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NOTICE OF PROPOSED RULEMAKING

INCLUDING STATEMENT OF NEED & FISCAL IMPACT

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

FILED: 10/12/2026 3:13 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.

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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:
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:

410-138-0005, 410-138-0007, 410-138-0009, 410-138-0020, 410-138-0080, 410-138-0390, 410-146-0020, 410-146-0040, 410-146-0060, 410-146-0075, 410-146-0086, 410-146-0100, 410-146-0120, 410-146-0160, 410-146-0200, 410-146-0240, 410-146-0440, 410-146-0470, 410-146-5000

AMEND: 410-138-0005

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

CHANGES TO RULE:

410-138-0005
Payment for Targeted Case Management Services Eligible for Federal Financial Participation ¶

(1) This rule is to be used in conjunction with Targeted Case Management (TCM) rules OAR 410-138-0000 through 410-138-0009 and 410-138-0390 and the Division's ~~G~~general ~~R~~rules chapter 410, division 120.~~-~~¶
(2) TCM ~~þ~~Provider ~~ø~~Organizations providing TCM services, as defined in Section 1915(g) of the Social Security Act, that have been authorized under these rules, are eligible to participate in a cost sharing (Federal Financial Participation (FFP) matching) program. The rules in this ~~C~~chapter 410, ~~D~~division 138 have been designed to assist TCM ~~þ~~Provider organizations with obtaining the federal funds that are available to be matched with the non-federal fund contribution requirement.~~-~~¶
(3) Providers of Tribal TCM, and TCM provided by the Newborn Nurse Home Visiting Program are exempt from cost-sharing requirements to pay non-federal matching funds.~~-~~¶
(4) Payment shall be made to the TCM ~~þ~~Provider enrolled with the Authority as a unit of government provider meeting the requirements set forth in the ~~þ~~Provider enrollment agreement.~~-~~¶
(5) Signing the ~~þ~~Provider enrollment agreement sets forth the relationship between the ~~S~~state of Oregon, the Authority, and the TCM ~~þ~~Provider and constitutes agreement by the TCM ~~þ~~Provider to comply with all applicable Authority rules and federal and state laws and regulations.~~-~~¶
(6) The TCM ~~þ~~Provider shall bill according to administrative rules in chapter 410, division 138 and the TCM supplemental information. Payments shall be made using the Medicaid Management Information System (MMIS), and the TCM ~~þ~~Provider shall retain the full payment for ~~c~~Covered ~~s~~Services provided. The TCM ~~þ~~Provider shall have a Trading Partner Agreement with the Authority prior to submission of electronic transactions.~~-~~¶
(7) Except for the TCM ~~þ~~Providers identified as exempt from cost-sharing requirements (which are identified in section (3) above this rule), a TCM ~~þ~~Provider that is public entity, unit of government, shall pay the non-federal matching share of the amount of the TCM claims, calculated using the Federal Medical Assistance Percentage (FMAP) rates in effect during the quarter when the TCM claims will be paid:~~-~~¶
(a) The TCM ~~þ~~Provider's non-federal matching share means the public funds share of the Medicaid payment amount. Pursuant to the Social Security Act, 42 CFR 433.51, public funds may be considered as the state's share in claiming federal financial participation, if the public funds meet the following conditions:~~-~~¶
(A) The public funds are transferred to the Authority from public entities that are units of government;~~-~~¶
(B) The public funds are not federal funds, or they are federal funds authorized by federal law to be used to match other federal funds; and~~-~~¶
(C) All sources of funds shall be allowable under the Social Security Act 42 CFR 433 Subpart B.~~-~~¶
(b) The unit of government TCM provider shall pay the non-federal matching share to the Authority in accordance with OAR 410-120-0035.~~-~~¶
(8) Before the Authority pays for TCM claims, the Authority shall receive the corresponding local match payment as described in this rule. Failure to timely pay the non-federal matching funds to the Authority will delay payment.¶
(9) The Authority shall not be financially responsible for payment of any claim that CMS disallows under the Medicaid program. If the Authority has previously paid the TCM provider for any claim, which CMS disallows, the TCM ~~þ~~Provider shall reimburse the Authority the amount of the claim that the Authority has paid to the TCM ~~þ~~Provider, less any amount previously paid by the unit of government TCM ~~þ~~Provider to the Authority for the non-federal match portion for that claim.~~-~~¶
(10) Providers shall only bill Medicaid for allowable activities in the TCM program that assist individuals eligible under the Medicaid State Plan to gain access to needed medical, social, educational, and other services. One or more of the following allowable activities shall occur before billing:~~-~~¶
(a) Assessment;~~-~~¶
(b) Development of a care plan;~~-~~¶

