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

FILING CAPTION: New CCO Rules on Contract Termination and Closeout Requirements and Sanctions

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RULES:
410-141-3258, 410-141-3259

ADOPT: 410-141-3258

RULE TITLE: Contract Termination and Close-Out Requirements

NOTICE FILED DATE: 10/11/2018

RULE SUMMARY: The Division needs to amend these rules to provide direction and clarification to the Coordinated Care Organizations and Prepaid Health Plans. Specifically, these proposed rules will: (1) Provide clarification on requirements for run-out reporting, ongoing obligations, and criteria for the release of restricted reserves; (2) Require CCOs to arrange for the orderly transfer of enrollees as directed by OHA including requirements for CCOs to provide all medical and financial records needed to transfer enrollees and coordinate their care without disruption; (3) Create a framework for the Authority to issue sanctions as authorized by federal law to address CCO performance issues if necessary.

RULE TEXT:
(1) This rule applies to any termination of an MCE contract, including but not limited to non-renewal under OAR 410-141-3041, expiration of the contract at the end of its term, or termination during the term of the contract initiated by either party. Consistent with OAR 410-141-3041, MCEs shall abide by all requirements in this rule regardless of whether termination notice is provided by the Authority or the MCE.
(2) The party initiating the termination shall render written notice of termination to the other party by certified mail, return receipt requested, or in person with proof of delivery and a contemporaneous copy emailed to the other party's contract administrator.
(3) The notice of termination shall specify the circumstances giving rise to termination and the date on which such termination shall become effective.
(4) After receipt of an MCE's notification of intent not to renew or notice of termination, the Authority shall issue written notice to the MCE specifying:
(a) The effective date of termination;
(b) The MCE's operational and reporting requirements; and

(c) Timelines for submission of deliverables.
(5) Upon notification of termination or non-renewal, an MCE shall submit to the Authority a transition plan detailing how it fulfills its continuing obligations for the duration of the contract. The transition plan shall include:
(a) How each of the MCE's members and contracted providers are notified of the termination of the contract;
(b) A plan to transition its members to other MCEs; and
(c) A plan for closing out its MCE business, including but not limited to the operational and reporting requirements and timelines for submission of deliverables, as specified by the Authority, and the requirements specified in this rule.
(6) Transition plans are subject to approval by the Authority:
(a) The MCE must revise the transition plan as necessary to obtain approval by the Authority;
(b) Failure to submit a transition plan and obtain written approval of the termination plan by the Authority may result in the Authority's withholding of 20 percent of the MCE's monthly capitation payment until the Authority has approved the transition plan;
(c) If the Authority's approval of the transition plan occurs less than 90 days before the effective date of termination, then the Authority may require the MCE to extend the contract to a later effective date of termination, including as necessary the MCE's acceptance of amendments to the contract generally applicable to MCE contracts through the extended effective date.
(7) The MCE shall designate an individual as the contract transition coordinator.
(8) The contract transition coordinator shall be the Authority's contact for ensuring the MCE's completion of the MCE's contractual obligations, performance, operations, and member transitions including the transition plan.
(9) MCEs must submit reports to the Authority every30 calendar days detailing the MCE's progress in executing its transition plan. In the event of the MCE's substantial failure to execute timely its transition plan, the Authority may withhold 20 percent of any payments due to the MCE from the Authority until such failure is corrected.
(10) MCEs shall submit a final report to the Authority describing how it fulfilled all transition and close-out activities described in the transition plan. The final report is subject to the Authority approval before issuance of any final payment.
(11) MCEs shall continue to perform all financial, management, and administrative services obligations identified in contract throughout the closeout period, including at minimum:
(a) Restricted reserves and insurance coverage for a period of 18 months following the notice of termination, or until the state provides the MCE with written release agreeing that all continuing obligations are fulfilled, whichever is earlier;
(b) Maintaining adequate staffing to perform all required functions as specified in contract;
(c) Supplying all information necessary to the Authority or its designee upon request for reimbursement of any outstanding claims at the time of termination;
(d) Assisting the Authority to ensure an orderly transition of member services after notice of termination consistent with the Authority's Transition of Care Policy; and
(e) To make available all signed provider agreements or subcontracts to the Authority upon request.
(12) The MCE must arrange for the orderly transfer of all OHP members assigned to the MCE to coverage under any new arrangement authorized by the Authority, including any actions required by the Authority to complete the transition of members and the termination of the MCE contract. These actions include:
(a) Forwarding of all medical or financial records related to the contractually obligated activities;
(b) High needs care coordination;
(c) Facilitation and scheduling of medically necessary appointments for care and services;
(d) Identification of chronically ill, high risk, hospitalized, and pregnant members in their last four weeks of pregnancy.
(13) If a change of providers may be harmful to the member, the MCE must continue to provide services until that treatment is concluded or appropriate transfer of care is arranged.
(14) The MCE shall make available and require its providers and subcontractors to make available to the Authority copies of medical, behavioral, oral and managed long-term services and supports records, patient files, and any other

