitting the pharmacy encounter data to the Authority within 45 days of receipt of the Invoiced Rebate Dispute.
(b) If the CCO disagrees with the Invoiced Rebate Dispute that an error has been made, the CCO shall send the details of the disagreement to the Authority's encounter data liaison within 45 days of receipt of the Invoiced Rebate Dispute.

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

STATUTES/OTHER IMPLEMENTED: 414.610 - 414.685

REPEAL: 410-141-3435

RULE TITLE: NEMT General Requirements

NOTICE FILED DATE: 09/16/2019

RULE SUMMARY: The agency has completed an exhaustive review and revision of all rules within Chapter 410 Division 141. As part of this process, OHA is renumbering rules within the Chapter and Division. Therefore, all existing rules need to be repealed to avoid redundant or conflicting rules in the oversight of the State's Coordinated Care Organizations (CCOs).

RULE TEXT:
(1) A Coordinated Care Organization shall provide all NEMT services for its members. The Authority shall provide NEMT services in CCO's service area only to members not enrolled in a CCO.
(2) A CCO shall provide a toll-free call center for members to request rides.
(3) A CCO and its contracted transportation provider may not bill a member for any transport to and from medical services that are covered and where the CCO or its contracted transportation provider denied reimbursement.
(4) Transportation providers shall be considered "participating providers" for the purposes of OAR 410-141-3180 (Record Keeping and Use of Health Information Technology).

STATUTORY/OTHER AUTHORITY: ORS 413.042, 414.625

STATUTES/OTHER IMPLEMENTED: ORS 414.625

REPEAL: 410-141-3440

RULE TITLE: Vehicle Equipment and Driver Standards

NOTICE FILED DATE: 09/16/2019

RULE SUMMARY: The agency has completed an exhaustive review and revision of all rules within Chapter 410 Division 141. As part of this process, OHA is renumbering rules within the Chapter and Division. Therefore, all existing rules need to be repealed to avoid redundant or conflicting rules in the oversight of the State's Coordinated Care Organizations (CCOs).

RULE TEXT:

(1) This rule does not apply to ambulance providers, ambulance vehicles, or ambulance personnel that are licensed and regulated by ORS Chapter 682 and OAR chapter 333, divisions 250, 255, 260 and 265, whether providing ambulance or stretcher transports.

(2) The CCO shall require all vehicles used for NEMT services to meet the following requirements for the comfort and safety of the members:

(a) The interior of the vehicle shall be clean and free from any debris impeding a member's ability to ride comfortably;

(b) Smoking, aerosolizing or vaporizing of inhalants is prohibited in the vehicle at all times in accordance with ORS 433.835 to 433.990 and OAR 333-015-0025 to 333-015-0090; and

(c) The transportation provider shall comply with appropriate local, state, and federal transportation safety standards regarding passenger safety and comfort. The vehicle shall include, but is not limited to, the following safety equipment:

(A) Safety belts for all passengers if the vehicle is legally required to provide safety belts;

(B) First aid kit;

(C) Fire extinguisher;

(D) Roadside reflective or warning devices;

(E) Flashlight;

(F) Tire traction devices when appropriate;

(G) Disposable gloves; and

(H) All equipment necessary to transport members using wheelchairs or stretchers, if the member is using a wheelchair or stretcher.

(3) A preventative maintenance schedule shall be followed for each vehicle that incorporates at least all of the maintenance recommended by the vehicle manufacturer. The vehicle must be in good operating condition and shall include, but is not limited to, the following equipment:

(a) Side and rear view mirrors;

(b) Horn; and

(c) Working turn signals, headlights, taillights, and windshield wipers.