(c) Referral and follow up; and.¶
(d) Monitoring and follow up.¶
(11) TCM claims may not duplicate payments made to:¶
(a) Public agencies or private entities for any other case management activities or direct services provided under the State Plan or OHP, through fee-for-service, managed care, or other contractual arrangement, that meet the same need for the same ~~client~~Member at the same point in time;¶
(b) A TCM ~~p~~Provider by program authorities under different funding authority than OHP, including but not limited to other public health funding;¶
(c) A TCM ~~p~~Provider for administrative expenditures reimbursed under agreement with the Authority or any other program or funding source.¶
(12) Medicaid is only liable for the cost of otherwise allowable ~~c~~Case ~~m~~Management ~~s~~Services if there are no other ~~t~~Third ~~p~~-Parties liable to pay. However, while schools are legally liable to provide IDEA-related health services at no cost to eligible children, Medicaid reimbursement is available for these services because section 1903(c) of the Act requires Medicaid to be primary to the U.S. Department of Education for payment for covered Medicaid services furnished to a child with a disability. These services may include health services included in a child's Individualized Education Program (IEP) or Individual Family Service Plan (IFSP) under the IDEA. Payment for those services that are included in the IEP or IFSP may not be available when those services are not covered Medicaid services.¶
(13) The Authority's acceptance of cost data provided by ~~p~~Provider ~~o~~Organizations for the purpose of establishing rates paid for TCM services does not imply or validate the accuracy of the cost data provided.¶
(14) Reimbursement is subject to all rules and laws pertaining to federal financial participation.
Statutory/Other Authority: ORS 413.042, 414.065
Statutes/Other Implemented: ORS 414.065

AMEND: 410-138-0007

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

CHANGES TO RULE:

410-138-0007
Targeted Case Management - Covered Services ¶

(1) Targeted ~~c~~Case ~~m~~Management (TCM) services shall be furnished only to assist individuals eligible under the Medicaid State Plan in gaining access to and effectively using needed medical, social, educational, and other services (such as housing or transportation) in accordance with 42 CFR 441.18.¶
(2) TCM services billed to Medicaid shall be for allowable activities and include one or more of the following components:¶
(a) Assessment of an eligible ~~client~~Member in the target group to determine the need for medical, educational, social, or other services as follows:¶
(A) Taking ~~client~~Member history;¶
(B) Identifying the needs of the ~~client~~Member, and completing related documentation;¶
(C) Gathering information from other sources, such as family members, medical ~~p~~Providers, ~~s~~Social ~~w~~Workers, and educators, if necessary, to form a complete assessment of the eligible ~~client~~Member;¶
(D) Periodically reassessing a ~~client~~Member to determine if the ~~client~~Member's needs or preferences have changed. A reassessment shall be conducted at least annually or more frequently if changes occur in the ~~client~~Member's condition;¶
(b) Development of a care plan based on the information collected through the assessment or periodic reassessment, specifying the goals and actions to address the medical, social, educational, and other services needed by the eligible ~~client~~Member. This may include:¶
(A) Active participation of the eligible ~~client~~Member in the target group; or¶
(B) Working with the eligible ~~client~~Member or the eligible ~~client~~Member's authorized health care decision maker and others to develop goals and identify a course of action to respond to the assessed needs of the eligible ~~client~~Member;¶
(c) Referral, linking, and coordination of services and related activities including but not limited to:¶
(A) Scheduling appointments for the eligible ~~client~~Member in the target group to obtain needed services; and¶
(B) Activities that help link the eligible ~~client~~Member with medical, social, or educational ~~p~~Providers, or other programs and services (e.g., food vouchers, transportation, child care, or housing assistance) that address identified needs and achieve goals specified in the care plan. The case management referral activity is completed once the referral and linkage have been made;¶
(C) Reminding and motivating the ~~client~~Member to adhere to the treatment and services schedules established by ~~p~~Providers.¶
(d) Monitoring or ongoing face-to-face or other contact:¶
(A) Monitoring and follow-up activities include activities and contacts:¶
(i) To ensure the care plan is effectively implemented;¶
(ii) To help determine if the services are being furnished in accordance with the eligible ~~client~~Member's care plan;¶
(iii) To determine whether the care plan adequately addresses the needs of the eligible ~~client~~Member in the target group;¶
(iv) To adjust the care plan to meet changes in the needs or status of the eligible ~~client~~Member.¶
(B) Monitoring activities may include contacts with:¶
(i) The participating eligible ~~client~~Member in the target group;¶
(ii) The eligible ~~client~~Member's health care decision makers, family members, ~~p~~Providers, or other entities or individuals when the purpose of the contact is directly related to the management of the eligible ~~client~~Member's care.¶
(3) TCM services billed to Medicaid shall be documented in the ~~client~~Member's case records for all ~~client~~Member's receiving case management. The documentation shall include:¶
(a) The ~~client~~Member's name;¶
(b) The dates of the case management services;¶
(c) The name of the provider agency (if relevant) and the person providing the ~~c~~Case ~~m~~Management ~~s~~Services;¶
(d) The nature, content, units of the ~~c~~Case ~~m~~Management ~~s~~Services received and whether goals specified in the care plan have been achieved;¶
(e) Whether the ~~client~~Member has declined services in the care plan;¶

