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TEMPORARY ADMINISTRATIVE ORDER

INCLUDING STATEMENT OF NEED & JUSTIFICATION

DMAP 20-2018

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

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FILING CAPTION: Coordinated Care Organization (CCO) Contract Renewal Notification Requirements

EFFECTIVE DATE: 04/06/2018 THROUGH 10/02/2018

AGENCY APPROVED DATE: 04/04/2018

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NEED FOR THE RULE(S):

The OHP program administrative rules govern the Division's payments for services provided to Coordinated Care Organizations. The Authority needs to temporarily amend OAR 410-141-3000 and 410-141-3010 and promulgate the new rule 410-141-3041 to ensure compliance with changes made during the 2018 legislative session to ORS 414.625 that were effective upon passage.

JUSTIFICATION OF TEMPORARY FILING:

The Authority finds that failure to act promptly will result in serious prejudice to the public interest, the Authority, providers, and clients receiving services.

DOCUMENTS RELIED UPON, AND WHERE THEY ARE AVAILABLE:

House Bill 4018 (Enrolled) of the 2018 Oregon Legislative session viewable at;
https://olis.leg.state.or.us/liz/2018R1/Downloads/MeasureDocument/HB4018/Enrolled

RULES:
410-141-3000, 410-141-3010, 410-141-3041

AMEND: 410-141-3000

RULE TITLE: Managed Care Entity Definitions

RULE SUMMARY: The OHP program administrative rules govern the Division's payments for services provided to Coordinated Care Organizations. The Authority needs to temporarily amend OAR 410-141-3000 and 410-141-3010 and promulgate the new rule 410-141-3041 to ensure compliance with changes made during the 2018 legislative session to ORS 414.625 that were effective upon passage. House Bill 4018 (Section 5) of the 2018 legislative session requires OHA to give CCOs a statutorily defined minimum number of days to review proposed contract changes and of CCOs to provide notice to the Authority of intent not to execute contract amendments.

RULE TEXT:

(1) The Oregon Health Authority adopts and incorporates by reference the definitions below for use by the Managed Care Entities in the following administrative rules and applies them to Health System Transformation:
(a) OARs 309-012-0140, 309-016-0605, 309-032-0860, 309-032-1505, 309-033-0210, applicable to mental health services;
(b) OAR 410-120-0000, definitions of the Oregon Health Plan's General Rules; and
(c) OAR 410-141-3000.
(2) "Adjudication" means the act of a court or entity in authority when issuing an order, judgment, or decree, as in a final MCE claims decision or the Authority issuing a final hearings decision. This function is non-delegable under the Coordinated Care contracts in the context of hearings and appeals.
(3) "Adverse Benefit Determination" means the denial or limited authorization of a requested service, including determinations based on the type or level of service, medical necessity, appropriateness, setting, or effectiveness of a covered benefit. The reduction, suspension, or termination of a previously authorized service or the denial of payment for a service. See OAR 410-141-3240 for a member enrolled in an MCE.
(4) "Alternate Format" means any alternate approach to presenting print information to an individual with a disability. The Americans with Disabilities Act (ADA) groups the standard alternate formats: braille, large (18 point) print, audio narration, oral presentation, and electronic file along with other aids and services for other disabilities, including sign language interpretation and sighted guide; CMS Section 1557 of the ACA outlines requirements for health plans and providers on alternative formats.
(5) "Applicant" means the entity submitting an application to be certified as a CCO or to enter into or amend a contract for coordinated care services.
(6) "Application" means an entity's written response to a Request for Application (RFA).
(7) "Auxiliary Aids and Services" are to be made available to members as defined in CMS Section 1557 of the ACA.
(8) "Award Date" means the date on which the Authority acts on the applications by issuing or denying certification and by awarding or not awarding contracts.
(9) "Benefit Period" means a period of time shorter than the five-year contract term, for which specific terms and conditions in a contract between a coordinated care organization and the Oregon Health Authority are in effect.
(10) "Business Day" means any day except Saturday, Sunday, or a legal holiday. The word "day" not qualified as business day means calendar day.
(11) "Capitated Services" means those covered services that a PHP agrees to provide for a capitation payment under contract with the Authority.
(12) "Capitation Payment" means monthly prepayment to a PHP for health services the PHP provides to members.
(13) "Certification" means the Authority's determination that an entity meets the criteria in OAR 410-141-3015 and the standards set forth in the RFA for being a CCO through initial certification or recertification.
(14) "CCO Payment" means the monthly payment to a CCO for services the CCO provides to members in accordance with the global budget.
(15) "Certificate of Authority" means the certificate issued by DCBS to a licensed health entity granting authority to transact insurance as a health insurance company or health care service contractor.
(16) "Cold Call Marketing" means an MCE's unsolicited personal contact, including texting and email, with a potential member for the purpose of marketing.
(17) "Community Advisory Council" means the CCO-convened council that meets regularly to ensure the CCO is addressing the health care needs of CCO members and the community consistent with ORS 414.625.
(18) "Community Standard" means typical expectations for access to the health care delivery system in the member's community of residence. Except where the community standard is less than sufficient to ensure quality of care, the Division requires that the health care delivery system available to Division members in MCEs take into consideration the community standard and be adequate to meet the needs of the Division's enrollment.
(19) "Contract" means an agreement between the State of Oregon acting by and through the Authority and an MCE to provide health services to eligible members.