(4) Prior to hiring an NEMT driver, the CCO shall require the following:

(a) The driver must have a valid driver license. The license must be the class of license with any required endorsements that permits the driver to legally operate the vehicle for which they are hired to drive pursuant to ORS chapter 807 and OAR chapter 735, division 062, or the applicable statutes of other states; and

(b) The driver must pass a criminal background check in accordance with ORS 181.534, 181.537, and OAR chapter 257, division 10. If the driver is employed by a mass transit district formed under ORS Chapter 267, the driver must pass a criminal background check in accordance with ORS 267.237 as well as the mass transit district's background check policies. A CCO shall have an exception process to the criminal background check requirement that may allow approval of a driver with a criminal background under certain circumstances. The exception process must include review and consideration of when the crime occurred, the nature of the offense, and any other circumstances to ensure that the member is not at risk of harm from the driver. Any approvals made through the exception process must be documented and maintained for three calendar years, even if the CCO is no longer a Medicaid enrolled provider before the end of the three years. The Authority may request this information at any time during the three year retention period.

(5) Drivers authorized to provide NEMT services must receive training on their job duties and responsibilities including:
(a) Understanding NEMT services in general, reporting forms, vehicle operation, requirements for fraud and abuse reporting, and the geographic area in which drivers will provide service;
(b) Completing the National Safety Council Defensive Driving course or equivalent within six months of the date of hire and at least every three years thereafter;
(c) Completing Red Cross-approved First Aid, Cardiopulmonary Resuscitation, and blood spill procedures courses or equivalent within six months of the date of hire and maintain the certification;
(d) Completing the Passenger Service and Safety course or equivalent course within six months of the date of hire and at least every three years thereafter; and
(e) Understanding the CCO's established procedures for responding to a member's needs for emergency care should they arise during the ride.
(6) For authorized out-of-state NEMT services in which the transportation provider solely performs work in the other state and for which the CCO has no oversight authority, the CCO is not responsible for requiring that the subcontractor's vehicle and standards meet the requirements set forth in this rule.

STATUTORY/OTHER AUTHORITY: ORS 413.042, 414.625

STATUTES/OTHER IMPLEMENTED: ORS 414.625

REPEAL: 410-141-3445

RULE TITLE: Out-of-Service-Area and Out-of-State Transportation

NOTICE FILED DATE: 09/16/2019

RULE SUMMARY: The agency has completed an exhaustive review and revision of all rules within Chapter 410 Division 141. As part of this process, OHA is renumbering rules within the Chapter and Division. Therefore, all existing rules need to be repealed to avoid redundant or conflicting rules in the oversight of the State's Coordinated Care Organizations (CCOs).

RULE TEXT:

(1) A CCO shall provide NEMT services outside the CCO's service area under the following circumstances:

(a) The member is receiving an OHP-covered health care service that is not available in the service area but is available in another area of the state;

(b) The member is receiving an OHP-covered service where the service location is no more than 75 miles from the Oregon border and contiguous to the CCO's service area;

(c) The CCO determines that no local medical provider or facility as outlined in OAR 410-141-3220 will provide OHP-covered medical services for the member; or,

(d) The member is receiving an OHP-covered service outside of Oregon that is not available in Oregon.

(2) Nothing in this rule prohibits a CCO from providing and paying for NEMT services to allow a client to access other services the CCO authorizes.

STATUTORY/OTHER AUTHORITY: ORS 413.042, 414.625

STATUTES/OTHER IMPLEMENTED: ORS 414.625

REPEAL: 410-141-3450

RULE TITLE: Attendants for Child and Special Needs Transports

NOTICE FILED DATE: 09/16/2019

RULE SUMMARY: The agency has completed an exhaustive review and revision of all rules within Chapter 410 Division 141. As part of this process, OHA is renumbering rules within the Chapter and Division. Therefore, all existing rules need to be repealed to avoid redundant or conflicting rules in the oversight of the State's Coordinated Care Organizations (CCOs).

RULE TEXT:

(1) This rule applies to NEMT for children under 12 years of age who are eligible for NEMT services to and from OHP-covered medical services. The rule also applies to children and young adults with special physical or developmental needs regardless of age.