(f) The need for, and occurrences of, coordination with other case managers;¶
(g) A timeline for obtaining needed services;¶
(h) A timeline for reevaluation of the plan.
Statutory/Other Authority: ORS 413.042, 414.065
Statutes/Other Implemented: ORS 414.065

AMEND: 410-138-0009

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

CHANGES TO RULE:

410-138-0009
Targeted Case Management - Services Not Covered ¶

Targeted Case Management (TCM) services do not cover:¶
(1) Direct delivery of an underlying medical, educational, social, or other service to which the eligible ~~client~~Member has been referred.¶
(2) Providing transportation to a service to which an eligible ~~client~~Member is referred.¶
(3) Escorting an eligible ~~client~~Member to a service.¶
(4) Providing child-care so that an eligible ~~client~~Member may access a service.¶
(5) Contacts with individuals who are not categorically eligible for Medicaid or who are categorically eligible for Medicaid but not included in the eligible target population when those contacts relate directly to the identification and management of the non-eligible or non-targeted individual's needs and care.¶
(6) Assisting an individual who has not yet been determined eligible for Medicaid to apply for or obtain eligibility.¶
(7) TCM services provided to an individual if the services are case management services funded by Title IV-E or Title XX of the Social Security Act, or federal or state funded parole and probation, or juvenile justice programs.¶
(8) Activities for which ~~t~~Third-~~p~~-Parties are liable to pay.
Statutory/Other Authority: ORS 413.042, 414.065
Statutes/Other Implemented: ORS 414.065

AMEND: 410-138-0020

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

CHANGES TO RULE:

410-138-0020
Targeted Case Management Programs ¶

(1) This rule includes services in the State Plan for Targeted Case Management.-¶
(2) TCM programs include the following:-¶
(a) Human Immunodeficiency Virus (HIV);-¶
(b) Public Health Nurse Home Visiting programs including, Babies First!, CaCoon, Newborn Nurse Home Visiting and Nurse-Family Partnership;-¶
(c) Reentry Targeted Case Management;-¶
(d) Federally Recognized Tribal Governments.-¶
(e) Oregon Youth Authority (OYA) Targeted Case Management Program-¶
(3) With the exception of the Newborn Nurse Home Visiting program, the TCM Programs are ~~m~~Medical ~~a~~Assistance ~~p~~Programs operated by public health authorities, unit of government providers, or Federally Recognized Tribal Governments in Oregon who are enrolled as TCM ~~p~~Providers with the Authority. Participation by ~~p~~Providers is voluntary and subject to approval by the Authority and CMS. With the exception of the Federally Recognized Tribal Governments TCM programs and the Newborn Nurse Home Visiting Program, the TCM programs authorized under these rules are cost-sharing (Federal Financial Participation (FFP) matching) programs in which the public fund agency, public entity, unit of government, shall pay the non-federal matching share of the amount of the TCM claims.-¶
(4) The Public Fund Agency may contract TCM services provided by a Local Public Health Authority or other public or private agency if the public fund agency's obligations for providing payment for the non-federal share for services provided and billed to Medicaid are met in compliance with 42 CFR 433.51 and the TCM services are provided by an enrolled Medicaid TCM ~~p~~Provider who will receive and retain 100 percent of the TCM payments. See OAR 410-138-0005 (Payment for Targeted Case Management Services Eligible for Federal Financial Participation).-¶
(5) Federally Recognized Tribal Governments TCM services authorized under these rules provided to tribal members (American Indian/Alaska Native) at an Indian Health Service (IHS/638) facility operated by the Indian Health Service, by an Indian tribe or tribal organization are reimbursed at 100 percent by Title XIX (Medicaid) and Title XXI Children's Health Insurance Program (CHIP). TCM services provided by IHS/638 facilities to non-tribal American Indian/Alaska Native members shall be reimbursed at the applicable FMAP rate.-¶
(6) The Authority may not authorize services or reimbursement for direct care as part of any TCM activity. The following are TCM programs and services:-¶
(a) The TCM HIV program improves access to needed medical and non-medical services, which address physical, psychosocial, nutritional, educational, and other services for Medicaid categorically eligible ~~client~~Members with symptomatic or asymptomatic HIV disease. Home visits constitute an integral part of the delivery of TCM services, provided by a TCM HIV case manager consistent with these rules. Without TCM ~~c~~Case ~~m~~Management ~~s~~Services, an eligible ~~client~~Member's ability to remain safely in their home may be at risk;-¶
(b) The TCM Public Health Nurse Home Visiting Programs, Babies First!, CaCoon, Newborn Nurse Home Visiting and Nurse-Family Partnership improve access to needed medical and non-medical services that address medical, social, educational, and other services:-¶
(A) The Babies First!, and Nurse-Family Partnership programs include Medicaid eligible perinatal people, eligible infants and children through four years of age who have one or more risk factors for poor perinatal, birth, and other poor health outcomes. TCM services may also be provided to a parent or other caretaker relative of the eligible child. See Table 1 and 2 Risk Criteria as outlined in OAR 410-138-0040 risk criteria;-¶
(B) The CaCoon program shall be provided to Medicaid eligible Children and Youth with Special Health Care Needs (CYSHCN), up to age 21, who have one or more diagnosis. TCM services may also be provided to a parent or other caretaker relative of the eligible child. See Table 1 and 2 as outlined in OAR 410-138-0040 risk criteria;-¶
(C) NNHV may be provided to Medicaid eligible infants 0 through 6 months of age. As part of a phased implementation services may be provided in the following counties: Lincoln, Benton, Crook, Deschutes, Gilliam, Hood River, Jefferson, Linn, Malheur, Wasco, Washington, Wheeler, Sherman, Baker, Clatsop, Marion, Lane, Polk, Yamhill, Douglas, Multnomah and Coos.-¶
(D) Home visits constitute a significant part of the delivery of targeted case management services, provided by a

