OFFICE OF THE SECRETARY OF STATE
TOBIAS READ
SECRETARY OF STATE

MICHAEL KAPLAN
DEPUTY SECRETARY OF STATE

ARCHIVES DIVISION
STEPHANIE CLARK
DIRECTOR

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

NOTICE OF PROPOSED RULEMAKING

INCLUDING STATEMENT OF NEED & FISCAL IMPACT

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

FILED: 10/08/2026 6:17 PM
ARCHIVES DIVISION SECRETARY OF STATE

FILING CAPTION: Transitioning defined term “Client” to “Member”, “CCO Member”, or “Open Card Member” where appropriate.

LAST DAY AND TIME TO OFFER COMMENT TO AGENCY: 11/21/2026 5:00 PM
The Agency requests public comment on whether other options should be considered for achieving the rule's substantive goals while reducing negative economic impact of the rule on business.

CONTACT:
Kelsey Gleeson
503-979-4579
medicaid.rules@oha.oregon.gov
500 Summer Street NE
Salem, OR 97301

Filed By:
Kelsey Gleeson
Rules Coordinator

HEARING(S)
Auxiliary aids for persons with disabilities are available upon advance request. Notify the contact listed above.

DATE: 11/17/2026
TIME: 9:00 AM - 9:45 AM
OFFICER: Kelsey Gleeson

REMOTE HEARING DETAILS
MEETING URL: Click here to join the meeting
PHONE NUMBER: 1-669-254-5252
CONFERENCE ID: 1658671365
SPECIAL INSTRUCTIONS:
Meeting ID: 165 867 1365
Passcode: 215425

NEED FOR THE RULE(S):

In the Oregon Health Authority’s (OHA) external communications, the agency has referred to individuals receiving

services from the Oregon Health Plan (Medicaid) as a “Member” for many years. This rule language change aligns rule language with external communications.

DOCUMENTS RELIED UPON, AND WHERE THEY ARE AVAILABLE:

None.

STATEMENT IDENTIFYING HOW ADOPTION OF RULE(S) WILL AFFECT RACIAL EQUITY IN THIS STATE:

The purpose of this rule change is to improve plain language and grammar. These changes are consistently applied to all rules within chapter 410 (Medical Assistance Programs). The Oregon Health Authority does not expect a disproportional impact to racial equity within any specific community as a result of this rulemaking.

FISCAL AND ECONOMIC IMPACT:

The purpose of this rule change is to improve clarity, plain language, and grammar. These changes do not effect policy, operations, or service delivery. The Oregon Health Authority does not expect any fiscal or economic impact to any entity or individual as a result of this rulemaking.

COST OF COMPLIANCE:
(1) Identify any state agencies, units of local government, and members of the public likely to be economically affected by the rule(s). (2) Effect on Small Businesses: (a) Estimate the number and type of small businesses subject to the rule(s); (b) Describe the expected reporting, recordkeeping and administrative activities and cost required to comply with the rule(s); (c) Estimate the cost of professional services, equipment supplies, labor and increased administration required to comply with the rule(s).

(1) Identify any state agencies, units of local government, and members of the public likely to be economically affected by the rule(s).
None.

(2) Effect on Small Businesses:
None.

(a) Estimate the number and type of small businesses subject to the rule(s);
None.

(b) Describe the expected reporting, recordkeeping and administrative activities and cost required to comply with the rule(s);
None.

(c) Estimate the cost of professional services, equipment supplies, labor and increased administration required to comply with the rule(s).
None.

DESCRIBE HOW SMALL BUSINESSES WERE INVOLVED IN THE DEVELOPMENT OF THESE RULE(S):

Small businesses were invited with the general public to participate in the rules advisory committee.

WAS AN ADMINISTRATIVE RULE ADVISORY COMMITTEE CONSULTED? YES

RULES PROPOSED:

410-136-3010, 410-136-3020, 410-136-3040, 410-136-3060, 410-136-3080, 410-136-3100, 410-136-3120, 410-136-3140, 410-136-3160, 410-136-3180, 410-136-3200, 410-136-3220, 410-136-3240, 410-136-3260, 410-136-3280, 410-136-3300, 410-136-3340, 410-136-3360, 410-136-3370, 410-136-3372

AMEND: 410-136-3010

RULE SUMMARY: Changing “client” and “recipient” to “Member” or “CCO Member” or “Open Card Member” where appropriate.

CHANGES TO RULE:

410-136-3010
Coordinated Care Organizations ¶

(1) The Authority contracts with Coordinated Care Organizations (CCOs) to provide ~~m~~Medical ~~s~~Services for ~~client~~CCO Members receiving Title XIX and Title XXI services for the purpose of providing integrated and coordinated care services across physical health, dental health, and ~~n~~Non-~~e~~Emergent ~~m~~Medical ~~t~~Transportation (NEMT). OAR chapter 410, division 120 including OAR 410-120-1210 describes services through CCOs and division 141 including OAR 410-141-3920 through OAR 410-141-3965 describes NEMT requirements through CCOs.¶
(2) For ~~clients enrolled in a CCO~~CCO Members, NEMT services are included in the budget provided to a CCO by the Authority. The CCO shall provide NEMT services to its enrolled ~~m~~CCO Members.¶
(3) For ~~clients enrolled in a CCO~~CCO Members, all ~~t~~Transportation services must be coordinated through the ~~m~~Member's CCO or the CCO's designated ~~t~~Transportation ~~p~~Provider prior to receiving services.
Statutory/Other Authority: ORS 413.042, ORS 414.625
Statutes/Other Implemented: ORS 414.625

AMEND: 410-136-3020

RULE SUMMARY: Changing “client” and “recipient” to “Member” or “CCO Member” or “Open Card Member” where appropriate.

CHANGES TO RULE:

410-136-3020
General Requirements for NEMT ¶

(1) The Authority may enroll governmental transportation brokerages (local units of government) or other entities contracted with the Authority as a "contractor" to arrange rides. Transportation brokerages pay subcontractors for NEMT services. The Authority may limit the enrollment with transportation brokerages to units of local government; Transportation brokerages shall be enrolled as an Oregon Health Plan (OHP) ~~p~~Provider and meet all requirements of OAR 410-120-1260 prior to delivering NEMT ~~s~~Services or receiving payment. A governmental transportation brokerage signing the Provider ~~E~~enrollment ~~A~~agreement constitute agreement to comply with all applicable Authority OHP ~~p~~Provider rules and federal and state laws and regulations.¶
(2) The actions described in this rule may not be delegated and must be performed by the brokerage contracted with the Authority. The brokerage shall:¶
(a) Provide Prior ~~a~~Authorize~~a~~ation and pay subcontractors for the least costly but most appropriate mode of transport for the ~~client~~Member's medical needs to and from ~~an~~ OHP ~~c~~Covered ~~medical s~~Services. The most appropriate and least costly ~~r~~Ride may include requiring the ~~client~~Member to share the ride with other ~~client~~Members. RHAF ~~client~~Members must not be required to share a ride with other ~~client~~Members;¶
(b) Verify that the ~~client~~Member is obtaining OHP ~~c~~Covered ~~medical s~~Services in the ~~client~~Member's local area;¶
(c) Verify the ~~client~~Member's OHP or RHAF eligibility and that the ~~client~~Member's ~~b~~Benefit ~~p~~Package includes NEMT ~~s~~Services on the scheduled ~~d~~Date of ~~s~~Service for the requested transport. The brokerage shall verify OHP eligibility and ~~b~~Benefits ~~p~~Packages through electronic eligibility information with the Authority Electronic Data Interchange (EDI). The brokerage shall verify RHAF eligibility through the RHAF eligibility database;¶
(d) Assess the ~~client~~Member's access to other means of ~~t~~Transportation, such as driving their own car or getting a ~~r~~Ride from a friend, family member or neighbor;¶
(e) Verify the ~~client~~Member's attendance for continuing requests for ~~r~~Rides if the medical ~~p~~Provider could not affirm an appointment for a previous ~~r~~Ride;¶
(f) Schedule a ~~r~~Ride with an alternate subcontractor if the subcontractor originally assigned is unable to provide the ~~r~~Ride; and¶
(g) Assign ~~r~~Rides to the subcontractor based on an evaluation of several factors including, but not limited to:¶
(A) Cost;¶
(B) The ~~client~~Member's need for appropriate equipment and ~~t~~Transportation;¶
(C) Any factors related to a subcontractor's capabilities, availability, and past performance; and¶
(D) Any factors related to the brokerage's need to maintain sufficient service capacity to meet ~~client~~Member needs.¶
(4) Pursuant to OAR 410-120-1210, Medical Assistance Benefit Packages and Delivery System, ~~client~~Members receiving the Qualified Medicare Beneficiary (QMB) only ~~b~~Benefit ~~p~~Package are not eligible for NEMT.¶
(5) The brokerage shall maintain records of ~~p~~Prior ~~a~~Authorization approval and denials of NEMT services. The brokerage shall also include the reasons for authorizing a ~~r~~Ride:¶
(a) That is not ~~c~~Cost ~~e~~Effective or not based on the factors specified in section (2) of this rule;¶
(b) With more than two (2) attendants for an ambulance or stretcher car; or¶
(c) With more than one (1) attendant for a wheelchair van.¶
(6) The brokerage shall provide a ~~r~~Ride to a ~~client~~Member to fill prescription medication only in the following situation:¶
(a) The ~~client~~Member needs to stop on the way home to fill or pick up prescribed medication related to the ~~c~~Covered ~~s~~Service for which the brokerage provided the ~~r~~Ride;¶
(b) It is ~~m~~Medically ~~n~~Necessary to fill or pick up the medication immediately; and¶
(c) The pharmacy is located on the return route or is the closest pharmacy to the return route.¶
(7) The brokerage may provide a ~~r~~Ride to a ~~client~~Member to fill prescribed medication under the following situations:¶
(a) The brokerage asks the ~~client~~Member if the prescription service is available through the Authority's contracted postal prescription service, and the ~~client~~Member responds that it is not available through that source;¶
(b) The ~~client~~Member has an urgent need to fill or pick up prescribed medication because the postal prescription service mailed the wrong medication, or the ~~client~~Member has an unexpected problem caused by the medication;

or¶
(c) The ~~client~~Member is transient or without regular access to a mailbox. In this situation, the brokerage may evaluate the need on a case-by-case basis.¶
(8) The brokerage shall provide ~~r~~Rides outside the brokerage's local service area as described in section (2)(b) of this rule, under the following circumstances:¶
(a) The ~~client~~Member is receiving a ~~c~~Covered ~~s~~Service that is not available in the service or local area but is available in another area of the state;¶
(b) The ~~client~~Member is receiving a ~~c~~Covered ~~s~~Service in California, Idaho, or Washington where the service location is no more than 75 miles from the Oregon border; or¶
(c) No local medical ~~p~~Provider or facility will provide the ~~c~~Covered ~~s~~Services for the ~~client~~Member; or¶
(d) For RHAF ~~client~~Members, no local medical ~~p~~Provider will provide the ~~c~~Covered ~~s~~Services within the timeline required to address the ~~client~~Member's medical condition.¶
(9) Brokerages may coordinate to provide a return ~~r~~Ride to a ~~client~~Member who receives a ~~c~~Covered ~~s~~Service outside the ~~client~~Member's local area.¶
(10) Brokerages shall retroactively authorize and pay for NEMT ~~s~~Services that have already occurred only when the brokerage could not provide Prior ~~a~~Authorization for the service because the brokerage was closed, and the request for authorization is received by the brokerage within thirty (30) days of the ~~d~~Date of ~~s~~Service. The brokerage shall confirm with the medical ~~p~~Provider that one of the following circumstances supported the ~~r~~Ride:¶
(a) The ~~client~~Member needed urgent medical care;¶
(b) The ~~client~~Member required secured transport pursuant to OAR 410-136-3120, Secured Transports; or¶
(c) The ~~client~~Member was in a ~~h~~Hospital, and the ~~h~~Hospital discharged or transferred the ~~client~~Member.¶
(11) In addition to section (10) of this rule, a brokerage shall retroactively authorize NEMT ~~s~~Services for ~~a~~Ambulance transports when:¶
(a) An ~~a~~Ambulance ~~p~~Provider responds to an emergency call, but the ~~client~~Member's medical condition does not warrant an emergency transport;¶
(b) The ~~a~~Ambulance ~~p~~Provider transports the ~~client~~Member as a NEMT ~~s~~Service; and¶
(c) The ~~a~~Ambulance ~~p~~Provider requests retroactive authorization within ~~thirty (~~30~~)~~ days of the NEMT ~~d~~Date of ~~s~~Service.¶
(12) Brokerages shall not authorize or pay subcontracted providers for ~~r~~Rides outside their service areas based only on ~~client~~Member preference or convenience.¶
(13) Brokerages shall provide toll-free call centers for ~~clients~~Member to request ~~r~~Rides. Brokerages shall have written policies and procedures regarding its NEMT ~~s~~Services that include all the requirements in this rule. Brokerages shall meet all the following requirements pertaining to the brokerage's call center and scheduling of ~~r~~Rides:¶
(a) The call center shall operate at a minimum Monday through Friday from 9:00 a.m. to 5:00 p.m., but the brokerage may close the call center on New Year's Day, Memorial Day, July 4th, Labor Day, Thanksgiving, and Christmas. The Authority may approve, in writing, additional days of closure if the brokerage requests the closure at least ~~thirty (~~30~~)~~ days in advance.¶
(b) Brokerages shall make all reasonable efforts for ~~client~~Members to have access to available NEMT ~~s~~Services 24 hours a day. When the call center is closed, the brokerages shall provide a recording or answering service in at a minimum, English and Spanish, to refer the ~~client~~Member directly to a subcontractor. If no subcontractor is available, the brokerage must provide ~~client~~Members with recorded information in at a minimum, English and Spanish, about service hours and how to reach emergency services by calling 911;¶
(c) The brokerage shall allow a ~~client~~Member or their ~~r~~Representative to schedule ~~r~~Rides at least ~~ninety (~~90~~)~~ days in advance of the ~~c~~Covered ~~s~~Service;¶
(d) The brokerage shall allow a ~~client~~Member or their ~~r~~Representative to request multiple ~~r~~Ride requests at one time;¶
(e) The brokerage shall develop and make all policies and procedures regarding its NEMT ~~s~~Services available to ~~client~~Members either in a OHP Open Card Member Handbook, RHAF NEMT Rider Guide, or in a stand-alone document referred to as a "OHP Open Card NEMT rider guide" that meets the delivery and content specifications defined by the Authority. The brokerage's written policies and procedures regarding NEMT services must be shared to subcontractors and shall be available upon request to the Authority for review.¶
(f) Allow a ~~client~~Member or their ~~r~~Representative, including ~~p~~Providers in accordance with OAR 410-172-0780, to schedule:¶
(A) NEMT ~~s~~Services up to ~~ninety (~~90~~)~~ days in advance;¶
(B) Multiple NEMT ~~s~~Services at one time for recurring appointments up to ~~ninety (~~90~~)~~ days in advance; and¶
(C) Same-day NEMT ~~s~~Services.¶
(g) Comply with the following criteria for ~~client~~Member drop-offs and pick-up protocols. A brokerage or subcontractors' drivers are not permitted to:¶