pertinent information necessary for efficient care management of enrollees, as determined by the Director of the Authority:
(a) Records shall be in a usable form and shall be provided at no expense to the Authority, using a file format and dates for transfer specified by the Authority;
(b) Under no circumstances shall a Medicaid member be billed for this service;
(c) Information that shall be required includes:
(A) Numbers and status of grievances in process;
(B) Numbers and status of hospital authorizations in process, listed by hospital;
(C) Daily hospital logs;
(D) Prior authorizations approved, pending, or denied;
(E) Program exceptions approved;
(F) Medical cost ratio data;
(G) Information on outstanding payments for medical care rendered to members;
(H) All encounter data required under the terminated agreement;
(I) Identification of members whose treatment or treatment plans require continuity of care consideration;
(J) Any other information or records deemed necessary by the Authority to facilitate the transition of care.
(15) Following expiration of the contract and the completion of closeout period obligations, the MCE shall:
(a) Maintain claims processing functions as necessary for a minimum of 18 months after the date of termination. If additional claims are outstanding, the MCE shall maintain the claims processing system as long as necessary to complete final adjudication of all claims;
(b) Remain liable and retain financial responsibility for all claims with dates of service prior to the date of termination;
(c) Maintain financial responsibility for patients who are hospitalized prior to the termination date through the date of discharge or for patients receiving post hospital extended care benefits after termination to the extent the MCE is responsible under the contract;
(d) Maintain financial responsibility for services rendered prior to the termination date, for which payment is denied by the MCE and subsequently approved upon appeal by the provider; and
(e) Assist the Authority with grievances and appeals for dates of service prior to the termination date.
(16) Runout activities shall consist of the processing, payment, and reconciliations necessary regarding all enrollees, claims for payment from providers, appeals by both providers and members, and financial reporting deemed necessary by the Authority, including:
(a) Monthly claims aging report including IBNR amounts;
(b) Quarterly financial statements and annual audited financial statements in conformity with the specification in the contract up to the date specified by the Authority;
(c) Certified encounter reporting until all services rendered prior to contract expiration or termination have reached adjudicated status and the Authority data validation of the information is complete;
(d) Arranging for the retention, preservation, and availability of all records, including those records related to member grievance and appeals, litigation, base data, Medical Loss Ratio (MLR) reports, claims settlement, and those records covered under HIPAA as required by contract and state and federal law;
(e) Details of any existing third-party liability (TPL) or personal injury lien (PIL) cases and making any necessary arrangements to transfer the cases to the Authority's TPL and PIL units; and
(f) Final reports that identify all expenditures for any period in which the MCE continued to pay claims for services provided during the contract period.
(17) The Authority may require status reports or updates to the data reporting requirements in section (16) upon request.
(18) MCEs shall submit to the Authority a written request for release certifying that all obligations have been satisfied. The Authority shall provide an official written release upon satisfaction of activities associated with the contract expiration or termination plan. The request must be signed, expressly under penalty of False Claims Act liability, by the

president and the chief financial officer of the MCE and must attest that, except as expressly described in a writing attached to the attestation:
(a) All payments are received by the MCE under the contract, and all the MCE's liabilities under the contract are extinguished;
(b) All reports, reconciliations, member matters, and provider matters are resolved and finalized; and
(c) The MCE complied with all contractual and legal requirements, including completion of the activities described in the transition plan.
(19) To the extent that the request for release under section (18) attaches any exception, the request for release must include a plan describing how each exception is resolved. Any payments due under the terms of the contract for services between the Authority and the MCE, including the distribution of restricted reserve funds or any withheld capitation amount, may be withheld until the Authority receives all written and properly executed documents from the MCE. The MCE is subject to all obligations under the contract, associated rules, and the transition plan until a final written release is issued by the Director of the Authority. Such release:
(a) Shall apply only to the extent of the MCE's responsibilities under the MCE contract, associated rules, and the transition plan;
(b) Shall apply only to the extent the MCE's submissions to the Authority are true, complete, and accurate;
(c) Shall apply only between the Authority and the MCE;
(d) May not bind third parties;
(e) May not preclude the Authority's assertion of indemnity, contribution, or other obligations based on third-party claims;
(f) May not preclude the Authority's assertion of false claims liability, Medicaid fraud, common-law fraud, or other claims, false statements, or fraud; and
(g) May not affect any post-termination obligations of the MCE under the contract for preservation of records or for auditors' access.