(2) Parents or guardians must provide an attendant to accompany these members while traveling to and from medical appointments except when:

(a) The driver is a Department of Human Services (Department) volunteer or employee or an Authority employee;

(b) The member requires secured transport pursuant to OAR 410-141-3437 (Secured Transports); or

(c) An ambulance provider transports the member for non-emergent services, and the CCO reimburses the ambulance provider at the ambulance transport rate, per CCO contract or non-contracted rate policy.

(3) NEMT ambulance transports shall have an attendant when the CCO uses an ambulance to provide wheelchair or stretcher car or van rides.

(4) The Department shall establish and administer written guidelines for members in the Department's custody including written guidelines for volunteer drivers. If the Department's requirements or administrative rules differ from this rule, the Department's requirements or administrative rules take precedence.

(5) An attendant may be the member's mother, father, stepmother, stepfather, grandparent, or guardian. The attendant may also be any adult the parent or guardian authorizes. An attendant may also be the member's brother, sister, stepbrother, or stepsister if the attendant is at least 18 years of age, and the parent or guardian authorizes it.

(6) CCOs may require the member's parent or guardian to provide written authorization for an attendant other than the parent or guardian to accompany the member.

(7) The CCO may not bill additional charges for a member's attendant.

(8) The attendant must accompany the member from the pick-up location to the destination and the return trip. The attendant must also remain with the member during their appointment.

(9) The member's parent, guardian, or adult caregiver shall provide and install safety seats as required by ORS 811.210–811.225. An NEMT driver may not transport a member if a parent or guardian fails to provide a safety seat that complies with state law.

STATUTORY/OTHER AUTHORITY: ORS 413.042, 414.625

STATUTES/OTHER IMPLEMENTED: ORS 414.625

REPEAL: 410-141-3455

RULE TITLE: Secured Transports

NOTICE FILED DATE: 09/16/2019

RULE SUMMARY: The agency has completed an exhaustive review and revision of all rules within Chapter 410 Division 141. As part of this process, OHA is renumbering rules within the Chapter and Division. Therefore, all existing rules need to be repealed to avoid redundant or conflicting rules in the oversight of the State's Coordinated Care Organizations (CCOs).

RULE TEXT:

(1) "Secured transport" means NEMT services for the involuntary transport of members who are in danger of harming themselves or others. Secured transports may be used when:

(a) The CCO verified that the secured transporter has met the requirements of the secured transport protocol pursuant to OAR 309-033-0200 through 309-033-0970, and the secured transporter is able to transport the member who is in crisis or at immediate risk of harming themselves or others due to mental or emotional problems or substance abuse; and

(b) The transport is to a Medicaid enrolled facility that the Authority recognizes as being able to treat the immediate medical or behavioral health care needs of the member in crisis.

(2) One additional attendant may accompany the member at no additional charge when medically appropriate, such as to administer medications in-route or to satisfy legal requirements including, but not limited to, when a parent, legal guardian, or escort is required during transport.

(3) The CCO shall authorize transports to and from OHP covered medical services for an eligible member for court ordered medical services with the following exceptions:

(a) The member is in the custody of or under the legal jurisdiction of any law enforcement agency;

(b) The member is an inmate of a public institution as defined in OAR 461-135-0950 (Eligibility for Inmates); or

(c) The Authority has suspended the member's OHP eligibility pursuant to ORS 411.443 or 411.439.

(4) The CCO shall assume that a member returning to their place of residence is no longer in crisis or at immediate risk of harming themselves or others, and is, therefore, able to use non-secured transportation. In the event that a secured transport is medically appropriate to return a member to their place of residence, the CCO shall obtain written documentation signed by the treating medical professional stating the circumstances that required secured transport. The CCO shall retain the documentation and a copy of the order in their record for the Authority to review.

(5) The CCO may approve and pay for secured medical transport provided to a person going to or from a court hearing or to or from a commitment hearing if there is no other source of funding for this transport.