(A) Drop-off a ~~client~~Member at an appointment more than 15 minutes prior to the office or other facility opening for business unless requested by the ~~client~~Member or, as applicable, the ~~client~~Member's guardian, parent, or ~~r~~Representative; and¶
(B) Pick-up a ~~client~~Member from an appointment more than 15 minutes after the office or facility closes for business unless the appointment is not reasonably expected to end within 15 minutes after closing, or as requested by the ~~client~~Member, or as applicable, the ~~client~~Member's guardian, parent, or ~~r~~Representative.¶
(h) The brokerage shall provide to the ~~client~~Member, or as applicable, the ~~client~~Member's guardian, parent, or ~~r~~Representative the name of subcontractor, or name and telephone number of the driver when available;¶
(i) The brokerage shall confirm the scheduled pick-up time and address with the ~~client~~Member;¶
(j) The brokerage shall make reasonable efforts to arrange a ~~r~~Ride requested on the day of the medical service when the service is:¶
(A) For an ~~u~~Emergen~~t m~~cy Medical ~~c~~Condition; and¶
(B) Due to the urgency of the medical condition, the ~~client~~Member scheduled an immediate medical appointment.¶
(14) The brokerage is not responsible for providing ~~e~~Emergency ~~m~~Medical ~~t~~Transportation services. However, brokerages shall have procedures for referring ~~client~~Members requesting ~~e~~Emergency ~~m~~Medical ~~t~~Transportation services to the appropriate emergency transportation resources and procedures for subcontractors per OAR 410-136-3040, Vehicle Equipment and Subcontractor Standards.¶
(15) The Authority shall collaborate with brokerages and CCOs to develop and conduct a statewide ~~client~~Member NEMT satisfaction survey at least once every two years. The Authority may contract with one or more brokerages, or a third-party, to conduct the survey. The Authority shall use the results of the survey to identify and address potential operational deficiencies and to identify and share successes in the NEMT program.¶
(16) Brokerages shall establish regional advisory groups consisting of representatives from the Authority, ODHS, Area Agencies on Aging, consumers, representatives of ~~client~~Member advocacy groups from within the service or local area, brokerage subcontractors, and ~~p~~Providers of NEMT ~~a~~Ambulance services. The role of the group includes, but is not limited to:¶
(a) Assisting in monitoring and evaluating the NEMT program; and¶
(b) Recommending potential policy or procedure changes and program improvements to brokerages and the Authority and assisting in prioritizing those changes and improvements.¶
(17) Brokerages shall have the discretion to use or not use Oregon Department of Human Services (ODHS)-approved volunteers. ODHS shall provide brokerages with a list of approved and trained ~~v~~Volunteers. ODHS shall supervise the ~~v~~Volunteers and assumes all liability for each ~~v~~Volunteer as provided by law.¶
(18) Brokerages or their subcontractors shall not bill eligible ~~client~~Members for any NEMT service to and from a ~~c~~Covered ~~s~~Service or any transports where the Authority denies reimbursement. Brokerages or their subcontractors shall not collect payment from the ~~client~~Member, or assign an unpaid claim to a collection agency, or similar entity pursuant to ORS 414.066.¶
(19) On a minimum of five percent of the ~~r~~Ride requests, brokerages shall contact medical ~~p~~Providers to verify appointments and that the appointments are for ~~c~~Covered ~~medical s~~Services.¶
(20) Brokerages may purchase tickets for common carrier transportation, such as inter- or intra-city bus, train, or commercial airline when deemed ~~c~~Cost ~~e~~Effective and safe for the ~~client~~Member.
Statutory/Other Authority: ORS 413.042
Statutes/Other Implemented: ORS 414.065

AMEND: 410-136-3040

RULE SUMMARY: Changing “client” and “recipient” to “Member” or “CCO Member” or “Open Card Member” where appropriate.

CHANGES TO RULE:

410-136-3040
Vehicle Equipment and Subcontractor Standards ¶

(1) Brokerages shall require all subcontractors, providers, and drivers to maintain their vehicles for the comfort and safety of the ~~client~~Members. The vehicles shall meet the following requirements:¶
(a) The interior of the vehicle shall be clean;¶
(b) The subcontractor, provider, or driver shall not smoke, aerosolize or vaporize an inhalant or permit smoking, aerosolizing or vaporizing of an inhalant in the vehicle at any time; and¶
(c) The subcontractor, provider, or driver 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) A first aid kit;¶
(C) A fire extinguisher;¶
(D) Roadside reflective or warning devices;¶
(E) A flashlight;¶
(F) Tire traction devices when appropriate;¶
(G) Disposable gloves; and¶
(H) All equipment necessary to transport ~~client~~Members using wheelchairs or stretchers in accordance with the Americans with Disabilities Act of 1990 (as amended) (ADA), Section 504 of the Rehabilitation Act of 1973, and Oregon Revised Statute 659A.103 if the subcontractor, provider, or driver uses the vehicle for these modes of transport.¶
(2) The subcontractor, provider, and driver shall follow a preventative maintenance schedule that incorporates at least all the maintenance recommended by the vehicle manufacturer. The vehicle must be in good operating condition and shall include, but is not limited to:¶
(a) Side and rear-view mirrors;¶
(b) Working horn;¶
(c) Working turn signals;¶
(d) Working headlights:¶
(e) Working taillights; and¶
(f) Working windshield wipers.¶
(3) Brokerages and subcontractors shall have and maintain records of inspection and compliance with the safety equipment and preventative maintenance requirements in sections (1) and (2) of this rule. All records shall be made available upon request for audit or review.¶
(4) Brokerages shall require the subcontractors, providers, call-center employees, and drivers receive and successfully complete training on their job duties, roles, and responsibilities, including but not limited to:¶
(a) Understanding NEMT services in general, reporting forms, vehicle operation, requirements for reporting of suspected fraud, abuse, or waste by any ~~p~~Provider or ~~client~~Member and the protections afforded to those who report FWA under applicable whistleblower laws in section 1902(a)(68) of the Social Security Act, and the geographic area in which subcontractors will provide service. Training shall be completed at the time of hire or contracting and at least annually;¶
(b) Requiring the subcontractors' drivers to complete the National Safety Council Defensive Driving course or an equivalent course within six (6) months of the date of hire and at least every three (3) years thereafter;¶
(c) Requiring the subcontractors' drivers to complete Red Cross-approved First Aid, Cardiopulmonary Resuscitation and blood spill procedures courses or equivalent courses within six (6) months of the date of hire and to maintain the certification as a condition of employment;¶
(d) Requiring the subcontractors' drivers to complete the Passenger Service and Safety course or an equivalent course within six (6) months of the date of hire and at least every three (3) years after that;¶
(e) Understanding established procedures for subcontractors and the subcontractors' drivers in the event that the ~~client~~Member needs emergency care during the ~~r~~Ride; and¶
(f) If providing ground or air ~~a~~Ambulance services, verifying that the Authority has licensed the subcontractor to operate ground or air ~~a~~Ambulance. If the subcontractor is located in a contiguous state and regularly provides

~~r~~Rides to OHP or RHAF eligible ~~client~~Members, the brokerage must ensure that both the Authority and the contiguous state have licensed the subcontractor.¶
(5) Brokerages shall require a subcontractor meet all the requirements of the chapter 410 division 136 rules at all times to be eligible to receive payment, including but not limited to the following for each of subcontractors' drivers:¶
(a) The subcontractor shall require each driver have a valid Oregon DMV-issued drivers license. Brokerages and subcontractors shall require drivers have current license and registration prior to providing an NEMT service. The driver's license must be the class of license, with any required endorsements, that permits the subcontractor's driver to legally operate the vehicle for which they are hired to drive per ORS Chapter 807 and OAR chapter 735, division 062, or the applicable statutes of other states; and¶
(b) The subcontractors' drivers whether directly employed by the subcontractor or under contract must pass a criminal background check in accordance with ORS 181A.195 and OAR chapter 257, division 10, at the time of hire or contracting or if the brokerage is a mass transit district formed under ORS chapter 267, the subcontractor's drivers must pass a criminal background check in accordance with ORS 267.237 and the mass transit district's background check policies. The brokerage or subcontractor must maintain records of background check results for each driver and may perform a background check at any time while the driver is employed or contracted. A driver who does not successfully pass a background check is not eligible to provide ~~r~~Rides or receive payment by the brokerage or subcontractor.¶
(6) For authorized out-of-state NEMT services described in OAR 410-136-3080, in which the subcontractor solely performs work in the other state and for which the brokerage has no oversight authority, the brokerage is not responsible for requiring that the subcontractor's vehicle and the subcontractor's standards meet the requirements set forth in this rule.
Statutory/Other Authority: ORS 413.042
Statutes/Other Implemented: ORS 414.065

AMEND: 410-136-3060

RULE SUMMARY: Changing “client” and “recipient” to “Member” or “CCO Member” or “Open Card Member” where appropriate.

CHANGES TO RULE:

410-136-3060
Insurance Requirements ¶

(1) Brokerages must obtain and maintain general and automobile liability coverage for personal injury and death in accordance with ORS 30.271, Limitations on Liability of State for Personal Injury and Death.¶
(2) Brokerages must obtain and maintain general and automobile liability coverage for property damage and destruction in accordance with ORS 30.273, Limitations on Liability of Public Bodies for Property Damage or Destruction.¶
(3) The liability coverage required by sections (1) and (2) of this rule shall include the State of Oregon, the Authority and its divisions, officers, employees, and agents as additional insureds but only as related to the brokerages' NEMT services.¶
(4) In lieu of purchasing liability coverage under sections (1) and (2) of this rule, the Authority may authorize a brokerage to establish and maintain a Self-Insurance Reserve Fund. The following apply to requirements of the fund:¶
(a) The Authority shall establish the fund at $1 million through the fixed rate for ~~r~~Rides established in OAR 410-136-3200, Reimbursement and Accounting for all Modes of Transport;¶
(b) The fund shall comply with Federal Acquisition Regulation (FAR) Office of Management and Budget (OMB) Circular 87;¶
(c) If the brokerage subsequently terminates its enrollment with the state as a Medicaid ~~p~~Provider, the brokerage shall refund the Authority the balance of any monies in the fund within two (2) years from the termination of its enrollment or at the conclusion of any claim or litigation related to the brokerage's NEMT services for eligible ~~client~~Members;¶
(d) Once funded, the fund shall be maintained at an amount not less than $1 million through the fixed rate for ~~r~~Rides established in OAR 410-136-3200, Reimbursement and Accounting for all Modes of Transport;¶
(e) The Authority shall reconcile the fund amount during the annual cost settlement process pursuant to OAR 410-136-3200, Reimbursement and Accounting for all Modes of Transport, and shall increase or decrease the fixed rate for rides to maintain the $1 million fund amount; and¶
(f) The brokerage shall maintain a separate account for the fund.¶
(5) Brokerages and their subcontractors that employ workers as defined in ORS 656.027 shall comply with 656.017 and shall provide workers' compensation insurance coverage for those workers unless they meet the requirement for an exemption under 656.126(2). Brokerages shall require each of their subcontractors to comply with this requirement.¶
(6) In lieu of purchasing workers' compensation insurance coverage as required by section (5), a brokerage may self-insure for all its subject workers. The Authority shall not fund this reserve and shall only reimburse the brokerage for costs of self-insurance in the event of a claim arising from the brokerage's NEMT services to eligible ~~client~~Members.¶
(7) Brokerages and their subcontractors shall furnish proof of liability coverage and insurance to the Authority upon request.
Statutory/Other Authority: ORS 413.042
Statutes/Other Implemented: ORS 414.065

AMEND: 410-136-3080

RULE SUMMARY: Changing “client” and “recipient” to “Member” or “CCO Member” or “Open Card Member” where appropriate.