(20) “Contract Renewal” means an agreement by a CCO to amend the terms or conditions of an existing contract for the next benefit period.
(21) “Converting MCO” means a CCO that:
(a) Is the legal entity that contracted as an MCO with the Authority as of July 1, 2011, or;
(b) Was formed by one or more MCEs that contracted with the Authority as of July 1, 2011.
(22) “Coordinated Care Organization (CCO)” means a corporation, governmental agency, public corporation, or other legal entity that is certified as meeting the criteria adopted by the Authority under ORS 414.625 to be accountable for care management and to provide integrated and coordinated health care for each of the organization’s members.
(23) “Coordinated Care Services” mean an MCE’s fully integrated physical health, behavioral health services, and oral health services.
(24) “Corrective Action or Corrective Action Plan” means a Division-initiated request for a contractor or a contractor-initiated request for a subcontractor to develop and implement a time specific plan for the correction of identified areas of noncompliance.
(25) “Dental Care Organization (DCO)” means an MCE that provides and coordinates dental services as capitated services under OHP.
(26) “Dental Case Management Services” means services provided to ensure the member receives dental services including a comprehensive, ongoing assessment of the member’s dental and medical needs related to dental care and the development and implementation of a plan to ensure the member receives those services.
(27) “DCBS Reporting CCO” means a CCO that reports its solvency plan and financial status to DCBS, not a CCO holding a certificate of authority.
(28) “Department of Consumer and Business Services (DCBS)” means Oregon’s business regulatory and consumer protection agency.
(29) “Disenrollment” means the act of removing a member from enrollment with an MCE.
(30) “Exceptional Needs Care Coordination (ENCC)” means for PHPs a specialized case management service provided to members identified as aged, blind, or disabled members who have complex health needs, high health care needs, multiple chronic conditions, behavioral health issues including chemical dependency, or those with severe and persistent behavioral health issues, or those receiving Medicaid-funded long-term care or long-term services and supports. Children and youth shall be provided intensive care coordination and behavioral health services according to presenting needs consistent with OAR 410-141-3170.
(31) “Enrollment” means the assignment of a member to an MCE for management and receipt of health services.
(32) “Entity” means a single legal entity capable of entering into a risk contract that covers coordinated care services with the state and conducting the business of a coordinated care organization.
(33) “Free-Standing Mental Health Organization (MHO)” means the single MHO in each county that provides only behavioral services and is not affiliated with a fully capitated health plan for that service area.
(34) “Fully-Capitated Health Plan (FCHP)” means an MCE that contracts with the Authority to provide capitated health services including inpatient hospitalization.
(35) “Global Budget” means the total amount of payment as established by the Authority to a CCO to deliver and manage health services for its members including providing access to and ensuring the quality of those services.
(36) “Grievance System” means the overall system that includes:
(a) Grievances to an MCE on matters other than actions;
(b) Appeals to an MCE on actions; and
(c) Contested case hearings through the state on actions and other matters for which the member is given the right to a hearing by rule or statute.
(37) “Health Literacy” means the degree to which individuals have the capacity to obtain, process, and understand basic health information needed to make appropriate health decisions regarding services needed to prevent or treat illness.
(38) “Health-Related Services” means non-covered services under Oregon’s Medicaid State Plan intended to improve care delivery and overall member and community health and well-being. Health-related services include flexible