Public Health Nurse Home Visiting (Babies First!, CaCoon, NNHV and Nurse Family Partnership) targeted case manager consistent with these rules. All providers for Babies First!, CaCoon, NNHV and Nurse-Family Partnership TCM programs shall follow a case management plan developed by the nurse.¶
(c) Reentry Targeted Case Management ~~s~~Services are provided to FCAA-Covered Youth as part of Reentry FCAA Services. The Reentry FCAA Service requirements are described in OAR 410-155-0000, and OAR 410-155-0010.¶
(d) The TCM Federally Recognized Tribal Government program improves access to needed medical and non-medical services, which address health, psychosocial, economic, educational, nutritional, and other services for Medicaid categorically eligible tribal members served by tribal programs, provided by an enrolled tribal TCM provider consistent with these rules. The target group includes those members receiving elder care; individuals with diabetes; children and adults with health and social service care needs, and pregnant women.¶
(e) The OYA provides TCM services to Medicaid-eligible youth under age 21 who are residing in independent living situations, in-home settings, foster homes, group homes, or residential care facilities under OYA's responsibility-including those transitioning to the community and those receiving services for up to 180 consecutive days during covered institutional stays-as described in Oregon's Title XIX State Plan (Transmittal 25-0018), effective July 1, 2025.¶
(7) Refer to the State Plan Amendments for participating counties for each TCM program. The State Plan Amendments are located at http://www.oregon.gov/OHA/HPA/HP/Pages/Medicaid-CHIP-State-Plans.aspx.¶
(8) Provision of any TCM Program services may not restrict an eligible ~~client~~Member's choice of ~~p~~Providers, in accordance with 42 CFR 441.18(a):¶
(a) Eligible ~~client~~Members shall have free choice of available TCM Program service ~~p~~Providers or other TCM service ~~p~~Providers available to the eligible ~~client~~Member, subject to the Social Security Act, 42 USC 1396n and 42 CFR 441.18(b);¶
(b) Eligible ~~client~~Members shall have free choice of the ~~p~~Providers of other medical care within their ~~b~~Benefit ~~p~~Package of ~~c~~Covered ~~s~~Services.
Statutory/Other Authority: ORS 413.042, 414.065
Statutes/Other Implemented: ORS 414.065

AMEND: 410-138-0080

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

CHANGES TO RULE:

410-138-0080
Targeted Case Management Program Billing Policy ¶

(1) Reimbursement is based on cost-based rate methodology and subject to all rules and laws pertaining to federal financial participation. The Authority's acceptance of cost data provided by ~~p~~Provider ~~o~~Organizations for the purpose of establishing rates paid for TCM services does not imply or validate the accuracy of the cost data provided.~~-~~¶
(2) The cost-based rate shall be derived by considering the following expenditures directly attributable to TCM staff:~~-~~¶
(a) TCM staff salaries and other personnel expenses;~~-~~¶
(b) Supervisory salaries and other personnel expenses;~~-~~¶
(c) Administrative support salaries and other personnel expenses;~~-~~¶
(d) Services and supply expenses;~~-~~¶
(e) Various overhead expenditures, if not already considered in the indirect rate.~~-~~¶
(3) The Division shall accept a claim up to 12 months from the date of service. See ~~provider rule~~ OAR 410-120-1300 (Timely Submission of Claims).~~-~~¶
(4) Providers shall only bill for allowable activities in the TCM programs that assist individuals eligible under the Medicaid State Plan to gain access to needed medical, social, educational, housing, environmental, and other services.~~-~~¶
(5) The Division may not allow duplicate payments to other public agencies or private entities under other program authorities for TCM services under the eligible ~~client~~Member's care plan. Medical services shall be provided and billed separately from ~~c~~Case ~~m~~Management ~~s~~Services. The Authority shall recover duplicate payments.~~-~~¶
(6) The Division may not reimburse for TCM services if the services are case management services funded by Title IV-E or Title XX of the Social Security Act. These services shall be billed separately.~~-~~¶
(7) Any place of service is valid.~~-~~¶
(8) Prior ~~a~~Authorization is not required.
Statutory/Other Authority: ORS 413.042, 414.065
Statutes/Other Implemented: ORS 414.065

AMEND: 410-138-0390

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

CHANGES TO RULE:

410-138-0390
Targeted Case Management Retroactive Payments ¶

(1) Providers may submit claims retroactively for services provided to the targeted populations described in OAR 410-138-0020(2) if the claims meet the following criteria:-¶
(a) Services were provided less than 12 months prior to the date of first claim submission and were provided on or after the date indicated in the rule listed above and were allowable services in accordance with OAR 410-138-0007;-¶
(b) The maximum number of units billed does not exceed the maximum allowed under each TCM program.-¶
(c) The case manager was appropriately licensed or certified and met all current requirements for case managers at the time the service was provided, as described in the ~~p~~Provider requirements rule OAR 410-138-0060 appropriate for the TCM program;-¶
(d) Documentation regarding ~~p~~Provider qualifications and the services that the ~~p~~Provider retroactively claims shall have been available at the time the services were performed.-¶
(2) The Division may not allow duplicate payments to be made to the same or different ~~p~~Providers for the same service for the same ~~client~~Member, nor will payment be allowed for services for which ~~t~~Third-~~p~~-Parties are liable to pay (see also OAR 410-138-0005).-¶
(3) Reimbursement is subject to all rules and laws pertaining to federal financial participation.
Statutory/Other Authority: ORS 413.042, 414.065
Statutes/Other Implemented: ORS 414.065