CHANGES TO RULE:

410-136-3080
Out-of-State Transportation ¶

(1) "Out-of-~~s~~State ~~t~~Transportation" means ~~t~~Transportation to or from any location outside Oregon, with the exception of contiguous areas up to 75 miles outside the Oregon border.¶
(2) The brokerage shall arrange ~~r~~Rides and pay for ~~o~~Out-of-~~s~~State ~~t~~Transportation, as defined in section (1) of this rule, to and from an out-of-state OHP or RHAF ~~c~~Covered ~~medical s~~Service when:¶
(a) The brokerage confirms that the Authority authorized the ~~OHP client~~Member's out-of-state OHP ~~c~~Covered ~~medical s~~ Service per OAR 410-120-1180, Medical Assistance Benefits: Out-of-State Services, or the CCO authorized per OAR 410-141-3930 Transportation: Out-of-Service Area and Out-of-State Transportation; and¶
(b) The ~~client~~Member is eligible for ~~t~~Transportation services per OAR 410-136-3020, General Requirements for NEMT.¶
(3) The brokerage shall arrange for and pay for the most appropriate mode of transportation, and necessary travel to and from an airport or other departure location within Oregon, for ~~o~~Out-of-~~s~~State ~~travel~~Transportation approved by the Authority.¶
(4) The brokerage may utilize any procurement method and criteria to purchase airline tickets, and any necessary travel to and from an airport or other departure location within Oregon, subject only to least expensive mode of transportation that meets the non-emergent medical needs of the ~~client~~Member.¶
(5) Brokerages shall not arrange or pay for:¶
(a) A ~~client~~Member's return from any foreign country to any location within the United States for the ~~client~~Member to obtain medical care because the care is not available in the foreign country;¶
(b) A ~~client~~Member's return to Oregon from another state when the ~~client~~Member was not in the other state to obtain authorized medical services or treatments, unless the ~~client~~Member is enrolled in RHAF, lives outside of Oregon, and is seeking RHAF ~~c~~Covered ~~s~~Services within Oregon.¶
(6) Brokerages may arrange ~~e~~Emergency ~~m~~Medical ~~t~~Transportation services if authorized by the Authority, for a ~~client~~Member traveling outside Oregon for a OHP ~~c~~Covered ~~medical s~~Service who experience an ~~e~~Emergency ~~m~~Medical ~~c~~Condition needing ~~e~~Emergency ~~m~~Medical ~~t~~Transportation as defined in OAR 410-120-0000.
Statutory/Other Authority: ORS 413.042
Statutes/Other Implemented: ORS 414.065

AMEND: 410-136-3100

RULE SUMMARY: Changing “client” and “recipient” to “Member” or “CCO Member” or “Open Card Member” where appropriate.

CHANGES TO RULE:

410-136-3100
Attendants for Child Transports ¶

(1) This rule applies to ~~n~~Non-~~e~~Emergent ~~m~~Medical ~~t~~Transportation (NEMT) for children ~~twelve (~~12~~)~~ years of age and under who are eligible for NEMT ~~s~~Services to and from Oregon Health Plan (OHP) and RHAF ~~c~~Covered ~~medical s~~Services. The rule also applies to children and young adults with special physical or developmental needs, regardless of age, hereafter referred to as "child" or "children."¶
(2) Parents or legal guardians must provide an attendant to accompany the children while traveling to and from medical appointments except when:¶
(a) The driver is a ~~n~~ ODHS ~~v~~Volunteer, ODHS employee or an Authority employee;¶
(b) The child requires secured transport per OAR 410-136-3120, Secured Transports;~~-~~¶
(c) An ~~a~~Ambulance subcontractor transports the child for NEMT services, and the brokerage reimburses the ~~a~~Ambulance subcontractor at the ~~a~~Ambulance transport rate; or¶
(d) The child is enrolled in RHAF and seeking RHAF ~~c~~Covered ~~s~~Services.~~-~~¶
(3) Attendants are required for NEMT ~~a~~Ambulance transports when the brokerage uses an ~~a~~Ambulance to provide wheelchair or stretcher car or van ~~r~~Rides.¶
(4) ODHS shall establish and administer written guidelines for children in the ~~d~~Department's custody, including written guidelines for ~~v~~Volunteer drivers. If ODHS's requirements or administrative rules differ from this rule, ODHS's requirements or administrative rules take precedence.¶
(5) An attendant may be the mother, father, stepmother, stepfather, grandparent or legal guardian of the child. The attendant also may be any adult that the parent or legal guardian authorizes to be an attendant. An attendant also may be a brother, sister, stepbrother or stepsister of the child, as long as the attendant is at least ~~eighteen (~~18~~)~~ years of age, and the parent or legal guardian authorizes it. An attendant also may be a behavioral health personal care attendant allowed to accompany the ~~client~~Member in accordance with OAR 410-172-0780.¶
(6) Brokerages or their subcontractors may require the child's parent or legal guardian to provide written authorization for an attendant other than themselves to accompany the child.¶
(7) Brokerages or their subcontractors shall not bill additional charges for a child's attendant.¶
(8) The attendant must accompany the child from the pick-up location to the destination and on the return trip. The attendant must also remain with the child during their appointment. Another person shall not accompany the attendant unless the parent or legal guardian authorizes it or unless the other person is an eligible child traveling to the same location for a medical appointment.¶
(9) The parent, guardian or adult caregiver for the child shall provide and install child safety seats as required by state law. The subcontractor shall not transport a child if a parent or legal guardian fails to provide a child safety seat that complies with state law.
Statutory/Other Authority: ORS 413.042
Statutes/Other Implemented: ORS 414.065

AMEND: 410-136-3120

RULE SUMMARY: Changing “client” and “recipient” to “Member” or “CCO Member” or “Open Card Member” where appropriate.

CHANGES TO RULE:

410-136-3120
Secured Transports ¶

(1) Secured transport NEMT services are for the involuntary transport of ~~client~~Members who are in danger of harming themselves or other individuals. Secured transports are allowable when:¶
(a) The brokerage verified that the subcontractor has met the requirements of the secured transport protocol pursuant to OAR 309-033-0200 through 309-033-0970, and, therefore, the subcontractor is able to transport the ~~client~~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 ~~client~~Member in crisis.¶
(2) One additional attendant may accompany the ~~client~~Member at no additional charge when ~~m~~Medically ~~a~~Appropriate, such as to administer medications, etc. 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 brokerage shall authorize transports to and from OHP ~~c~~Covered ~~medical s~~Services for an eligible ~~client~~Member when the court orders the ~~m~~Medical ~~s~~Services with the following exceptions:¶
(a) The ~~client~~Member is in the custody of or under the legal jurisdiction of any law enforcement agency;¶
(b) The ~~client~~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 ~~client~~Member's OHP eligibility pursuant to ORS 414.420 or 414.424.¶
(4) The brokerage shall assume that a ~~client~~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 ~~m~~Medically ~~a~~Appropriate to return a ~~client~~Member to their place of residence, the brokerage shall obtain written documentation, signed by the treating medical professional, stating the circumstances that required secured transport. The brokerage shall retain the documentation and a copy of the order in their record for the Authority to review.¶
(5) The brokerage shall not approve or pay for secured medical transport provided to a person going to or from a court hearing or to or from a commitment hearing.¶
(6) The Authority is not a law enforcement agency as defined in OAR 461-135-0950 in accordance with ORS 131.930, and as stated in OAR 461-135-0950(2)(a)(A) for an inmate living in a public institution awaiting trial or an individual serving a sentence for a criminal offense. If an NEMT eligible ~~client~~Member is not in criminal custody as an inmate under the jurisdiction of a law enforcement agency, then transport from a penal or detention facility to a Medicaid enrolled facility for an OHP ~~c~~Covered ~~s~~Service is authorized.
Statutory/Other Authority: ORS 413.042
Statutes/Other Implemented: ORS 414.065

AMEND: 410-136-3140

RULE SUMMARY: Changing “client” and “recipient” to “Member” or “CCO Member” or “Open Card Member” where appropriate.

CHANGES TO RULE:

410-136-3140
Transports of ~~Client~~Members Changing Hospitals or Other Facilities ¶

(1) Brokerages shall arrange and pay for ~~t~~Transporting an eligible ~~client~~Member who has had a change in condition, noted in the ~~client~~Member's Oregon Department of Human Services (ODHS) care plan, resulting in a need for a new service setting with a lower or higher level of care. This includes ~~client~~Members who are changing levels of care between their community-based care settings or between institutional and community-based settings. The ~~client~~Member's ODHS worker must request the ~~r~~Ride.¶
(2) Brokerages shall not arrange or pay for:¶
(a) The transport or return of an inpatient ~~client~~Member from an admitting ~~h~~Hospital to another ~~h~~Hospital (or facility) for diagnostic or other short-term services when the patient will return to the admitting ~~h~~Hospital within the first 24-hours of admission. The subcontractor shall bill the admitting ~~h~~Hospital directly for these transports;¶
(b) The transport of a ~~client~~Member receiving ~~l~~Long-~~t~~Term ~~c~~Care service in their home or residing in a ~~l~~Long-~~t~~Term ~~c~~Care ~~f~~Facility for the sole purpose of shopping for another ~~l~~Long-~~t~~Term ~~c~~Care ~~f~~Facility, even if the ~~client~~Member is looking for a new facility to receive a lower or higher level of care;¶
(c) The transport of a ~~client~~Member moving from one type of facility to a facility of the same type, such as from an adult foster home to another adult foster home; and¶
(d) The transport of a ~~client~~Member who is relocating to another state, unless the transport is to receive an OHP ~~c~~Covered ~~medical s~~Service pursuant to OAR 410-136-3080, Out-of-State Transportation.
Statutory/Other Authority: ORS 413.042
Statutes/Other Implemented: ORS 414.065

AMEND: 410-136-3160

RULE SUMMARY: Changing “client” and “recipient” to “Member” or “CCO Member” or “Open Card Member” where appropriate.

CHANGES TO RULE:

410-136-3160
Ground and Air Ambulance Transports ¶

(1) Transporting a ~~client~~Member via ~~a~~Ambulance is required when a medical facility or ~~p~~Provider states the ~~client~~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 ~~n~~Non-~~e~~Emergent ~~m~~Medical ~~t~~Transportation (NEMT) services, the brokerage shall authorize the transport.¶
(3) Brokerages shall provide ~~a~~Ambulance or stretcher transports with a medical technician when:¶
(a) A ~~client~~Member's medical condition requires a stretcher;¶
(b) The length of transport would require a personal care attendant; and¶
(c) The ~~client~~Member does not have an attendant who can assist with personal care during the ~~r~~Ride.¶
(4) Emergency ~~a~~Ambulance ~~t~~Transportation is required when a ~~client's m~~Member is experiencing an Emergency Medical ~~c~~Condition ~~is an emergency~~ pursuant to OAR 410-120-0000, Acronyms and Definitions. The ~~a~~Ambulance must transport the ~~client~~Member to the nearest appropriate facility able to meet the ~~client~~Member's medical needs. Brokerages do not arrange ~~e~~Emergency ~~t~~Medical Transportation.¶
(5) The following apply to air-ambulance NEMT services:¶
(a) The brokerage shall approve air-ambulance NEMT only when another mode of ~~t~~Transportation would further jeopardize or compromise the ~~client~~Member's medical condition due to:¶
(A) The length of time required to transport the ~~client~~Member by ground-ambulance;¶
(B) Current road conditions preclude the use of ground transportation; or¶
(C) Ground-ambulance is not available.¶
(b) As an exception to subsection (4)~~-~~(a) of this rule, the brokerage may grant air-ambulance ~~t~~Transportation if it determines the ~~t~~Transportation is ~~c~~Cost ~~e~~Effective. The brokerage shall document how air-ambulance is more ~~c~~Cost ~~e~~Effective than ground transportation;¶
(c) The brokerage must obtain a written recommendation from the ~~client~~Member's medical ~~p~~Provider indicating ~~m~~Medical ~~a~~Appropriateness before authorizing air-ambulance ~~t~~Transportation.
Statutory/Other Authority: ORS 413.042
Statutes/Other Implemented: ORS 414.065

AMEND: 410-136-3180

RULE SUMMARY: Changing “client” and “recipient” to “Member” or “CCO Member” or “Open Card Member” where appropriate.