(6) This rule does not apply to ambulance providers, ambulance vehicles, or ambulance personnel that are licensed and regulated by ORS chapter 682 and OAR chapter 333, divisions 250, 255, 260 and 265, whether providing ambulance or stretcher transports.

STATUTORY/OTHER AUTHORITY: ORS 413.042, 414.625

STATUTES/OTHER IMPLEMENTED: ORS 414.625

REPEAL: 410-141-3460

RULE TITLE: Ground and Air Ambulance Transports

NOTICE FILED DATE: 09/16/2019

RULE SUMMARY: The agency has completed an exhaustive review and revision of all rules within Chapter 410 Division 141. As part of this process, OHA is renumbering rules within the Chapter and Division. Therefore, all existing rules need to be repealed to avoid redundant or conflicting rules in the oversight of the State's Coordinated Care Organizations (CCOs).

RULE TEXT:

(1) Transporting a member via ambulance is required when a medical facility or provider states the member's medical condition requires the presence of a health care professional during the emergency or non-emergency transport. This includes neonatal transports.

(2) For NEMT services, the CCOs shall authorize the transport.

(3) CCOs shall provide ambulance transports with a medical technician when:

(a) A member's medical condition requires a stretcher;

(b) The length of transport would require a personal care attendant; and

(c) The member does not have an attendant who can assist with personal care during the ride.

(4) When a member's medical condition is an emergency as defined in OAR 410-120-0000, emergency ambulance transportation must be used. The ambulance must transport the member to the nearest appropriate facility able to meet the member's medical needs.

(5) CCOs shall verify that the Authority has licensed providers of ground or air ambulance services to operate ground or air ambulances. If the ambulance service provider is located in a contiguous state and regularly provides rides to OHP members, the CCO must ensure that both the Authority and the contiguous state have licensed the ambulance service provider.

STATUTORY/OTHER AUTHORITY: ORS 413.042, 414.625

STATUTES/OTHER IMPLEMENTED: ORS 414.625

REPEAL: 410-141-3465

RULE TITLE: Modifications for Individuals with Disabilities

NOTICE FILED DATE: 09/16/2019

RULE SUMMARY: The agency has completed an exhaustive review and revision of all rules within Chapter 410 Division 141. As part of this process, OHA is renumbering rules within the Chapter and Division. Therefore, all existing rules need to be repealed to avoid redundant or conflicting rules in the oversight of the State's Coordinated Care Organizations (CCOs).

RULE TEXT:

(1) For the purposes of this rule, "direct threat" means a significant risk to the health or safety of others. A direct threat is one that:

(a) Cannot be eliminated or reduced to an acceptable level through the provision of auxiliary aids and services or through reasonably modifying policies, practices, or processes.

(b) Is identified through an individual assessment that relies on current medical evidence or the best available objective evidence that shows:

(A) The nature, duration, and severity of the risk;

(B) The probability that a potential injury will actually occur; and

(C) Whether reasonable modification of policies, practices, or processes will lower or eliminate the risk.

(2) CCO's may not apply criteria, standards, or practices that screen out or tend to screen out individuals in a protected class from fully and equally enjoying any goods, services, programs, or activities unless:

(a) The criteria can be shown to be necessary for providing those goods and services; or

(b) The CCO determines the screening or exclusion identifies a direct threat to the health and safety of others.

(3) CCOs and their subcontractors shall comply with the Authority's non-discrimination and modification rules found at OAR 943-005-0000 to 943-005-0070.

(4) CCO members may use the processes and rights specified in OAR 410-141-3260 through 3264 (Grievance System and Contested Case Hearings Rules).

STATUTORY/OTHER AUTHORITY: ORS 413.042, 414.625

STATUTES/OTHER IMPLEMENTED: ORS 414.625

REPEAL: 410-141-3470

RULE TITLE: Service Modifications

NOTICE FILED DATE: 09/16/2019

RULE SUMMARY: The agency has completed an exhaustive review and revision of all rules within Chapter 410 Division 141. As part of this process, OHA is renumbering rules within the Chapter and Division. Therefore, all existing rules need to be repealed to avoid redundant or conflicting rules in the oversight of the State's Coordinated Care Organizations (CCOs).