services and community benefit initiatives. Flexible services are cost-effective services offered to an individual member to supplement covered benefits. Community benefit initiatives are community-level interventions that include but are not necessarily limited to members and are focused on improving population health and health care quality:
(a) The goals of health-related services are to promote the efficient use of resources and address members' social determinants of health to improve health outcomes, alleviate health disparities, and improve overall community well-being. Health-related services are provided as a supplement to billable office visits and are often cost-effective services offered as an adjunct to covered benefits. Health-related services lack traditional billing or encounter codes, are not encounterable, and may not be reported for utilization purposes;
(b) To be considered a health-related service, a service must meet the requirements for:
(A) Activities that improve health care quality as defined in 45 CFR 158.150; or
(B) Expenditures related to Health Information Technology and meaningful use requirements to improve health care quality, as defined in 45 CFR 158.151.
(39) "Holistic Care" means incorporating the care of the entire member in all aspects of well-being including physical, psychological, cultural, linguistic, and social and economic needs of the member. Holistic care utilizes a process whereby providers work with members to guide their care and identify needs. This also involves identifying with principles of holism in a system of therapeutics, especially one considered outside the mainstream of scientific medicine as naturopathy or chiropractic and often involving nutritional measures.
(40) "Home CCO" means enrollment in a CCO in a given service area based upon a client's most recent permanent residency, determined at the time of original eligibility or most current point of CCO enrollment prior to hospitalization.
(41) "Indian" means any individual defined at 25 USC 1603(13), 1603(28), or 1679(a), or who has been determined eligible as an Indian, under 42 CFR 136.12 and:
(a) Is a member of a federally recognized Indian tribe;
(b) Resides in an urban center and meets one or more of the four criteria;
(c) Is a member of a tribe, band, or other organized group of Indians, including those tribes, bands, or groups terminated since 1940 and those recognized now or in the future by the state in which they reside or who is a descendant in the first or second degree of any such member:
(A) Is an Eskimo or Aleut or other Alaska Native;
(B) Is considered by the Secretary of the Interior to be an Indian for any purpose; or
(C) Is determined to be an Indian under regulations issued by the Secretary:
(i) Is considered by the Secretary of the Interior to be an Indian for any purpose; or
(ii) Is considered by the Secretary of Health and Human Services to be an Indian for purposes of eligibility for Indian health care services, including as a California Indian, Eskimo, Aleut, or other Alaska Native.
(42) "Indian Health Care Provider (IHCP)" means a health care program operated by the Indian Health Service (IHS) or by an Indian Tribe, Tribal Organization, or Urban Indian Organization (otherwise known as an I/T/U) as those terms are defined in section 4 of the Indian Health Care Improvement Act (25 U.S.C. 1603).
(43) "Institution for Mental Diseases (IMD)" means, as defined in 42 CFR 435.1010, a hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing inpatient psychiatric services such as diagnosis, treatment, or care of individuals with mental diseases, including medical attention, nursing care, and related services. Its primary character is that of a facility established and maintained primarily for the care and treatment of individuals with mental diseases, whether or not it is licensed as such.
(44) "Intensive Case Management (ICM)" means a specialized case management service provided by CCOs to members identified as aged, blind, or disabled members who have complex health needs, high health care needs, multiple chronic conditions, behavioral health issues including chemical dependency or with severe and persistent behavioral health issues, or those receiving Medicaid-funded long-term care or long-term services and supports. Children and youth shall be provided intensive care coordination and behavioral health services according to presenting needs consistent with OAR 410-141-3170.
(45) "Licensed Health Entity" means a CCO that has a Certificate of Authority issued by DCBS as a health insurance