CHANGES TO RULE:

410-136-3180
Reimbursement for Ground and Air Ambulance Transports ¶

(1) The following applies to how the Oregon Health Authority (Authority) shall reimburse ~~p~~Providers of NEMT ground and air ambulance services that brokerages arrange for eligible ~~client~~Members. This applies to ~~clients receiving services through the fee-for-service (FFS) delivery system or a Coordinated Care Organization (CCO).¶~~
~~(2) FFS~~Open Card Members or CCO Members.¶
(2) Fee-for-service brokerages shall submit documentation to the Authority stating the brokerage authorized the ~~t~~Transportation. The documentation also shall inform the Authority to reimburse at the Authority's base rate or another amount the brokerage specifies. Ambulance ~~p~~Providers shall bill the Authority for payment of authorized rides.¶
(3) If brokerage does not specify another amount, the Authority's reimbursement shall include:¶
(a) The base rate established in the Authority's fee schedule posted on the OHP Web page at www.oregon.gov/OHA/HSD/OHP/Pages/Fee-Schedule.aspx.¶
(A) The base rate for NEMT ground ~~a~~Ambulances includes:¶
(i) Any procedures or services provided, all medications, non-reusable supplies or oxygen and all direct or indirect costs. "Indirect costs" include general operating costs, personnel costs, neonatal intensive care teams employed by the ~~a~~Ambulance subcontractor, use of reusable equipment and any other miscellaneous medical items or special handling that may be required in the course of transport;¶
(ii) The first ~~ten~~10 miles for ground ~~a~~Ambulance transports.¶
(B) The base rate for NEMT air ambulances includes:¶
(i) Any procedures or services provided, all medications, non-reusable supplies or oxygen and all direct or indirect costs. "Indirect costs" include general operating costs, personnel costs, neonatal intensive care teams employed by the ambulance subcontractor, use of reusable equipment and any other miscellaneous medical items or special handling that may be required in the course of transport;¶
(ii) ~~d~~Different rates shall apply for ~~u~~Urban and ~~r~~Rural using the statewide average adjustments for the geographic regions of Oregon at a percent of Medicare. This methodology includes the mileage rate reimbursed separately instead of included into the base rate. The ~~u~~Urban and ~~r~~Rural rates are defined by Zip Code-Point of Pick Up.¶
(b) A modified base rate for each additional ~~client~~Member, according to OAR 410-136-3220, Brokerage Reimbursements to Subcontractors, if applicable;¶
(c) Payment for an extra attendant, if applicable; and¶
(d) Compensation for service or care provided at the scene when the ~~client~~Member did not require transport, if applicable.¶
(4) Reimbursement outlined in section (3) of this rule also applies to the Authority's reimbursements to ~~p~~Providers of emergency ground or air ~~a~~Ambulance services for ~~clients who receive services through the fee-for-service delivery system~~Open Card Members.¶
(5) A CCO is responsible for reimbursement to ~~p~~Providers of emergency ground or air ~~a~~Ambulance for ~~clients who are CCO enrollee~~CCO Members.
Statutory/Other Authority: ORS 413.042
Statutes/Other Implemented: ORS 414.065

AMEND: 410-136-3200

RULE SUMMARY: Changing “client” and “recipient” to “Member” or “CCO Member” or “Open Card Member” where appropriate.

CHANGES TO RULE:

410-136-3200
Reimbursement and Accounting for all Modes of Transports ¶

(1) The following applies to the rate the Oregon Health Authority (Authority) pays brokerages:¶
(a) The Authority shall calculate and pay a brokerage a fixed rate for ~~r~~Rides based on the following formula: Direct costs plus indirect costs divided by the number of projected monthly ~~r~~Rides. "Direct costs" are ~~t~~Transportation costs plus administrative costs;¶
(b) The Authority shall notify the brokerages of their specific ~~r~~Ride rates; and¶
(c) The Authority shall assess any needed modifications to this rate:¶
(A) Quarterly;¶
(B) When the Authority changes any program affecting eligibility or scope; or¶
(C) If other factors impact the brokerage's cost of delivering service.¶
(2) Brokerages shall account for costs and expenses of ~~n~~Non-~~e~~Emergent ~~m~~Medical ~~t~~Transportation (NEMT) ~~s~~Services to O~~regon Health Plan (OHP) Fee For Service (FFS) client~~pen Card Member~~s~~ and RHAF ~~client~~Member~~s separate from any other services the brokerage provides. Brokerages shall require all subcontractors to account for costs and expense for NEMT services separate from any other services the subcontractors provide. Brokerages shall use and require all subcontractors to adopt generally accepted accounting principles or accounting standards or cost principles required by federal or state laws, rules, or regulations.¶
(3) The Authority shall reimburse brokerages for ~~v~~Valid ~~c~~Claims submitted to the Authority, using the standardized electronic billing format prescribed by the Authority for OHP ~~client~~Member~~s and the specified billing format prescribed by the Authority for RHAF ~~client~~Member~~s. All brokerages' professional claims for ~~t~~Transportation services shall include a HIPAA-compliant, the Centers for Medicare and Medicaid Services (CMS)-defined 2- digit POS code to indicate the type of ~~t~~Transportation service used and have the required combination of modifier and procedure code. All required billing information must be included on the claim for the additional ~~client~~Member. Medicaid is always the payer of last resort. If a ~~client~~Member has Medicare or ~~t~~Third-~~p~~Party insurance, the brokerages shall bill these insurers before billing the Authority.¶
(4) The Authority shall conduct an annual cost settlement to review brokerages costs and expenses and determine any ~~o~~Overpayment or underpayment for costs the brokerage incurred for covered NEMT services for eligible ~~client~~Member~~s. The following applies to the Authority's cost settlement process:¶
(a) The Authority shall request cost and expense settlement information from the brokerages ~~6~~six months after the end of the fiscal year. The request shall include file(s) detailing the brokerages claims, a template for the brokerages to submit their cost and expenses information and instructions for completing the template. The Authority uses the Oregon Medicaid Management Information System (MMIS) to create file(s) detailing the brokerages claims data for the applicable procedure codes per NEMT provider;¶
(b) Brokerages shall submit the requested information, certified by a Certified Public Accountant, and complete the template provided by the Authority within 90 days of receiving the Authority's request;¶
(c) The Authority shall verify the reported costs and expenses and notify the brokerages in writing of the Authority's determination;¶
(d) Brokerages shall comply with the allowable cost requirements established by the Authority;¶
(e) If the Authority's determination results in an adjustment, the brokerages may request an ~~a~~Appeal pursuant to OAR 410-120-1560 through 410-120-1600, pertaining to ~~p~~Provider ~~a~~Appeals.¶
(f) The brokerage shall refund the amount of the ~~o~~Overpayment determined by the Authority within ~~sixty (~~60~~)~~ days or as specified by the Authority in its written notice to the brokerage.¶
(g) Payment by the Authority does not restrict or limit the Authority or any state or federal oversight entity's right to review or audit before or after the payment is made to a brokerage. Payments may be denied or subject to recovery by the Authority if medical review, audit, or other post-payment review of the supplemental payment or the claim upon the basis a supplemental payment was issued determines the service was not provided in accordance with applicable rules, by an eligible NEMT provider, or does not meet the criteria for quality of care or ~~m~~Medical ~~a~~Appropriateness of the care or payment.¶
(5) To be eligible for payment brokerages and subcontractors must meet all of the requirements in chapter 410 division 136 rules and chapter 410 division 120 rules. The Authority shall pay for ~~c~~Covered ~~s~~Services the brokerage authorized and provided in good faith, including mailing transit passes to ~~client~~Member~~s. The Authority

shall use the rate in effect on the day of the transport or the mailing date of the transit passes. For the purpose of this rule "Good faith" means:¶
(a) The brokerage verified ~~client~~Member eligibility on the ~~d~~Date of ~~s~~Service or the date of mailing the transit passes, using the Authority's eligibility information; or¶
(b) The ~~client~~Member eligibility information was inconsistent or not available, and the brokerage used the most recent ~~client~~Member information available immediately before the time of service or mailing of transit passes.¶
(6) Each brokerage may establish a working capital reserve with funds the Authority provides. The following applies to any established working capital reserve:¶
(a) The working capital reserve shall represent ~~thirty (~~30~~)~~ days of cash expenses for normal operating purposes. The Authority may base the reserve on a time other than ~~thirty (~~30~~)~~ days if circumstances warrant the change;¶
(b) The Authority shall calculate the reserve amount as part of the annual cost settlement for the most recent past fiscal year;¶
(c) The Authority shall base the reserve amount on an average of six (6) months of operating expenses that the brokerage reports in its monthly NEMT financial reports. However, the Authority may base the reserve amount on more or less than six (6) months of expenses when a six-month average does not reflect an accurate accounting of expenses;¶
(d) Brokerages shall maintain a separate account for the reserve funds; and¶
(e) The Authority may require the brokerage to return any funds in excess of the amount the Authority calculated, or the Authority may decrease the ~~r~~Ride rate to reduce the reserves. If the Authority requires the brokerage to return the excess funds, the brokerage shall do so within ~~fourty-five (~~45~~)~~ days of receipt of the Authority notification.
Statutory/Other Authority: ORS 413.042
Statutes/Other Implemented: ORS 414.065

AMEND: 410-136-3220

RULE SUMMARY: Changing “client” and “recipient” to “Member” or “CCO Member” or “Open Card Member” where appropriate.

CHANGES TO RULE:

410-136-3220
Brokerage Reimbursements to Subcontractors ¶

(1) Brokerages shall reimburse their ~~n~~Non-~~e~~Emergent ~~m~~Medical ~~t~~Transportation (NEMT) subcontractors for the most ~~c~~Cost-~~e~~ Effective route from point of origin to point of destination that most benefits the ~~client~~Member's condition.¶
(2) Brokerages shall establish a base rate with its subcontractors. "Base rate" for all modes of ~~t~~Transportation except ground and air ~~a~~Ambulance means the rate the brokerage and its subcontractors agree on for each mode of ~~t~~Transportation.¶
(3) If a subcontractor uses an ~~a~~Ambulance as a stretcher car or van, the brokerage shall reimburse the subcontractor using the base rate for stretcher cars or vans.¶
(4) As an exception section (3) of this rule, brokerages shall pay ~~a~~Ambulance subcontractors at the ~~a~~Ambulance rate instead of the stretcher car or van rate when the transport exceeds two hours, necessitating a health care professional to care for the ~~client~~Member during the ~~r~~Ride.¶
(5) Brokerages shall not reimburse their subcontractors for waiting for ~~client~~Members to get to the vehicle or for assisting ~~client~~Members to get in or out of a vehicle.¶
(6) Brokerages may reimburse their subcontractors for waiting time:¶
(a) In special situations, such as when the subcontractor must wait for a ~~client~~Member who is using the subcontractor's gurney and cannot transfer to a gurney at a medical facility; or¶
(b) Because of a medical issue during the ~~r~~Ride, such as:¶
(A) The ~~client~~Member is nauseous or is vomiting after dialysis or chemotherapy; or¶
(B) The ~~client~~Member needs to stop to get prescription medication or medical supplies related to the ~~m~~Medical ~~s~~Services.¶
(7) Brokerages shall reimburse their subcontractors at the base rate for ambulatory vehicles if the subcontractor provides a ~~r~~Ride to an ambulatory ~~client~~Member in a non-ambulatory vehicle.¶
(8) Brokerages may authorize a subcontractor to transport a non-ambulatory ~~client~~Member in an ambulatory vehicle if the vehicle can accommodate and transport the ~~client~~Member and if allowed by local ordinance. The brokerage shall reimburse its subcontractor at the non-ambulatory vehicle rate.¶
(9) The wheelchair base rate applies to the transport of a ~~client~~Member with a reclining wheelchair; wheelchairs do not qualify as stretchers or gurneys.¶
(10) The following applies to reimbursement for deceased ~~client~~Members:¶
(a) If a ~~client~~Member dies before the subcontractor arrives at the scene, the brokerage shall not reimburse its subcontractors; or¶
(b) If a ~~client~~Member dies after the transport begins but before reaching the destination, the brokerage's payment is limited to the base rate for the mode of ~~t~~Transportation and mileage. For ~~a~~Ambulance transports, the payment also would include costs for an extra attendant, if applicable.¶
(11) Brokerages may authorize shared-ride transports of two or more ~~client~~Members at the same time when the shared-ride transports are allowable under the Health Insurance Portability and Accountability Act of 1996 (HIPAA).¶
(12) Brokerages shall reimburse subcontractors:¶
(a) At the full base rate for the first ~~client~~Member and one-half the base rate for each additional ~~client~~Member when all of these ~~client~~Members need the same mode of ~~t~~Transportation, such as by wheelchair van; or¶
(b) At the full base rate for the ~~client~~Member with the need for the highest mode of ~~t~~Transportation and one-half the base rate of the appropriate mode of ~~t~~Transportation for each additional ~~client~~Member. This applies when the additional ~~client~~Member needs a less costly mode of ~~t~~Transportation than the first ~~client~~Member. For example, the first ~~client~~Member needs an ~~a~~Ambulance, but the additional ~~client~~Member needs a less costly wheelchair van.¶
(13) When transporting two or more ~~client~~Members at the same time, brokerages shall pay subcontractors only from the first pick-up point to the final destination under the following circumstances:¶
(a) The ~~client~~Members have a single pick-up point but different destinations;¶
(b) The ~~client~~Members have different pick-up points but a single destination; or¶
(c) The ~~client~~Members have different pick-up points and different destinations.¶
(14) Brokerages shall reimburse subcontractors only for actual miles traveled, regardless of the number of