AMEND: 410-146-0020

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

CHANGES TO RULE:

410-146-0020
Memorandum of Agreement Reimbursement Methodology ¶

(1) In 1996, a Memorandum of Agreement (MOA) between the Centers for Medicare and Medicaid Services (CMS) and the Indian Health Service (IHS) established the roles and responsibilities of CMS and IHS regarding the Division's American Indian/Alaska Native (AI/AN) Program individuals. The MOA addresses payment for Medicaid services provided to AI/AN individuals on and after July 11, 1996, through health care facilities owned and operated by AI/AN tribes and tribal organizations, which are funded through Title I or V of the Indian Self-Determination and Education Assistance Act (Public Law 93-638).¶
(2) The IHS and CMS, pursuant to an agreement with the Office of Management and Budget (OMB), developed an all-inclusive rate to be used for billing directly to and reimbursement by Medicaid. This rate is sometimes referred to as the "OMB," "IHS," "All-Inclusive" (AIR), "encounter," or "MOA" rate and is referenced throughout these rules as the "IHS rate." The IHS rate is updated and published in the Federal Register each fall:¶
(a) The rate is retroactive to the first of the year;¶
(b) The Division automatically processes a retroactive billing adjustment each year to ensure payment of the updated rate.¶
(3) IHS direct health care service facilities established, operated, and funded by IHS shall enroll as an IHCP and receive the IHS rate.¶
(4) Under the MOA, Tribal 638 health care facilities may choose to be designated a certain type of ~~p~~Provider or facility for enrollment with OHP. The designation determines how the Division pays for the Medicaid services provided by that ~~p~~Provider or facility. Under the MOA, a Tribal 638 health care facility may do one of the following:¶
(a) Operate as a Tribal 638 health care facility. The health center would enroll as an IHCP and choose reimbursement for services at either:¶
(A) The IHS rate; or¶
(B) A cost-based rate according to the Prospective Payment System (PPS). Refer to OAR 410-147-0360, Encounter Rate Determinations, 410-147-0440, Medicare Economic Index (MEI), 410-147-0480, Cost Statement (OHP 3027) Instructions, and OAR 410-147-0500, Total Encounters for Cost Reports; or¶
(b) If it so qualifies, operate as any other ~~p~~Provider type recognized under the State Plan and receive that respective reimbursement methodology.¶
(5) AI/AN and the Division's FQHC and RHC program ~~p~~Providers may be eligible to receive the supplemental/wraparound payment for services furnished to ~~client~~Members enrolled with a Prepaid Health Plan (PHP). Refer to AI/AN OAR 410-146-0420 and FQHC/ RHC administrative rules ~~OAR~~ chapter 410, division 147.¶
(6) IHCPs may be eligible for an administrative match contract with the Division. IHCPs may not participate in the Medicaid Administrative Claiming (MAC) program if they:¶
(a) Receive reimbursement for services according to the cost-based PPS rate methodology; or¶
(b) Receive financial compensation for Out-Stationed Outreach Worker (OSOW) activities.¶
(7) An IHCP that chooses to participate in the Patient Centered Primary Care Home program (PCPCH) must meet the requirements and adhere to rules outlined in OAR 409-055-0000 through 409-055-0080 Health Policy and Analytics and OAR 410-141-0860 Oregon Health Plan Primary Care Manager and Patient Centered Primary Care Home Provider Qualification and Enrollment. The PCPCH program is outside the Prospective Payment System and the IHS/MOA rate. IHCPs who choose to participate and meet all PCPCH related requirements shall receive a separate reimbursement per the per ~~m~~Member per month (PMPM) payment established by OAR 410-141-0860.
Statutory/Other Authority: ORS 413.042, ORS 414.065
Statutes/Other Implemented: ORS 414.065