company or health care service contractor.
(46) “Limited English Proficient (LEP)” means potential members who do not speak English as their primary language and who have a limited ability to read, write, speak, or understand English may be LEP and may be eligible to receive language assistance for a particular type of service, benefit, or encounter.
(47) “Line Items” means condition/treatment pairs or categories of services included at specific lines in the Prioritized List of Health Services.
(48) “Managed Care Entity (MCE)” means, as stated in 42 CFR 457.10, an entity that enters into a contract to provide services in a managed care delivery system including but not limited to managed care organizations, prepaid health plans, and primary care case managers.
(49) “Marketing” means any communication from a PHP or a CCO to a potential member who is not enrolled in the PHP or CCO, and the communication can reasonably be interpreted as intended to compel or entice the potential member to enroll in that particular PHP or CCO.
(50) “Medicaid-funded Long-term Care or Long-term Services and Supports” means all Medicaid funded services CMS defines as long-term services and supports that include both:
(a) “Long-term Care” means the system through which the Department of Human Services provides a broad range of social and health services to eligible adults who are aged, blind, or have disabilities for extended periods of time. This includes nursing homes and behavioral health care outlined in OAR chapter 410 division 172 Medicaid Behavioral Health, including state psychiatric hospitals;
(b) “Long-term Services and Supports” means the Medicaid services and supports provided under a CMS approved waiver to assist individual’s needs and to avoid institutionalization as defined in OAR 411, chapter 4 and defined as Medicaid Home and Community-Based Settings and Services (HCBS) and as outlined in OAR chapter 410 division 172 (Medicaid Behavioral Health).
(51) “Medical Case Management Services” means services provided to ensure members obtain health services necessary to maintain physical and emotional development and health.
(52) “Member” has the meaning given that term in OAR 410-120-0000.
(53) “Mental Health Organization (MHO)” means an MCE that provides capitated behavioral services for clients.
(54) “National Association of Insurance Commissioners (NAIC)” means the U.S. standard-setting and regulatory support organization created and governed by the chief insurance regulators from the 50 states, the District of Columbia, and five U.S. territories.
(55) “Net Premium” means the premium, net of reinsurance premiums paid, HRA and GME payments, and MCO tax expenses.
(56) “Non-Participating Provider” means a provider that does not have a contractual relationship with an MCE and is not on their panel of providers.
(57) “Oregon Health Authority or Authority Reporting CCO” means a CCO that reports its solvency plan and financial status to the Authority under these rules.
(58) “Participating Provider” means a provider that has a contractual relationship with an MCE and is on their panel of providers.
(59) “Potential Member” means an individual who meets the eligibility requirements to enroll in the Oregon Health Plan but has not yet enrolled with a specific PHP or CCO.
(60) “Prevalent Non-English Language” means all non-English languages that are identified as the preferred written language by the lesser of either:
(a) Five percent of the MCE’s total OHP enrollment; or
(b) One thousand of the MCE’s members.
(61) “Readily Accessible” means electronic information and services that comply with modern accessibility standards such as section 508 guidelines, section 504 of the Rehabilitation Act, and W3C’s Web Content Accessibility Guidelines (WCAG) 2.0 AA and successor versions.
(62) “Request for Applications (RFA)” means the document used for soliciting applications for certification as a CCO,

award of or amendment of a CCO services contract, or other objectives as the Authority may determine appropriate for procuring coordinated care services.
(63) “Service Area” means the geographic area within which the PHP or CCO agreed under contract with the Authority to provide health services.
(64) “Treatment Plan” means a documented plan that describes the patient's condition and procedures that will be needed, detailing the treatment to be provided and expected outcome and expected duration of the treatment prescribed by the healthcare professional. This therapeutic strategy shall be designed in collaboration with the member, the member’s family, or the member representative.