~~client~~Members transported.¶
(15) A brokerage shall not reimburse a subcontractor if:¶
(a) A county or city ordinance prohibits any charging for services identified in the ~~m~~Medical ~~t~~Transportation services administrative rules; or¶
(b) The subcontractor does not charge the public for such services.¶
(16) In accordance with costs and expenses reporting described in OAR 410-136-3200 a brokerage may require the subcontractor to provide documents and records to support the costs and expense that the brokerage must report to OHA.
Statutory/Other Authority: ORS 413.042
Statutes/Other Implemented: ORS 414.065

AMEND: 410-136-3240

RULE SUMMARY: Changing “client” and “recipient” to “Member” or “CCO Member” or “Open Card Member” where appropriate.

CHANGES TO RULE:

410-136-3240
~~Client~~Member Reimbursed Mileage, Meals and Lodging ¶

(1) The brokerage must provide Prior ~~a~~Authorize~~a client~~ation for a Member's mileage, meals, and lodging to an Oregon Health Plan (OHP) or RHAF ~~c~~Covered ~~medical s~~Service in order for the ~~client~~Member to qualify for reimbursement. If the brokerage provided Prior ~~a~~Authorize~~d~~ation for the travel costs, a ~~client~~Member may request reimbursement up to 45 days after the travel.¶
(2) The ~~client~~Member must return any documentation the brokerage requires before receiving reimbursement. Documentation required shall include a receipt for lodging.¶
(3) A ~~client~~Member must be reimbursed within ~~fourteen (~~14~~)~~ days of the brokerage after verification of the ~~client~~Member's attendance at the appointment for the reimbursement request received.¶
(a) A brokerage may hold reimbursements under the amount of $10 until the ~~client's~~Members reimbursement reaches $10; or¶
(b) A brokerage must issue the ~~client~~Member a notice within ~~fourteen (~~14~~)~~ days if the ~~client~~Member reimbursement is denied for any reason. If the ~~client~~Member reimbursement request is incomplete the brokerage shall take an additional ~~fourteen (~~14~~)~~ days to assist the ~~client~~Member in completing the submission;¶
(c) The ~~fourteen (~~14~~)~~ days in section (3) of this rule occur after a ~~client~~Member requests reimbursement.¶
(4) Brokerages shall reimburse ~~client~~Members for meals when a ~~client~~Member, with or without an attendant, travels a minimum of four (4) hours round-trip out of their local area. The travel, however, must span the following meal times:¶
(a) For a breakfast allowance, the travel must begin before 6 a.m.;¶
(b) For a lunch allowance, the travel must span the entire period from 11:30 a.m. through 1:30 p.m.; and¶
(c) For a dinner allowance, the travel must end after 6:30 p.m.¶
(5) Brokerages shall reimburse for meals at the Authority's allowable rate.¶
(6) Brokerages shall not reimburse ~~client~~Members for meals that a ~~h~~Hospital or other medical facility provides.¶
(7) Brokerages shall reimburse ~~client~~Members for lodging when:¶
(a) A ~~client~~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 ~~client~~Member's health care ~~p~~Provider documents a medical need.¶
(8) Brokerages shall reimburse for lodging at the Authority's allowable rate or the actual cost of the lodging, whichever is less.¶
(9) Brokerages shall reimburse for meals or lodging for only one attendant, which may be a parent, to accompany the ~~client~~Member if medically necessary but only if:¶
(a) The ~~client~~Member is a minor child and unable to travel without an attendant;¶
(b) The ~~client~~Member's attending ~~p~~Physician provides a signed statement indicating the reason an attendant must travel with the ~~client~~Member;¶
(c) The ~~client~~Member is mentally or physically unable to reach ~~his or he~~their medical appointment without assistance; or¶
(d) The ~~client~~Member is or may be unable to return home without assistance after the treatment or service.¶
(10) The brokerage shall not reimburse for the attendant's time or services.¶
(11) If a ~~client~~Member's health care ~~p~~Provider admits the ~~client~~Member for inpatient care, an attendant is no longer ~~m~~Medically ~~n~~Necessary because the facility provides all necessary services for the ~~client~~Member. Therefore, the attendant is no longer eligible for lodging and travel expenses. The brokerage shall reimburse for meals and lodging for the attendant's transportation home. However, the brokerage may pay for the attendant's meals and lodging if it is more ~~c~~Cost ~~e~~Effective for the attendant to remain near the ~~client~~Member to accompany the ~~client~~Member on the return trip as allowed by section (12) of this rule.¶
(12) Upon the ~~client~~Member's release from inpatient care, if the attendant is ~~m~~Medically ~~n~~Necessary based on one of the conditions or circumstances listed in section (9) of this rule, the brokerage shall reimburse for the attendant to return to the inpatient facility to accompany the ~~client~~Member on the return trip. This only applies if the brokerage provides Prior ~~a~~Authorize~~s~~ation for the attendant's travel.¶
(13) Brokerages shall not reimburse for mileage, meals, and lodging for an attendant visiting an inpatient

~~client~~Member unless the ~~p~~Physician provides a signed statement of the medical need. This exclusion includes, but is not limited to, parents of minors, breastfeeding mothers, and spouses.¶
(14) The ~~state~~Authority shall recover ~~o~~Overpayments made to a ~~client~~Member. Overpayments occur when the brokerage paid the ~~client~~Member:¶
(a) For mileage, meals, and lodging, and another resource also paid:¶
(A) The ~~client~~Member or;¶
(B) The ~~r~~Ride, meal, or lodging provider directly;¶
(b) Directly to travel to medical appointments, and the ~~client~~Member did not use the money for that purpose, did not attend the appointment, or shared the ~~r~~Ride with another ~~client~~Member whom the brokerage also directly paid;¶
(c) For common carrier or public transportation tickets or passes, and the ~~client~~Member sold or otherwise transferred the tickets or passes to another person.¶
(15) If a person or entity other than the ~~client~~Member or the minor ~~client~~Memeber's parent or legal guardian provides the ~~r~~Ride, the brokerage may reimburse the person or entity that provided the ~~r~~Ride. However, the ~~client~~Member or the minor ~~client~~Member's parent or legal guardian must approve in writing of the reimbursement.
Statutory/Other Authority: ORS 413.042
Statutes/Other Implemented: ORS 414.065

AMEND: 410-136-3260

RULE SUMMARY: Changing “client” and “recipient” to “Member” or “CCO Member” or “Open Card Member” where appropriate.

CHANGES TO RULE:

410-136-3260
Modifications Based on ~~Client~~Member Circumstances ¶

(1) A ~~client~~Member may request modification of ~~n~~Non-~~e~~Emergent ~~m~~Medical ~~t~~Transportation (NEMT) ~~s~~Services when the NEMT driver:¶
(a) Threatens to harm the ~~client~~Member or others in the vehicle;¶
(b) Drives or engages in other behavior that places the ~~client~~Member or others in the vehicle at risk of harm;~~-~~¶
(c) Threatens to or breaks the ~~client~~Member's confidentiality; or¶
(d) Presents a perceived or direct threat to the ~~client~~Member or others in the vehicle.¶
(2) A brokerage may modify NEMT services when the ~~client~~Member:¶
(a) Is threatening harm to the driver or others in the vehicle;¶
(b) Presents a direct threat to the driver or others in the vehicle;¶
(c) Has a health condition that creates health or safety concerns to the driver or others in the vehicle;¶
(d) Engages in behaviors or circumstances that place the driver or others in the vehicle at risk of harm;¶
(e) Frequently does not show up for scheduled ~~r~~Rides;¶
(f) Frequently cancels the ~~r~~Ride on the day of the scheduled ~~r~~Ride time;¶
(g) Engages in behaviors that cause local medical ~~p~~Providers or facilities to refuse to provide further services without modifying NEMT services; or¶
(h) Has special needs that require special accommodations.¶
(2) For the purposes of this rule, "direct threat" means a significant risk to the health or safety of others and which:¶
(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; and¶
(b) Is identified through an individual assessment that relies on current medical evidence or the best available objective evidence which shows:¶
(A) The nature, duration, and severity of the risk;¶
(B) The probability that a potential injury shall actually occur; and¶
(C) Whether reasonable modification of policies, practices, or processes shall lower or eliminate the risk.¶
(3) Reasonable modifications include, but are not limited to requiring the ~~client~~Member to:¶
(a) Use a specific transportation subcontractor;¶
(b) Travel with an attendant;¶
(c) Use public transportation where available;¶
(d) Drive themselves or locate someone to drive them and receive mileage reimbursement; or¶
(e) Confirm the ~~r~~Ride with the brokerage on the day of or the day before the scheduled ~~r~~Ride.¶
(4) Before requiring any modifications, the brokerage shall talk with the ~~client~~Member about the reason for imposing a modification, explore modifications that are appropriate to the needs of the ~~client~~Member and that address the health and safety concerns of the brokerages. The brokerage or ~~client~~Member may include the ~~client~~Member's worker, or CCO in the discussion. The ~~client~~Member may include other individuals in the discussion.¶
(5) 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.¶
(6) Brokerages may not modify NEMT services under this rule unless the modification is permitted under this rule or required in order to accommodate a disability requiring modification or auxiliary aid.¶
(7) Brokerages may not make a reasonable modification based on the criteria in subsections (1)(a)-(g) in this rule that results in a denial of NEMT services to a ~~client~~Member and must make all reasonable efforts to offer an appropriate alternative to meet the ~~client~~Member's needs under the circumstances.¶
(8) Brokerages shall draft policies and procedures that ensure the safety of all passengers in NEMT vehicles which shall include, without limitation, policies and procedures that comply with this rule and in accordance with OAR 410-136-3020 (13)(e). Brokerages shall include passenger safety policy and procedures in a OHP Open Card Member Handbook or in a stand-alone document, and ensure the information is available on the Brokerages' website for passengers. Brokerages shall also provide passenger safety policy and procedures information to their

NEMT subcontractors and require the NEMT subcontractors to follow the policies and procedures.
Statutory/Other Authority: ORS 413.042
Statutes/Other Implemented: ORS 414.065

AMEND: 410-136-3280

RULE SUMMARY: Changing “client” and “recipient” to “Member” or “CCO Member” or “Open Card Member” where appropriate.