RULE TEXT:

(1) CCOs shall draft policies and procedures describing passenger rights and responsibilities including the right to file a complaint and request reconsideration and provide this information in all general information materials such as handbooks.

(2) CCOs shall draft policies and procedures that ensure the safety of all passengers in NEMT vehicles and provide the information to contractors, subcontractors, and members receiving NEMT services.

(3) A CCO may modify or a member may request modification of NEMT services when the member:

(a) Threatens harm to the driver or others in the vehicle.

(b) Has a health condition that creates a health or safety concern to the driver, others in the vehicle, or the member as described in OAR 410-141-3439.

(c) Engages in behaviors or circumstances that place the driver or others in the vehicle at risk of harm.

(d) Engages in behavior that, in the CCO's judgment, causes local medical providers or facilities to refuse to provide further services without modifying NEMT services.

(e) Frequently does not show up for scheduled rides.

(f) Frequently cancels the ride on the day of the scheduled ride time.

(4) Reasonable modifications include, but are not limited to, requiring members to:

(a) Use a specific transportation provider;

(b) Travel with an attendant;

(c) Use public transportation where available;

(d) Drive or locate someone to drive the member and receive mileage reimbursement;

(e) Confirm the ride with the NEMT provider on the day of or the day before the scheduled ride.

(5) Before modifying services, the NEMT provider, a CCO representative, and the member shall:

(a) Communicate about the reason for imposing a modification;

(b) Explore options that are appropriate to the member's needs;

(c) Address health and safety concerns;

(d) The CCO or member may include the member's care team in the discussion;

(e) The member may include another individual of their choosing in the discussion.

(6) Responses to requests for modification or auxiliary aids based on disability or other protected class status under state or federal rule or law must comply with the Americans with Disabilities Act and all other applicable state and federal laws and rules.

(7) A CCO may not modify NEMT services under this rule due solely to a request for modification or auxiliary aid based on disability or other protected class status.

(8) A CCO may not modify NEMT services to result in a denial of NEMT services to a member.

(9) A CCO shall make all reasonable efforts to offer an appropriate alternative to meet a member's needs under the circumstances.

STATUTORY/OTHER AUTHORITY: ORS 413.042, 414.625

STATUTES/OTHER IMPLEMENTED: ORS 414.625

REPEAL: 410-141-3475

RULE TITLE: Contested Case Hearings

NOTICE FILED DATE: 09/16/2019

RULE SUMMARY: The agency has completed an exhaustive review and revision of all rules within Chapter 410 Division 141. As part of this process, OHA is renumbering rules within the Chapter and Division. Therefore, all existing rules need to be repealed to avoid redundant or conflicting rules in the oversight of the State's Coordinated Care Organizations (CCOs).

RULE TEXT:

As required by 42 CFR 431, the CCO shall comply with OAR 410-141-3264 pertaining to contested case hearings when it denies a ride with the following exceptions:

(1) Prior to mailing a notice of action to a member, the CCO must provide a secondary review by another employee when the initial screener denies a ride.

(2) The CCO shall mail a notice of action to a member denied a ride within 72 hours of denial.

STATUTORY/OTHER AUTHORITY: ORS 413.042, 414.625

STATUTES/OTHER IMPLEMENTED: ORS 414.625

REPEAL: 410-141-3480

RULE TITLE: Member Reimbursed Mileage, Meals, and Lodging

NOTICE FILED DATE: 09/16/2019

RULE SUMMARY: The agency has completed an exhaustive review and revision of all rules within Chapter 410 Division 141. As part of this process, OHA is renumbering rules within the Chapter and Division. Therefore, all existing rules need to be repealed to avoid redundant or conflicting rules in the oversight of the State's Coordinated Care Organizations (CCOs).