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

STATUTES/OTHER IMPLEMENTED: ORS 414.610 - 414.685

AMEND: 410-141-3010

RULE TITLE: CCO Application, Certification, and Contracting Procedures

RULE SUMMARY: The OHP program administrative rules govern the Division's payments for services provided to Coordinated Care Organizations. The Authority needs to temporarily amend OAR 410-141-3000 and 410-141-3010 and promulgate the new rule 410-141-3041 to ensure compliance with changes made during the 2018 legislative session to ORS 414.625 that were effective upon passage. House Bill 4018 (Section 5) of the 2018 legislative session requires OHA to give CCOs a statutorily defined minimum number of days to review proposed contract changes and of CCOs to provide notice to the Authority of intent not to execute contract amendments.

RULE TEXT:

(1) The Authority shall establish an application process for entities seeking certification and contracts as CCOs.

(2) The Authority shall use the following RFA processes for CCO certification and contracting:

(a) The Authority shall provide public notice of every RFA on its website. The RFA shall indicate how prospective applicants are made aware of addenda by posting notice of the RFA on the electronic system for notification to the public of Authority procurement opportunities or, upon request, by mailing notice of the availability of the RFA to persons that have expressed interest in the RFA;

(b) The RFA process begins with a public notice that shall be communicated using the Authority's website. A public notice of an RFA shall identify the certification requirements for the contract, the designated service areas where coordinated care services are requested, and a sample contract;

(c) The RFA may specify that applicants must submit a letter of intent to the Authority within the specified time period. The letter of intent does not commit any applicant to apply. If a letter of intent is required, the Authority may not consider applications from applicants who fail to submit a timely letter of intent except as provided in the RFA;

(d) The RFA may request applicants to appear at a public meeting to provide information about the application;

(e) The RFA shall request information from applicants in order to allow the Authority to engage in appropriate state supervision necessary to promote state action immunity under state and federal antitrust laws;

(f) The Authority shall consider only applications that are responsive, completed as described in the RFA, and submitted in the time and manner described in the RFA. The RFA may require submission of the application on its web portal in accordance with OAR 137-047-0330 Electronic Procurements. If electronic procurement is used, applications shall be accepted only from applicants who accept the terms and conditions for use of the Authority's web portal.

(3) At recertification the Authority may permit a current CCO contractor to submit an abbreviated application that focuses only on additional or different requirements specific to the recertification and new contract or the new addenda or capacity or other purposes within the scope of the RFA.

(4) The Authority shall evaluate applications for certification on the basis of criteria in OAR 410-141-3015, information contained in the RFA, the application, and any additional information that the Authority obtains. Application evaluations shall be based on RFA criteria:

(a) The Authority may enter into negotiation with applicants concerning potential capacity and enrollment in relation to other available or potentially available capacity, the number of potential enrollees within the service area, and other factors identified in the RFA;

(b) The Authority shall notify each applicant that applies for certification of its certification status;

(c) Applicants that meet the RFA criteria shall be certified to contract as a CCO.