CHANGES TO RULE:

410-136-3280
~~Client~~Member Rights and Confidentiality ¶

(1) Brokerages shall treat all information gathered on the ~~client~~Member as privileged and confidential communications. The brokerage shall apply confidentiality policies to all requests for information from outside sources. Nothing prohibits the disclosure of information in summaries, statistical reports or other forms as long as the document does not identify particular individuals and cannot lead to the identification of individuals. Brokerages and any subcontractors may share information as necessary to serve the ~~client~~Member effectively. The brokerage shall not divulge the information without the written consent of the ~~client~~Member, the responsible parent of a minor child or the ~~client~~Member's legal guardian. The use or disclosure of information is limited to persons directly administrating NEMT services.¶
(2) Brokerages and their subcontractors shall comply with OAR 943-014-0300 through 943-014-0320 pertaining to access control if the Authority grants them access to any secure computer system or information asset.¶
(3) Brokerages 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) The brokerage shall not deny or allow subcontractors to deny any ~~client~~Member NEMT services based on race, color, sex, gender, gender identity, gender presentation, sexual orientation, religion, national origin, creed, marital status, age, health status or the presence of any sensory, mental, intellectual, developmental, IQ score, or physical disability.¶
(5) Brokerages must treat ~~client~~Members and require subcontractors and all drivers to treat ~~client~~Members in accordance with OAR 410-120-1855, ~~Client~~Member Rights and Responsibilities, including but not limited to:¶
(a) To ensure ~~client~~Members and their ~~r~~Representatives have communications and materials explained in their preferred spoken or sign language;¶
(b) To ensure ~~client~~Members receive written materials describing rights, responsibilities, benefits available, how to access services, and what to do in an emergency.¶
(6) The brokerages shall have educational materials available for ~~client~~Members on its NEMT services. The Oregon Health Authority (Authority) must first approve the materials and document the approval in writing. Subcontractors shall use Authority approved NEMT education materials.¶
(7) As required by 42 CFR 431, a brokerage shall follow OAR 410-120-1855 through 410-120-1865 pertaining to ~~c~~Contested ~~c~~Case ~~h~~Hearings when it denies a ~~r~~Ride, with the following exceptions:¶
(a) The brokerage must immediately provide a secondary review by another employee when the initial screener denies a ~~r~~Ride; and¶
(b) The brokerage must mail a notice of ~~a~~Action to a ~~client~~Member denied a ~~r~~Ride within 72 hours of denying a ~~r~~Ride explaining why the ~~client~~Member's ~~r~~Ride has been denied and hearing rights to ~~a~~Appeal the denial.¶
(8) The brokerages shall reinstate a denied service consistent with 42 CFR 431.231 in the following circumstances:¶
(a) ~~i~~If ~~a~~Action is taken without the advance notice required;¶
(b) ~~i~~If a ~~beneficiary~~Member requests a hearing within ~~ten (~~10~~)~~ days after the date of ~~a~~Action, or if determined ~~a~~Action had resulted from other than the application of ~~F~~federal or ~~S~~state law or policy; or¶
(c) ~~i~~If a ~~beneficiary~~Member's whereabouts become known during a time they are eligible for services.¶
(9) Brokerages must have and maintain documentation pertaining to all authorization and denial of services. Upon the Authority's request, brokerages shall provide documentation pertaining to discovery for any investigation, or for ~~c~~Contested ~~c~~Case ~~h~~Hearings pursuant to OAR 410-120-1360.¶
(10) Brokerages shall provide documentation pertaining to discovery for or investigation of ~~c~~Contested ~~c~~Case ~~h~~Hearings when the ~~client~~Member, the responsible parent of a minor child or the ~~client~~Member's legal guardian requests the documentation. The brokerage shall provide the documentation to the ~~client~~Member's legal ~~r~~Representative upon written consent from the ~~client~~Member, the responsible parent of a minor child or the ~~client~~Member's legal guardian.¶
(11) Brokerages shall have and maintain policies and procedures which shall include, without limitation, policies and procedures that comply with this rule. Brokerages shall provide ~~client~~Member rights and responsibilities policy and procedures information from this rule to its NEMT subcontractors and require the NEMT subcontractors to implement and follow such policies and procedures. Brokerages shall include ~~client~~Member rights and

responsibilities policy and procedures in their member handbooks and posted on their websites. Brokerages must monitor subcontractors' compliance with ~~client~~Member rights and responsibilities policies and procedures of this rule.
Statutory/Other Authority: ORS 413.042
Statutes/Other Implemented: ORS 414.065

AMEND: 410-136-3300

RULE SUMMARY: Changing “client” and “recipient” to “Member” or “CCO Member” or “Open Card Member” where appropriate.

CHANGES TO RULE:

410-136-3300
Reports and Documentation ¶

(1) Brokerages shall maintain documentation of ~~r~~Rides denied and ~~r~~Rides provided to ~~client~~Members. This documentation shall include, but is not limited, to:¶
(a) The name of the ~~client~~Member and the person requesting the ~~r~~Ride on behalf of the ~~client~~Member, if applicable;¶
(b) The ~~client~~Member's Oregon Health Plan (OHP) or RHAF medical care identification number;¶
(c) The date and time of the request for ~~t~~Transportation;¶
(d) The mode of transport authorized for the ~~client~~Member and a justification for authorizing a mode of transport that is not reasonably understandable;¶
(e) The location for picking-up the ~~client~~Member and the destination;¶
(f) The medical reason for the appointment;¶
(g) The availability of other ~~t~~Transportation resources and the justification for authorizing a ~~r~~Ride when the ~~client~~Member has other resources;¶
(h) The subcontractor assigned to give the ~~r~~Ride and the date and time the brokerage notified the subcontractor of the assignment;¶
(i) The name of the employee who approved a ~~r~~Ride and the name of the driver for the ~~r~~Ride, as applicable; and¶
(j) In the case of a denial of a ~~r~~Ride:¶
(A) The name of the employee who denied a ~~r~~Ride;¶
(B) The name of the employee who performed the secondary review before denying the ~~r~~Ride;¶
(C) The reason for the denial and the applicable OAR that supports the denial;¶
(D) The date on the notice of ~~a~~Action the brokerage mailed to the ~~client~~Member;¶
(E) Documentation on the brokerage's review, resolution, or disposition of the matter, if applicable, including the reason for the decision and the date of the resolution or disposition; and¶
(F) Notations of oral and written communications with the ~~client~~Member and documentation of the outcome of any ~~a~~Appeal of a denied service.¶
(2) The brokerage shall retain the documentation on denials of ~~r~~Rides for three calendar years, even if the brokerage is no longer a Medicaid enrolled ~~p~~Provider before the end of the three years. The Authority may request this information at any time during the three year retention period.¶
(3) The brokerage shall maintain service and billing files organized by subcontractor that justify the number of transports and with cross references to actual ~~r~~Rides and specific ~~client~~Members. The record keeping system developed and maintained by brokerages and their subcontractors shall include sufficient detail and clarity to permit internal and external review to validate claim submissions and to assure NEMT services are provided consistent with the documented needs of the ~~client~~Member. Brokerages information for actual ~~r~~Rides shall include the date, mode of transport, the driver's first and last name.¶
(4) The brokerages shall report monthly on estimated revenue and expenses that affect the balance of the working capital reserve amount. The report must contain the following costs as they pertain to providing NEMT services:¶
(a) Sub-totals of administrative expenses, including:¶
(A) Salaries and wages of the brokerage's employees;¶
(B) Payroll related expenses for the brokerage's employees;¶
(C) Other employee related expenses, such as recruitment and advertising;¶
(D) Computer hardware and software purchased, leased or licensed;¶
(E) Office supplies such as stamps, paper or printing;¶
(F) Non-computer related equipment purchased, leased or licensed;¶
(G) Telephone;¶
(H) Administrative support and other indirect charges;¶
(I) Education and training;¶
(J) Building expenses such as leases, rents, security, janitorial services and repairs that retain the property's operating condition but do not add to the permanent value of the property;¶
(K) Subcontractor identification and drug testing, such as fingerprinting and drug analysis;¶
(L) Legal expense not related to the Authority, such as attorney fees; fines or penalties;¶

(M) Indirect expenses, such as accounting, human resources, risk management or insurance;¶
(N) Sub-contracts for operations or temporary employees;¶
(O) Required driver training, if applicable;¶
(P) The ~~client~~Member satisfaction survey, if applicable;¶
(Q) Software maintenance, if applicable; and¶
(R) Details of other administrative expenses not specified above.¶
(b) The number and costs of the following:¶
(A) Stretcher car ~~r~~Rides;¶
(B) Wheelchair ~~r~~Rides;¶
(C) Ambulatory ~~r~~Rides;¶
(D) Secured transports;¶
(E) Bus tickets;¶
(F) Bus passes;¶
(G) NEMT ~~a~~Ambulance transports;¶
(H) Reimbursements to ~~client~~Members; and¶
(I) Commercial transports.¶
(c) The amount of credits to subcontractors.¶
(d) Information on the brokerage's working capital reserve, including:¶
(A) The Authority-calculated working capital reserve;¶
(B) The estimated working capital reserve as of the beginning of the fiscal year;¶
(C) The estimated working capital reserve as of this report; and¶
(D) The difference between above ~~sub-sections~~ paragraphs (4)(d)(B) and (4)(d)(C) of this rule.¶
(5) The financial reports must show the number of ~~r~~Rides that ~~v~~Volunteer drivers provide.¶
(6) Brokerages must submit the financial report required in ~~S~~section (4) of this rule within 45 days of the end of the reporting month.¶
(7) Brokerages shall submit a cost allocation plan that includes anticipated expenses, certified by the brokerage's Chief Financial Officer, to the Authority no later than April 1 of each year for the upcoming fiscal year.¶
(8) Brokerages must report monthly on data that meets the delivery and content specifications as defined by the Authority.¶
(a) ~~m~~Monthly data for quality assurance must include at minimum the following:¶
(A) Driver ~~C~~cancellations reported as a numeric value of the total number of times within the reporting period that a driver cancels a ~~r~~Ride less than 24 hours in advance, resulting in ~~client~~Member not receiving scheduled ~~r~~Ride;¶
(B) Driver ~~N~~no-~~S~~shows reported as a numeric value of the total number of times within the reporting period that a driver was not at pick up location as pre-arranged resulting in ~~client~~Member not receiving scheduled ride;¶
(C) ~~Client C~~Member cancellations reported as a numeric value of total number of times within the reporting period that a ~~clients~~Member cancels a ~~r~~Ride less than 24 hours in advance;¶
(D) ~~Client N~~Member no-~~S~~shows reported as a numeric value of the total number of times within the reporting period that a ~~client~~Member was not at pick-up location as pre-arranged, after the allowed 15-minute window of time, resulting in a ~~r~~Ride cancellation;¶
(E) Late Rides reported as a numeric value of the total number of ~~r~~Rides within the reporting period where driver arrived 15 minutes or more past scheduled pick-up time.¶
(F) Rides scheduled reported as a numeric value of the total number of ~~r~~Rides scheduled in the reporting period regardless of whether driver/member no-show or cancelled.¶
(G) Rides denied reported as a numeric value of the total number of ~~r~~Rides denied by brokerage during the reporting period.¶
(b) Brokerages must submit monthly data quality assurance report to the Authority no later than 45 days after the end of each month within each calendar year.¶
(9) Brokerages must maintain written policies and procedures outlining the activities of NEMT services for ongoing monitoring, evaluation, and improvement of the quality and appropriateness of NEMT services, and with procedures for processes.¶
(10) Brokerages must submit written policies and procedures to the Authority no later than December 1 of each year for the upcoming calendar year.¶
(11) Brokerages must develop and conduct a ~~client~~Member satisfaction survey, including at minimum the following:¶
(a) Processes for conducting ~~client~~Member satisfaction surveys at least annually;¶
(b) Satisfaction surveys must be sent to a minimum of five percent of all ~~client~~Members who scheduled NEMT ~~r~~Rides;¶
(c) Submit completed ~~client~~Member satisfaction survey results to the Authority, at least annually, for review of results to identify potential areas of enhancement or improvement within the program.¶

(12) Brokerages must maintain a log of all ~~OHA Client g~~Member Grievances, complaints that are referred by brokerage to the Authority, and of which brokerage receives notice from subcontractors or the Authority. The log shall identify at minimum:¶
(a) ~~Client~~Member name;¶
(b) Date of the ~~g~~Grievance;¶
(c) The allegation or ~~g~~Grievance;¶
(d) Resolution; and¶
(e) Date of resolution.¶
(13) The Authority may request, and the brokerage shall provide, other reports or information not specified in sections ~~1~~(1) through (11) of this rule. OHA has the right to request all NEMT documentation, information, reports, phone call recordings, ~~g~~Grievances or other complaints submitted, policies and procedures, systems, facilities that provide or otherwise relate to NEMT services for purposes of determining compliance.
Statutory/Other Authority: ORS 413.042
Statutes/Other Implemented: ORS 414.065

AMEND: 410-136-3340

RULE SUMMARY: Changing “client” and “recipient” to “Member” or “CCO Member” or “Open Card Member” where appropriate.

CHANGES TO RULE:

410-136-3340
Brokerage Service Areas ¶

(1) Brokerages enrolled with the Oregon Health Authority (Authority) shall arrange and pay for NEMT services to all eligible ~~client~~Members in the counties shown in Table 136-3340.¶
(2) Oregon Health Plan (OHP) ~~client~~Members and RHAF ~~client~~Members residing in Oregon shall use only the brokerages available in their county of residence unless they have permission from their local brokerage to use another brokerage.¶
(3) Nothing in this rule precludes brokerages from coordinating to provide ~~r~~Rides to ~~client~~Members in another brokerage if it would be more ~~c~~Cost ~~e~~Effective or provide better service for the ~~client~~Member.¶
[ED. NOTE: Table referenced is available from the Oregon Health Authority (OHA) and on the Authority's website.]
Statutory/Other Authority: ORS 413.042
Statutes/Other Implemented: ORS 414.065

AMEND: 410-136-3360

RULE SUMMARY: Changing “client” and “recipient” to “Member” or “CCO Member” or “Open Card Member” where appropriate.