STATUTORY/OTHER AUTHORITY: ORS 413.042

STATUTES/OTHER IMPLEMENTED: ORS 414.065

ADOPT: 410-141-3259

RULE TITLE: Sanctions

NOTICE FILED DATE: 10/11/2018

RULE SUMMARY: The Division needs to amend these rules to provide direction and clarification to the Coordinated Care Organizations and Prepaid Health Plans. Specifically, these proposed rules will: (1) Provide clarification on requirements for run-out reporting, ongoing obligations, and criteria for the release of restricted reserves; (2) Require CCOs to arrange for the orderly transfer of enrollees as directed by OHA including requirements for CCOs to provide all medical and financial records needed to transfer enrollees and coordinate their care without disruption; (3) Create a framework for the Authority to issue sanctions as authorized by federal law to address CCO performance issues if necessary.

RULE TEXT:

(1) The Authority may establish and impose sanctions on CCOs, pursuant to 42 CFR § 438.700, if the Authority makes a determination specified in paragraph (3) of this rule.

(2) The Authority may base its determinations on findings from onsite surveys, enrollee or other complaints, financial status, or any other source.

(3) The Authority may impose sanctions if the Authority determines that an MCE acts or fails to act as follows:

(a) Fails substantially to provide medically necessary services required under law or under its contract with the Authority to an enrollee covered under the contract;

(b) Imposes on enrollees premiums or charges that are in excess of the premiums or charges permitted under the Medicaid program;

(c) Acts to discriminate among enrollees on the basis of their health status or need for health care services. This includes termination of enrollment or refusal to re-enroll a beneficiary, except as permitted under the Medicaid program, or any practice that would reasonably be expected to discourage enrollment by beneficiaries whose medical condition or history indicates probable need for substantial future medical services;

(d) Misrepresents or falsifies information that it furnishes to the Centers for Medicare and Medicaid Services (CMS) or to the state;

(e) Misrepresents or falsifies information that it furnishes to an enrollee, potential enrollee, or health care provider;

(f) Fails to comply with the requirements for physician incentive plans, as set forth in 42 CFR §§ 422.208 and 422.210;

(g) Distributes directly or indirectly through any agent or independent contractor marketing materials that are not approved by the Authority or that contain false or materially misleading information;

(h) Violates any of the other applicable requirements of state or federal Medicaid law.

(4) The Authority may impose a range of sanctions under this rule including the following:

(a) Civil monetary penalties in the amounts specified in section (5) of this rule;

(b) Appointment of temporary management for an MCE as permitted under 42 CFR 438.706;

(c) Granting members the right to terminate enrollment without cause and notifying the affected members of their right to disenroll;

(d) Suspension of all new enrollment, including default enrollment, after the date the Authority notifies the MCE of a determination of a violation of rule or contract requirements;

(e) Suspension of payment for members enrolled after the effective date of the sanction and until the Authority is satisfied that the reason for imposition of the sanction no longer exists and is not likely to recur;

(f) Additional sanctions available under Oregon Revised Statutes and Oregon Administrative Rules that address areas of noncompliance specified in section (3) of this rule or any additional areas of noncompliance.

(5) If the Authority imposes civil monetary penalties:

(a) The maximum civil monetary penalty the Authority may impose varies depending on the nature of the MCE's action or failure to act, subject to the limits in 42 CFR § 422.204(b) and (c);

(b) The Authority may issue penalties as specified on a per event, per member impacted, or per day basis for the

duration of noncompliance.
(6) Before imposing any sanctions, the Authority must give the affected MCE timely written notice that explains the following:
(a) The basis and nature of the sanction;
(b) Any appeal rights under this rule and any other appeal rights that the Authority elects to provide.
(7) Administrative review, and if requested mediation:
(a) Are available for review of sanction decisions in accordance with OAR 410-120-1580 and 410-141-3267;
(b) If the Authority determines that there is continued egregious behavior, or that such action is necessary to ensure the health or safety of members, the Authority may impose the sanction before an administrative review opportunity is provided.
(8) Before terminating an MCE's contract for cause, the Authority must provide the MCE the opportunity for a pre-termination hearing. The Authority must do all of the following:
(a) Give the MCE written notice of its intent to terminate, the reason for termination, and the time and place of the hearing;
(b) After the hearing, give the MCE written notice of the decision affirming or reversing the proposed termination of the contract and for an affirming decision the effective date of termination;
(c) For an affirming decision, give enrollees of the MCE notice of the termination and information on their options for receiving Medicaid services following the effective date of termination.

STATUTORY/OTHER AUTHORITY: ORS 413.042

STATUTES/OTHER IMPLEMENTED: ORS 414.065