RULE TEXT:

(1) A CCO may prior authorize a member's mileage, meals, and lodging to covered medical service in order for the member to qualify for reimbursement.

(2) A CCO may disallow a client reimbursement request received more than 45 days after the travel.

(3) A CCO shall reimburse a member for mileage, meals, and lodging at rates not less than the Authority's allowable rates. See the Division's fee schedule, available at: http://www.oregon.gov/OHA/HSD/OHP/Pages/Fee-Schedule.aspx.

(4) The member must return any documentation a CCO requires before receiving reimbursement.

(5) A CCO may hold reimbursements under the amount of $10 until the member's reimbursement reaches $10.

(6) A CCO shall reimburse members for meals when a member travels:

(a) Out of their local area as outlined in OAR 410-141-3220(4)(a) and (b); and

(b) For a minimum of four hours round-trip.

(7) A CCO's brokerage or other transportation subcontractor shall reimburse members for lodging when:

(a) A member would otherwise be required to begin travel before 5 a.m. in order to reach a scheduled appointment;

(b) Travel from a scheduled appointment would end after 9 p.m.; or

(c) The member's health care provider documents a medical need.

(8) A CCO may reimburse members for lodging under additional circumstances at the CCO's discretion.

(9) A CCO shall reimburse for meals or lodging for one attendant, which may be a parent, to accompany the member if medically necessary, if:

(a) The member is a minor child and unable to travel without an attendant;

(b) The member's attending physician provides a signed statement indicating the reason an attendant must travel with the member;

(c) The member is mentally or physically unable to reach his or her medical appointment without assistance; or

(d) The member is or would be unable to return home without assistance after the treatment or service.

(10) A CCO may reimburse members for meals or lodging for additional attendants or under additional circumstances at the CCOs discretion.

(11) A CCO may recover overpayments made to a member. Overpayments occur when a CCO's brokerage or other transportation subcontractor paid the member:

(a) For mileage, meals, and lodging, and another resource also paid:

(A) The member; or

(B) The ride, meal, or lodging provider directly;

(b) Directly to travel to medical appointments, and the member did not use the money for that purpose, did not attend the appointment, or shared the ride with another member whom the brokerage also paid directly;

(c) For common carrier or public transportation tickets or passes, and the member sold or otherwise transferred the tickets or passes to another individual.

(12) If an individual or entity other than the member or the minor member's parent or guardian provides the ride, a CCO's brokerage or other transportation subcontractor may reimburse the individual or entity that provided the ride.

STATUTORY/OTHER AUTHORITY: ORS 413.042, 414.625

STATUTES/OTHER IMPLEMENTED: ORS 414.625

REPEAL: 410-141-3485

RULE TITLE: Reports and Documentation

NOTICE FILED DATE: 09/16/2019

RULE SUMMARY: The agency has completed an exhaustive review and revision of all rules within Chapter 410 Division 141. As part of this process, OHA is renumbering rules within the Chapter and Division. Therefore, all existing rules need to be repealed to avoid redundant or conflicting rules in the oversight of the State's Coordinated Care Organizations (CCOs).

RULE TEXT:

(1) CCOs shall maintain documentation of rides denied and rides provided to members.

(2) For NEMT services provided to members, this documentation shall include:

(a) All encounter data required in the current CCO contract;

(b) Names of the company and driver transporting the member.

(3) For NEMT services denied to members, this documentation shall include:

(a) The name of the member and the individual requesting the ride on behalf of the member, if applicable;

(b) The member's OHP medical care identification number;

(c) The date and time of the request for transportation;

(d) The name of the employee who denied a ride;

(e) The name of the employee who performed the secondary review before denying the ride;

(f) The reason for the denial and the applicable OAR supporting the denial;

(g) The date on the notice of action the brokerage mailed to the member;

(h) Documentation on the review, resolution, or disposition of the matter, if applicable, including the reason for the decision and the date of the resolution or disposition; and

(i) Notations of oral and written communications with the member.