CHANGES TO RULE:

410-136-3360
Discontinuation of Brokerage as Enrolled Provider ¶

(1) A brokerage may discontinue being an enrolled ~~p~~Provider for NEMT services only with notice to the Oregon Health Authority (Authority). The following establishes the requirements for notice:¶
(a) If the reason is for the brokerage's convenience:¶
(A) The effective date must be at least 90 days after the brokerage sends written notice; and¶
(B) ~~t~~The effective date must be on the first calendar date of the month.¶
(b) The brokerage must provide 45 days advance written notice if the brokerage does not obtain funding, appropriations and other expenditure authorizations from its governing body, federal, state or other sources sufficient to permit the brokerage to satisfy its requirements pursuant to these rules (OAR 410-136-3000 through 410-136-3360);¶
(c) Immediately upon written notice if the Oregon Legislative Assembly, the federal government or a court interprets, modifies or changes Oregon statutes or federal laws, regulations or guidelines in such a way that the brokerage immediately has no authority to satisfy the requirements of these rules.¶
(2) The Authority may discontinue allowing a brokerage to provide NEMT services as an enrolled ~~p~~Provider only with notice to the brokerage. The following establishes the requirements for notice:¶
(a) If the reason is for the Authority's convenience:¶
(A) The effective date must be at least 90 days after the Authority sends written notice; and¶
(B) ~~t~~The effective date must be on the first calendar date of a month.¶
(b) The Authority must provide 45 days advance written notice if the Authority does not obtain funding, appropriations and other expenditure authorizations from its governing body, federal, state or other sources sufficient to meet its payment obligations pursuant to OAR 410-136-3200, Reimbursement and Accounting for all Modes of Transportation;¶
(c) Immediately upon written notice if the Oregon Legislative Assembly, the federal government or a court interprets, modifies or changes Oregon statutes or federal laws, regulations or guidelines in such a way that the Authority immediately has no authority to provide NEMT services pursuant to these rules;¶
(d) Immediately upon written notice to the brokerage if the Oregon Legislative Assembly or Emergency Board reduces the Authority's expenditure authorization, resulting in the following:¶
(A) The Authority cannot meet its payment obligations pursuant to OAR 410-136-3200, Reimbursement and Accounting for all Modes of Transportation; and¶
(B) The effective date for the reduction in expenditure authorization is less than 45 days from the date the Legislative Assembly or Emergency Board takes the action.¶
(e) Immediately upon written notice to the brokerage if a law or regulation requires a brokerage to have any license or certificate, and the license or certificate is denied, revoked, suspended, not renewed or changed in such a way that brokerage no longer meets requirements to deliver NEMT services. The Authority may only exercise this right with respect to the particular service impacted by the loss of the licensure or certification;¶
(f) Immediately upon written notice to the brokerage, if the Authority determines the brokerage or any of its subcontractors, have endangered or are endangering the health or safety of a ~~client~~Member or others.
Statutory/Other Authority: ORS 413.042
Statutes/Other Implemented: ORS 414.065

AMEND: 410-136-3370

RULE SUMMARY: Changing “client” and “recipient” to “Member” or “CCO Member” or “Open Card Member” where appropriate.

CHANGES TO RULE:

410-136-3370
General Requirements for GEMT
(1) The Ground Emergency Medical Transportation (GEMT) program is a voluntary program that makes supplemental payments to eligible GEMT ~~p~~Providers who furnish qualifying emergency ~~a~~Ambulance services to ~~Oregon Health Authority (Authority) Medicaid recipient~~Members:¶
(a) The supplemental payment covers the gap between the eligible GEMT ~~p~~Provider's total allowable costs for providing GEMT services as reported on the Centers for Medicare and Medicaid Services (CMS) approved cost report and the amount of the base payment, mileage, and all other sources of reimbursement;¶
(b) The Authority makes supplemental payments only up to the amount uncompensated by all other sources of reimbursement. Total reimbursements from Medicaid including the supplemental payment may not exceed one hundred percent of actual costs;¶
(c) The supplemental payments shall be made at least annually on a lump-sum basis after the conclusion of each state fiscal year. These payments are not an increase to current fee-for-service (FFS) reimbursement rates;¶
(d) This supplemental payment applies only to GEMT services rendered to Oregon ~~FFS Medicaid recipient~~Open Card Members by eligible GEMT ~~p~~Providers on or after July 1, 2017.¶
(2) Definitions:¶
(a) "Agency" means the Oregon Health Authority (Authority);¶
(b) Advanced Life Support" means special services designed to provide definitive prehospital emergency medical care, including but not limited to cardiopulmonary resuscitation, cardiac monitoring, cardiac defibrillation, advanced airway management, intravenous therapy, administration of drugs and other medicinal preparations, and other specified techniques and procedures;¶
(c) "Allowable Costs" means an expenditure that complies with the regulatory principles as listed in chapter 2 of the Code of Federal Regulations (CFR) Section 200;¶
(d) "Basic Life Support" means emergency first aid and cardiopulmonary resuscitation procedures to maintain life without invasive techniques;¶
(e) "Contracts with a Local Government" means contracts pursuant to a county plan for ~~a~~Ambulance and ~~e~~Emergency ~~medical s~~Services that is approved by the Oregon Health Authority with a;¶
(A) City, county, an Indian tribe as defined in Section 4 of the Indian Self-Determination and Education Assistance Act; or¶
(B) Local service district, including but not limited to;¶
(i) A rural fire protection district; or¶
(ii) All administrative subdivisions of such city, county, or local service district.¶
(f) "Direct Costs" means all costs that can be identified specifically with a particular final cost objective in order to meet ~~e~~Emergency ~~m~~Medical ~~t~~Transportation requirements. This includes unallocated payroll costs for the shifts of personnel, medical equipment and supplies, professional and contracted services, travel, training, and other costs directly related to the delivery of covered medical transport services;¶
(g) "Eligible GEMT Provider" means a GEMT ~~p~~Provider that meets all the eligibility requirements described in OAR 410-136-3370(3);¶
(h) "Federal Financial Participation (FFP)" means the portion of medical assistance expenditures for ~~e~~Emergency ~~medical s~~Services that are paid or reimbursed by the Centers for Medicare and Medicaid Services in accordance with the State Plan for medical assistance. ~~Client~~Members under Title XIX are eligible for FFP;¶
(i) "GEMT Services" means the act of transporting an individual by ground from any point of origin to the nearest medical facility capable of meeting the emergency medical needs of the patient, as well as the advanced, limited-advanced, and basic life support services provided to an individual by eligible GEMT ~~p~~Providers before or during the act of ~~t~~Transportation;¶
(j) "Governmental Unit" means the entire state, local, or federally-recognized Indian tribal government, including any component thereof;¶
(k) "Indirect Costs" means the costs for a common or joint purpose benefitting more than one cost objective that is allocated to each objective using an agency-approved indirect rate or an allocation methodology;¶
(l) "Limited Advanced Life Support" means special services to provide prehospital emergency medical care limited to techniques and procedures that exceed basic life support but are less than advanced life support services;¶
(m) "Publicly Owned or Operated" means a unit of government that is a state, a city, a county, a special purpose

district, or other governmental unit in the state that has taxing authority, has direct access to tax revenues, or is an Indian tribe as defined in Section 4 of the Indian Self-Determination and Education Assistance Act;¶
(n) "Service Period" means July 1 through June 30 of each Oregon State Fiscal Year (SFY);¶
(o) "Shift" means a standard period of time assigned for a complete cycle of work, as set by each eligible GEMT provider. The number of hours in a shift may vary by GEMT provider but shall be consistent to each GEMT provider.¶
(p) "Treatment in ~~þ~~Place" means EMT services (basic, limited-advanced, and advanced life support services) provided by a Medicaid-enrolled EMS professional to an individual who is released on the scene without ~~ŧ~~Transportation by ~~a~~Ambulance to a medical facility.¶
(3) GEMT Provider Eligibility Requirements:¶
(a) To be eligible for supplemental payments, GEMT ~~þ~~Providers shall meet the following requirements:¶
(A) Be enrolled as an Oregon Health Plan Medicaid ~~þ~~Provider for the period being claimed on their annual cost report; and¶
(B) Provide ground emergency medical transport services to Me~~dicaid recipient~~mbers.¶
(b) GEMT providers must classify as a Governmental Unit provider in accordance with 2 CFR 200.¶
(4) Supplemental Reimbursement Methodology General Provisions:¶
(a) Computation of ~~a~~Allowable ~~c~~Costs and their allocation methodology shall be determined in accordance with the CMS Provider Reimbursement Manual (CMS Pub. 15-1), CMS non-institutional reimbursement policies, and 2 C.F.R. Part 200, which establish principles and standards for determining allowable costs and the methodology for allocating and apportioning those expenses to the Medicaid program, except as expressly modified below;¶
(b) Medicaid base payments to the eligible GEMT ~~þ~~Providers for providing GEMT services are derived from the ~~a~~Ambulance FFS fee schedule established for reimbursements payable by the Medicaid program by procedure code. The primary source of paid claims data, managed care encounter data, and other Medicaid reimbursements is the Oregon Medicaid Management Information System (MMIS). The number of paid Medicaid FFS GEMT transports is derived from and supported by the MMIS reports for services during the applicable service period;¶
(c) The total uncompensated care costs of each eligible GEMT ~~þ~~Provider available to be reimbursed under this supplemental reimbursement program shall equal the shortfall resulting from the ~~a~~Allowable ~~c~~Costs determined using the Cost Determination Protocols for each eligible GEMT ~~þ~~Provider providing GEMT services to Oregon Medicaid beneficiaries, net of the amounts received and payable from the Oregon Medicaid program and all other sources of reimbursement for such services provided to Oregon Medicaid beneficiaries. If the eligible GEMT ~~þ~~Providers do not have any uncompensated care costs, then the ~~þ~~Provider may not receive a supplemental payment under this supplemental reimbursement program. Total reimbursement from Medicaid may not exceed one hundred percent of actual cost of providing services to Oregon Medicaid beneficiaries.¶
(5) Cost Determination Protocols:¶
(a) An eligible GEMT ~~þ~~Provider's specific ~~a~~Allowable ~~c~~Cost per-medical transport rate shall be calculated based on the ~~þ~~Provider's audited financial data reported on the CMS-approved cost report. The per-medical transport cost rate shall be the sum of actual allowable direct and indirect costs of providing medical transport services divided by the actual number of medical transports provided for the applicable service period;¶
(b) Direct costs for providing medical transport services include only the unallocated payroll costs for the shifts when personnel dedicate 100 percent of their time to providing medical transport services, medical equipment and supplies, and other costs directly related to the delivery of ~~c~~Covered ~~s~~Services, such as first-line supervision, materials and supplies, professional and contracted services, capital outlay, travel, and training. These costs shall be in compliance with Medicaid non-institutional reimbursement policy and are directly attributable to the provision of the medical transport services;¶
(c) Indirect costs are determined in accordance with one of the following options:¶
(A) Eligible GEMT ~~þ~~Providers that receive more than $35 million in direct federal awards shall either have a Cost Allocation Plan (CAP) or a cognizant agency-approved indirect rate agreement in place with its federal cognizant agency to identify indirect cost. If the eligible GEMT ~~þ~~Provider does not have a CAP or an indirect rate agreement in place with its federal cognizant agency and it would like to claim indirect cost in association with a non-institutional service, it shall obtain one or the other before it can claim any indirect cost; or¶
(B) Eligible GEMT ~~þ~~Providers that receive less than $35 million of direct federal awards are required to develop and maintain an indirect rate proposal for purposes of audit. In the absence of an indirect rate proposal, eligible GEMT ~~þ~~Providers may use methods originating from a CAP to identify its indirect cost. If the eligible GEMT ~~þ~~Provider does not have an indirect rate proposal on file or a CAP in place and it would like to claim indirect cost in association with a non-institutional service, it shall secure one or the other before it can claim any indirect cost; or¶
(C) Eligible GEMT ~~þ~~Providers that receive no direct federal funding can use any of the following previously established methodologies to identify indirect cost:¶
(i) A CAP with its local government; or¶
(ii) An indirect rate negotiated with its local government; or¶