(5) Review for certification:

(a) The Authority shall issue certification only to applicants that meet the criteria in OAR 410-141-3015, meet the requirements, and provide the assurances specified in the RFA. The Authority determines whether the applicant qualifies for certification based on the application and any additional information and investigation that the Authority may require;

(b) The Authority determines an applicant is eligible for certification when the applicant meets the requirements of the RFA including written assurances satisfactory to the Authority that the applicant:

(A) Provides the coordinated care services in the manner described in the RFA and the Authority's rules;
(B) Is responsible and meets standards established by the Authority and DCBS for financial reporting and solvency;
(C) Is organized and operated and shall continue to be organized and operated in the manner required by the contract and described in the application; and
(D) Shall comply with any assurances it gives the Authority.
(6) The Authority shall certify CCOs for a period of six years from the date the certification application is approved, unless the Authority certifies a CCO for a shorter period.
(7) The Authority may determine that an applicant is potentially eligible for certification in accordance with section (9). The Authority is not obligated to determine whether an applicant is potentially eligible for certification if, in its discretion, the Authority determines that sufficient applicants eligible for certification are available to attain the Authority's objectives under the RFA.
(8) The Authority may determine that an applicant is potentially eligible for certification if:
(a) The Authority finds that the applicant is reasonably capable of meeting the operational and solvency requirements of the RFA within a specified period of time; and
(b) The applicant enters into discussions with the Authority about areas of qualification that must be met before the applicant is operationally and financially eligible for certification. The Authority shall determine the date and required documentation and written assurances required from the applicant;
(c) If the Authority determines that an applicant potentially eligible for certification cannot become certified within the time announced in the RFA for contract award, the Authority may:
(A) Offer certification at a future date when the applicant demonstrates to the Authority's satisfaction that the applicant is eligible for certification within the scope of the RFA; or
(B) Inform the applicant that it is not eligible for certification.
(9) The Authority may award contracts to certified CCOs for administering the Oregon Integrated and Coordinated Health Care Delivery System.
(10) The Authority shall enter into a new contract or contract renewal with a CCO only if the CCO has been certified and the Authority determines that the contract would be within the scope of the RFA and consistent with the purposes and effective administration of the Oregon Integrated and Coordinated Health Care Delivery System that includes but is not limited to:
(a) The capacity of any existing CCO in the region compared to the capacity of an additional CCO for the number of potential enrollees in the addenda;
(b) The number of CCOs in the region.
(11) The application is the applicant's offer to enter into a contract and is a firm offer for the period specified in the RFA. The Authority's award of the contract constitutes acceptance of the offer and binds the applicant to the contract:
(a) Except to the extent the applicant is authorized to propose certain terms and conditions pursuant to the RFA, an applicant may not make its offer contingent on the Authority's acceptance of any terms or conditions other than those contained in the RFA;
(b) Only an entity that the Authority certified to contract as a CCO may enter into a contract as a CCO. Certification to contract as a CCO does not assure the CCO will be offered a contract;
(c) The Authority may award multiple contracts or make a single award or limited number of awards to all certified or potentially certified applicants in order to meet the Authority's needs, including but not limited to adequate capacity for the potential enrollees in the service area, maximizing the availability of coordinated care services, and achieving the objectives in the RFA;
(d) Subject to any limitations in the RFA, the Authority may execute a contract renewal for CCO services by amending an existing contract or issuing a replacement contract without issuing a new RFA;
(e) The suspension or termination of a CCO contract issued under an RFA due to noncompliance with contract requirements or by a CCO's voluntary suspension or termination shall also be a suspension or termination of certification.