(4) The CCO shall retain the documentation on NEMT service denials for three calendar years, even if the CCO, its brokerage, or subcontractor that denied the service is no longer a Medicaid enrolled provider before the end of the three years. The Authority may request this information at any time during the three year retention period.

(5) The Authority may request and the CCO shall provide other reports or information not specified in sections (1-4) of this rule.

STATUTORY/OTHER AUTHORITY: ORS 413.042, 414.625

STATUTES/OTHER IMPLEMENTED: ORS 414.625

REPEAL: 410-141-4000

RULE TITLE: Definitions

NOTICE FILED DATE: 09/16/2019

RULE SUMMARY: The agency has completed an exhaustive review and revision of all rules within Chapter 410 Division 141. As part of this process, OHA is renumbering rules within the Chapter and Division. Therefore, all existing rules need to be repealed to avoid redundant or conflicting rules in the oversight of the State's Coordinated Care Organizations (CCOs).

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

STATUTORY/OTHER AUTHORITY: ORS 413.042, ORS 414.025

STATUTES/OTHER IMPLEMENTED: ORS 414.065, 2017 HB 2391

REPEAL: 410-141-4005

RULE TITLE: General Administration

NOTICE FILED DATE: 09/16/2019

RULE SUMMARY: The agency has completed an exhaustive review and revision of all rules within Chapter 410 Division 141. As part of this process, OHA is renumbering rules within the Chapter and Division. Therefore, all existing rules need to be repealed to avoid redundant or conflicting rules in the oversight of the State's Coordinated Care Organizations (CCOs).

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 premium equivalents 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 premium equivalents 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.

STATUTORY/OTHER AUTHORITY: ORS 413.042, ORS 414.025

STATUTES/OTHER IMPLEMENTED: ORS 414.065, 2017 HB 2391

REPEAL: 410-141-4010

RULE TITLE: Disclosure of Information

NOTICE FILED DATE: 09/16/2019

RULE SUMMARY: The agency has completed an exhaustive review and revision of all rules within Chapter 410 Division 141. As part of this process, OHA is renumbering rules within the Chapter and Division. Therefore, all existing rules need to be repealed to avoid redundant or conflicting rules in the oversight of the State's Coordinated Care Organizations (CCOs).

RULE TEXT:

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

(2) The Authority may:

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

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

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

STATUTORY/OTHER AUTHORITY: ORS 413.042, ORS 414.025

STATUTES/OTHER IMPLEMENTED: ORS 414.065, 2017 HB 2391

REPEAL: 410-141-4020

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

NOTICE FILED DATE: 09/16/2019

RULE SUMMARY: The agency has completed an exhaustive review and revision of all rules within Chapter 410 Division 141. As part of this process, OHA is renumbering rules within the Chapter and Division. Therefore, all existing rules need to be repealed to avoid redundant or conflicting rules in the oversight of the State's Coordinated Care Organizations (CCOs).

RULE TEXT:

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

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

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

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

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

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

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

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

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

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

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

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

STATUTORY/OTHER AUTHORITY: ORS 413.042, ORS 414.025

STATUTES/OTHER IMPLEMENTED: ORS 414.065, 2017 HB 2391

REPEAL: 410-141-4030

RULE TITLE: Filing an Amended Report

NOTICE FILED DATE: 09/16/2019

RULE SUMMARY: The agency has completed an exhaustive review and revision of all rules within Chapter 410 Division 141. As part of this process, OHA is renumbering rules within the Chapter and Division. Therefore, all existing rules need to be repealed to avoid redundant or conflicting rules in the oversight of the State's Coordinated Care Organizations (CCOs).

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

REPEAL: 410-141-4040

RULE TITLE: Determining the Date Filed

NOTICE FILED DATE: 09/16/2019

RULE SUMMARY: The agency has completed an exhaustive review and revision of all rules within Chapter 410 Division 141. As part of this process, OHA is renumbering rules within the Chapter and Division. Therefore, all existing rules need to be repealed to avoid redundant or conflicting rules in the oversight of the State's Coordinated Care Organizations (CCOs).