(iii) Direct identification through use of a cost report.¶
(D) If the eligible GEMT ~~þ~~Provider never established any of the above methodologies, it may do so, or it may elect to use the 10 percent de minimis rate to identify its indirect cost.¶
(d) The GEMT ~~þ~~Provider-specific, per-medical transport cost rate is calculated by dividing the total net medical transport ~~a~~Allowable ~~c~~Costs of the specific provider by the total number of medical transports provided by the ~~þ~~Provider for the applicable service period;¶
(e) The costs associated with Treatment in ~~þ~~Place shall not be included in the total ~~a~~Allowable ~~c~~Costs and must not be counted as an allowable medical transport.¶
(6) Interim Supplemental Payment:¶
(a) Each eligible GEMT ~~þ~~Provider shall compute the annual cost in accordance with OAR 410-136-3370(5) and shall submit the completed annual as-filed cost report to the Authority within five months after the close of the state's fiscal year;¶
(b) The Authority shall make annual interim supplemental payments to eligible GEMT ~~þ~~Providers. The interim supplemental payment for each eligible GEMT ~~þ~~Provider is based on the ~~þ~~Provider's completed annual cost report in the format prescribed by the Authority and approved by CMS for the applicable cost reporting year;¶
(c) To determine the interim supplemental GEMT payment rate, the Authority shall use the most recently filed cost reports of all eligible GEMT ~~þ~~Providers to determine the average cost per transport, which varies between the ~~þ~~Providers.¶
(7) Cost Settlement Process:¶
(a) The payments and the number of transport data reported in the as-filed cost report shall be reconciled to the Authority's MMIS reports generated for the cost reporting period within one year of receipt of the as-filed cost report. The Authority shall make adjustments to the as-filed cost report based on the reconciliation results of the most recently retrieved MMIS report;¶
(b) Each eligible GEMT ~~þ~~Provider shall receive payments in an amount equal to the greater of the interim payment or the total CMS approved Medicaid-~~a~~Allowable ~~c~~Costs for GEMT services;¶
(c) The Authority shall perform a final reconciliation where it will settle the ~~þ~~Provider's annual cost report as audited within the following calendar quarter. The Authority shall compute the net GEMT ~~a~~Allowable ~~c~~Costs using audited per-medical transport cost and the number of fee-for-service GEMT transports data from the updated MMIS reports. Actual net ~~a~~Allowable ~~c~~Costs shall be compared to the total base and interim supplemental payment and settlement payments made and any other source of reimbursement received by the ~~þ~~Provider for the period;¶
(d) If, at the end of the final reconciliation, it is determined that the eligible GEMT ~~þ~~Provider is overpaid, the ~~þ~~Provider shall return the ~~o~~Overpayment to the Authority, and the Authority shall return the ~~o~~Overpayment to the federal government pursuant to section 433.316 of Title 42 of the Code of Federal Regulations. If an underpayment is determined, then the eligible GEMT ~~þ~~Provider shall receive an interim supplemental payment in the amount of the underpayment. Overpayments and underpayments shall be processed in accordance with OAR 410-120-1397;¶
(e) The ~~þ~~Provider may ~~a~~Appeal an Authority notice of ~~o~~Overpayment in the manner provided in OAR 410-120-1560.¶
(8) Eligible GEMT Provider Reporting Requirements:¶
(a) Submit CMS approved cost reports to the Authority no later than five months after the close of the SFY, unless the eligible GEMT ~~þ~~Provider made a written request for an extension and such request is granted by the Authority;¶
(b) Provide any supporting documentation to serve as evidence supporting information on the cost report and the cost determination, if specifically requested by the Authority;¶
(c) Keep, maintain, and have readily retrievable such records to fully disclose reimbursement amounts that the eligible GEMT ~~þ~~Provider is entitled to and any other records required by CMS;¶
(d) Comply with the ~~a~~Allowable ~~c~~Cost requirements provided in Part 413 of Title 42 of the Code of Federal Regulations, 2 CFR Part 200, and Medicaid non-institutional reimbursement policy.¶
(9) Agency Responsibilities:¶
(a) The Authority shall, on an annual basis, submit any necessary materials to the federal government to provide assurances that claims shall include only those expenditures that are allowable under federal law;¶
(b) The Authority shall complete the audit and final reconciliation process of the interim supplemental payments for the service period within nine months of the postmark date of the cost report and conduct on-site audits as necessary.
Statutory/Other Authority: ORS 413.234
Statutes/Other Implemented: ORS 413.235

AMEND: 410-136-3372

RULE SUMMARY: Changing “client” and “recipient” to “Member” or “CCO Member” or “Open Card Member” where appropriate.

CHANGES TO RULE:

410-136-3372
General Requirements for Ground Emergency Medical Transportation Emergency Medical Services Transport Private Provider Program
(1) The Ground Emergency Medical Transportation (GEMT) Emergency Medical Services Transport (EMST) private provider program makes supplemental payments to eligible GEMT EMST private providers who furnish qualifying emergency ~~a~~Ambulance services to ~~Oregon Health Authority (Authority) Medicaid recipient~~Members:~~-~~¶
(a) The supplemental payment is for an add-on reimbursement fee to the base rates for eligible ~~e~~Emergency ~~m~~Medical ~~t~~Transportation services. The/supplemental payment is an add-~~-~~on to the base rates for eligible ~~e~~Emergency ~~m~~Medical ~~t~~Transportation services, excludes Emergency Medical Services (EMS) air transports. The calculation is based on the gross receipts reported on the Centers for Medicare and Medicaid Services (CMS) approved data request template;~~-~~¶
(b) The Authority makes supplemental payments only up to the amount calculated by the gross receipts. Total reimbursements from Medicaid including the supplemental payment may not exceed one hundred percent of actual costs;~~-~~¶
(c)/The supplemental payment shall cover GEMT EMST private providers and shall be applied in lump sum payment at least annually to eligible providers using the Healthcare Common Procedure Coding System (HCPCS) emergency transport codes.//OHA will apply the supplemental payment only to GEMT EMST private provider services rendered to ~~FFS Medicai~~Open Card ~~m~~Members by eligible GEMT EMST Private Providers on or after April 1, 2023;~~-~~¶
(d) The supplemental payments shall be made at least annually;~~-~~¶
(e) The base rates for GEMT EMST private providers shall not change with this amendment to Oregon's Medicaid's State Plan that authorizes federal participation in this program.~~-~~¶
(2) Definitions:~~-~~¶
(a) "Authority" means the Oregon Health Authority;~~-~~¶
(b) "Advanced Life Support" means special services designed to provide definitive prehospital emergency medical care, including but not limited to, cardiopulmonary resuscitation, cardiac monitoring, cardiac defibrillation, advanced airway management, intravenous therapy, administration with drugs and other medicinal preparations, and other specified techniques and procedures;~~-~~¶
(c) "Basic Life Support" means emergency first aid and cardiopulmonary resuscitation procedures to maintain life without invasive techniques;~~-~~¶
(d) "Eligible Emergency Medical Services Transport Private Provider" means an EMS private provider that meets all the eligibility requirements described in ~~(S~~subsection ~~2~~(2)(e) below. A nonfederal or nonpublic entity that:~~-~~¶
(A) Employs individuals who are licensed by the Authority under ORS chapter 682 to provide emergency medical services; and~~-~~¶
(B) Contracts with a local government pursuant to a plan described in ORS 682.062.~~-~~¶
(e) "Emergency Medical Services"/means/the act of transporting an individual by ground from any point of origin to the nearest medical facility capable of meeting the emergency medical needs of the patient, as well as the advanced, limited-advanced, and basic life support services provided to an individual by Eligible Emergency Medical Services Provider before or during the act of transportation.~~-~~¶
(A) This includes to assess, treat, and stabilize the individual's medical condition; or~~-~~¶
(B) Prepare and transport the individual to a medical facility.~~-~~¶
(f) "Emergency Medical Services Transport" means an emergency medical services provider's evaluation of an individual experiencing a medical emergency and the transportation of the individual to the nearest medical facility capable of meeting the needs of the individual./For the purposes of this state plan, EMS air transports are excluded;~~-~~¶
(g) "Emergency Medical Services Fund" is a fund established in the state treasury, separate and distinct from the General Fund. The Emergency Medical Services Fund consist of moneys collected by the Authority as a quality assurance fee;~~-~~¶
(h) "Federal Financial Participation (FFP)"/means the portion of medical assistance expenditures for emergency medical services that are paid or reimbursed by the Centers for Medicare and Medicaid Services in accordance with the State Plan for medical assistance. Clients under Title XIX are eligible for FFP;~~-~~¶
(i) "Gross Receipts" means gross payments received as patient care revenue for emergency medical services

transports, determined on a cash basis of accounting./Gross receipts do not include Medicaid Supplemental Reimbursement pursuant to Attachment 4.19-B, pages 31-39 of Oregon's Medicaid State Plan;¶
(j) "Local Government" means all cities, counties and local service districts located in this state, and all administrative subdivisions of those cities, counties and local service districts as defined in ORS 174.116;¶
(k) "Limited Advanced Life Support" means special services to provide prehospital emergency medical care limited to techniques and procedures that exceed basic life support but are less than advanced life support services;¶
(l) "Treatment in Place" means EMT services (basic, limited-advanced, and advanced life support services) provided by a Medicaid-enrolled EMS professional to an individual who is released on the scene without transportation by ambulance to a medical facility;¶
(m) "Usual Charge" means the lesser of the following unless prohibited by federal statute or regulation:¶
(A) The ~~þ~~Providers charge per unit of service for the majority of non-medical assistance users of the same service based on the preceding months charges;¶
(B) The ~~þ~~Providers lowest charge per unit of service on the same date that is advertised, quoted, or posted. The lesser of these applies regardless of the payment source or means of payment;¶
(C) Where the ~~þ~~Provider has established a written sliding fee scale based upon income for individuals and families with income equal to or less than 200 percent of the federal poverty level, the fees paid by these individuals and families are not considered in determining the ~~u~~Usual ~~c~~Charge. Any amounts charged to ~~t~~Third ~~þ~~-Party ~~r~~Resources are to be considered.¶
(3) GEMT EMST Private Provider Eligibility Requirements./To be eligible for the supplemental payment, GEMT EMST private ~~þ~~Providers must meet all the following requirements:¶
(a) Be enrolled as an Oregon Health Plan Medicaid ~~þ~~Provider;¶
(b) Provide ground emergency medical transport services to Me~~dicaid recipient~~mbers;/¶
(c) The organization is not a publicly owned or operated, and not participating in the GEMT supplemental program.¶
(4) Enhanced Reimbursement Methodology:¶
(a) A uniform supplemental payment rate per emergency transport shall be determined at least annually and shall not exceed ~~one hundred~~100 percent ~~(100%)~~ of the difference between Medicaid payments otherwise made to each GEMT EMST private ~~þ~~Provider for EMS services (base rates) and the ~~u~~Usual ~~c~~Charge for the service;¶
(b) Medicaid base rate to the GEMT EMST private ~~þ~~Providers for providing EMS services are derived from the ~~a~~Ambulance FFS fee schedule established for reimbursements payable by the Medicaid program by procedure code:¶
(A) The primary source of paid claims data, managed care encounter data, and other Medicaid reimbursements is the Oregon Medicaid Management Information System (MMIS);¶
(B) The number of paid Medicaid EMS transports is derived from and supported by the MMIS reports and the data from the Data Request Report for services during the applicable twelve-month period./¶
(c) The ~~a~~Ambulance add-on payments shall not exceed the funding collected by OHA as a quality assurance fee specified in OAR 410-136-3373 in the Emergency Medical Services Fund established in ORS 413.234. /Reimbursement may not exceed the costs for the emergency medical service transport, less the amount of reimbursement that the emergency medical services provider is eligible to receive from all public and private sources;¶
(d) Supplemental payments for each GEMT EMST private ~~þ~~Provider shall be calculated for each ~~þ~~Provider at least annually by multiplying the uniform add-on rate by the ~~þ~~Provider's volume of Medicaid transports billed with Healthcare Common Procedure Coding System (HCPCS) codes A0429 BLS Emergency, A0427 ALS Emergency (Level 1). A0998 Ambulance Treatment in ~~þ~~Place will be paid at least annually as determined through the Medicaid Management Information System if federally approved for this program supplemental payments.¶
(e) GEMT EMST private ~~þ~~Providers not licensed within the State of Oregon shall not receive the enhanced supplemental payment.¶
(5) Eligible GEMT EMST Private Provider Reporting Requirements:¶
(a) Submit CMS approved data request template to the Authority;¶
(b)/Provide any supporting documentation to serve as evidence supporting information on the data request template, if specifically requested by the Authority./ Any supporting documentation provided to the Authority is protected and not subjected to a public records release;¶
(c) Keep, maintain, and have readily retrievable such records to fully disclose reimbursements amounts that the eligible GEMT EMST private ~~þ~~Provider is entitled to, and any other records required by CMS for seven (7) years.¶
(6) Agency Responsibilities:¶
(a) The Authority shall submit any necessary materials to the federal government to provide assurances that all gross receipts are allowable under federal law;¶
(b) The Authority shall complete an annual audit and reconciliation process within a nine-month period.
Statutory/Other Authority: ORS 413.234

Statutes/Other Implemented: ORS 413.234