(12) Disclosure of application contents and release of information:
(a) Except for the letter of intent to apply and the technical application (with the exception of information that has been clearly identified and labeled confidential in the manner specified in the RFA), information may not be disclosed to any applicant or the public until the award date. No information may be given to any applicant or the public relative to its standing with other applicants before the award date except under the following circumstances:
(A) The information in the application may be shared with the Authority, DCBS, CMS, and those individuals involved in the application review and evaluation process; and
(B) Information may be provided by the applicant to the public as part of a public review process.
(b) Application information may be disclosed on the award date (with the exception of information that has been clearly identified and labeled confidential in the manner specified in the RFA) if the Authority determines it meets the disclosure exemption requirements.
(13) CCOs may apply to participate in the CMS Medicare/Medicaid Alignment Demonstration, but participation is not required. This rule does not replace the CMS requirements related to the Medicare/Medicaid Alignment Demonstration, such as the CMS notice of intent to apply and required components for Part D coverage. The RFA provides information about the demonstration requirements. Upon approval of the demonstration by CMS, the Authority shall conduct jointly with CMS the evaluation for certification for the Medicare/Medicaid Alignment Demonstration and the award of three-way contracts between CMS, the state, and applicants who have been certified to contract as a CCO and participate in the demonstration.
(14) The Authority shall interpret and apply this rule to satisfy federal procurement and contracting requirements in addition to state requirements applicable to contracts with CCOs. The Authority must seek and receive federal approval of CCO contracts.
(15) Except where inconsistent with the preceding sections of this rule, the Authority adopts the following Department of Justice (DOJ) Model Public Contract Rules (as in effect on January 1, 2012) to govern RFAs and certification and contracting with CCOs:
(a) General Provisions Related to Public Contracting: OARs 137-046-0100, 137-046-0110, and 137-046-0400 through 137-046-0480;
(b) Public Procurements for Goods or Services: OARs 137-047-0100, 137-047-0260 through 137-047-0670, 137-047-700 to 137-047-0760 (excluding provisions governing judicial review), and 137-047-0800;
(c) In applying the DOJ Model Rules to RFAs under this rule:
(A) An application is a proposal under the DOJ Model Rules;
(B) An RFA is an RFP under the DOJ Model Rules;
(C) Certification as a CCO is pre-qualification under the DOJ Model Rules;
(D) Provisions of the Public Contracting Code referenced in the DOJ Model Rules are considered to be incorporated therein;
(E) Definitions in the DOJ Model Rules govern this rule except where a term is defined in section (1) of this rule.
(16) Judicial review of the Authority's decisions relating to a solicitation protest, certification, or contract award is governed by the Oregon Administrative Procedures Act (APA). The RFA may establish when an Authority decision may be considered a final order for purposes of APA review.

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

STATUTES/OTHER IMPLEMENTED: ORS 414.610 - 414.685

ADOPT: 410-141-3041

RULE TITLE: CCO Contract Renewal Notification Requirements

RULE SUMMARY: The OHP program administrative rules govern the Division's payments for services provided to Coordinated Care Organizations. The Authority needs to temporarily amend OAR 410-141-3000 and 410-141-3010 and promulgate the new rule 410-141-3041 to ensure compliance with changes made during the 2018 legislative session to ORS 414.625 that were effective upon passage. House Bill 4018 (Section 5) of the 2018 legislative session requires OHA to give CCOs a statutorily defined minimum number of days to review proposed contract changes and of CCOs to provide notice to the Authority of intent not to execute contract amendments.

RULE TEXT:

(1) No later than 134 days prior to the end of a benefit period, the Authority shall provide each CCO with notice of the proposed changes to the terms and conditions of the contract for the next benefit period that the Authority submits to the Centers for Medicare and Medicaid Services for approval.

(2) If a CCO declines a contract renewal with the Authority, the CCO must notify the Authority of its intention not to enter into the contract renewal no later than 14 days after the Authority's notice of proposed changes as described in section (1).

(3) A CCO's notice to the Authority of intent not to enter into a contract renewal terminates the contract at the end of the benefit period unless:

(a) The Authority at its discretion requires the contract to remain in force into the next benefit period and be amended as proposed by the Authority until 90 days after the CCO has in accordance with criteria prescribed by the Authority:

(A) Notified each of its members and contracted providers of the termination of the contract;

(B) Provided to the Authority a plan to transition its members to other CCOs; and

(C) Provided to the Authority a plan for closing out its CCO business.

(b) The Authority may at its discretion waive compliance with the deadlines stated in sections (2) or (3) if the Authority determines such waiver to be consistent with the effective and efficient administration of the medical assistance program and the protection of medical assistance recipients.

STATUTORY/OTHER AUTHORITY: ORS 413.042, 414.615, 414.625, 414.635, 414.651, 414.652

STATUTES/OTHER IMPLEMENTED: ORS 414.610 - 414.685