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

REPEAL: 410-141-4050

RULE TITLE: Authority to Audit Records

NOTICE FILED DATE: 09/16/2019

RULE SUMMARY: The agency has completed an exhaustive review and revision of all rules within Chapter 410 Division 141. As part of this process, OHA is renumbering rules within the Chapter and Division. Therefore, all existing rules need to be repealed to avoid redundant or conflicting rules in the oversight of the State's Coordinated Care Organizations (CCOs).

RULE TEXT:

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

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

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

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

STATUTORY/OTHER AUTHORITY: ORS 413.042, ORS 414.025

STATUTES/OTHER IMPLEMENTED: ORS 414.065, 2017 HB 2391

REPEAL: 410-141-4060

RULE TITLE: Determining Assessment Liability on Failure to File

NOTICE FILED DATE: 09/16/2019

RULE SUMMARY: The agency has completed an exhaustive review and revision of all rules within Chapter 410 Division 141. As part of this process, OHA is renumbering rules within the Chapter and Division. Therefore, all existing rules need to be repealed to avoid redundant or conflicting rules in the oversight of the State's Coordinated Care Organizations (CCOs).

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

REPEAL: 410-141-4070

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

NOTICE FILED DATE: 09/16/2019

RULE SUMMARY: The agency has completed an exhaustive review and revision of all rules within Chapter 410 Division 141. As part of this process, OHA is renumbering rules within the Chapter and Division. Therefore, all existing rules need to be repealed to avoid redundant or conflicting rules in the oversight of the State's Coordinated Care Organizations (CCOs).

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

REPEAL: 410-141-4080

RULE TITLE: Notice of Proposed Action

NOTICE FILED DATE: 09/16/2019

RULE SUMMARY: The agency has completed an exhaustive review and revision of all rules within Chapter 410 Division 141. As part of this process, OHA is renumbering rules within the Chapter and Division. Therefore, all existing rules need to be repealed to avoid redundant or conflicting rules in the oversight of the State's Coordinated Care Organizations (CCOs).

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

REPEAL: 410-141-4090

RULE TITLE: Required Notice

NOTICE FILED DATE: 09/16/2019

RULE SUMMARY: The agency has completed an exhaustive review and revision of all rules within Chapter 410 Division 141. As part of this process, OHA is renumbering rules within the Chapter and Division. Therefore, all existing rules need to be repealed to avoid redundant or conflicting rules in the oversight of the State's Coordinated Care Organizations (CCOs).

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

REPEAL: 410-141-4100

RULE TITLE: Hearing Process

NOTICE FILED DATE: 09/16/2019

RULE SUMMARY: The agency has completed an exhaustive review and revision of all rules within Chapter 410 Division 141. As part of this process, OHA is renumbering rules within the Chapter and Division. Therefore, all existing rules need to be repealed to avoid redundant or conflicting rules in the oversight of the State's Coordinated Care Organizations (CCOs).

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

REPEAL: 410-141-4110

RULE TITLE: Final Order of Payment

NOTICE FILED DATE: 09/16/2019

RULE SUMMARY: The agency has completed an exhaustive review and revision of all rules within Chapter 410 Division 141. As part of this process, OHA is renumbering rules within the Chapter and Division. Therefore, all existing rules need to be repealed to avoid redundant or conflicting rules in the oversight of the State's Coordinated Care Organizations (CCOs).

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

REPEAL: 410-141-4120

RULE TITLE: Remedies Available after Final Order of Payment

NOTICE FILED DATE: 09/16/2019

RULE SUMMARY: The agency has completed an exhaustive review and revision of all rules within Chapter 410 Division 141. As part of this process, OHA is renumbering rules within the Chapter and Division. Therefore, all existing rules need to be repealed to avoid redundant or conflicting rules in the oversight of the State's Coordinated Care Organizations (CCOs).

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