AMEND: 410-146-0040

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

CHANGES TO RULE:

410-146-0040
ICD-10-CM Diagnosis Codes and CPT/HCPCs Procedure Codes ¶

(1) The Division requires diagnosis codes on all claims including those submitted by independent ~~l~~Laboratories and portable radiology and including nuclear medicine and diagnostic ultrasound ~~p~~Providers. A clinic must always provide the ~~client~~Member's diagnosis to ancillary service ~~p~~Providers when prescribing services, equipment, and supplies.~~-~~¶
(2) The appropriate ICD-10-CM code must be used to identify:~~-~~¶
(a) Diagnoses;~~-~~¶
(b) Symptoms;~~-~~¶
(c) Conditions;~~-~~¶
(d) Problems;~~-~~¶
(e) Complaints; or~~-~~¶
(f) Other reasons for the encounter/visit.~~-~~¶
(3) Clinics must list the principal diagnosis in the first position on the claim. Clinics must use the principal diagnosis code for the diagnosis, condition, problem, or other reason for an encounter/visit shown in the medical record to be chiefly responsible for the services provided. Clinics may list up to three additional diagnosis codes on the claim for documented conditions that coexist at the time of the encounter/visit and require or affect ~~client~~Member care, treatment, or management.~~-~~¶
(4) Clinics must list the diagnosis codes using the highest degree of specificity available in the ICD-10-CM. The Division considers a diagnosis code invalid if it has not been coded to its highest specificity.~~-~~¶
(5) The Division requires ~~p~~Providers to use the standardized code sets required by the Health Insurance Portability and Accountability Act (HIPAA) and adopted by CMS. Unless otherwise directed in rule, ~~p~~Providers must accurately code claims according to the national standards in effect for the date the service was provided:~~-~~¶
(a) For dental services, use codes that are in effect for the date the services was provided that are found in Dental Procedures and Nomenclature as maintained and distributed by the American Dental Association;~~-~~¶
(b) For health care services, use the combination of Health Care Common Procedure Coding System (HCPCS) and Current Procedural Terminology (CPT) codes in effect for the date the services was provided. These services include, but are not limited to, the following:~~-~~¶
(A) Physician services;~~-~~¶
(B) Physical and ~~o~~Occupational ~~t~~Therapy services;~~-~~¶
(C) Radiology procedures;~~-~~¶
(D) Clinical ~~l~~Laboratory tests;~~-~~¶
(E) Other medical diagnostic procedures;~~-~~¶
(F) Hearing and vision services.~~-~~¶
(6) The Division maintains unique coding and claim submission requirements for Administrative Exams and Death with Dignity services. Refer to OAR 410 division 150, Administrative Examination and Billing Services, and OAR 410-130-0670, Death with Dignity Services for specific requirements.
Statutory/Other Authority: ORS 413.042, ORS 414.065
Statutes/Other Implemented: ORS 414.065

AMEND: 410-146-0060

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

CHANGES TO RULE:

410-146-0060
Prior Authorization ¶

(1) Some ~~c~~Covered ~~s~~Services or items require ~~p~~Prior ~~a~~Authorization (PA) by the Division before the service may be provided or before payment will be made. Refer to Oregon Administrative Rule (OAR) 410-120-1320 Authorization of Payment.~~-~~¶
(2) Most Oregon Health Plan (OHP) ~~client~~Members have prepaid health services contracted by the Oregon Health Authority (Authority) through enrollment in a PHP. Refer to OAR 410-120-1140 Verification of Eligibility.~~-~~¶
(3) An OHP ~~client~~Member who is an American Indian or Alaska Native (AI/AN) with proof of Indian heritage is exempt from mandatory enrollment in a PHP and can request disenrollment from a PHP if automatically enrolled. An AI/AN OHP ~~client~~Member may choose to remain in the Medicaid fee-for-service (FFS) delivery system for physical, dental, and behavioral health care, including SUD health care and receive services from an Indian Health Service facility, tribal health clinic or program or urban clinic. Refer to OAR 410-141-0060.~~-~~¶
(4) If a ~~client~~Member is enrolled in a PHP there may be PA requirements for some services that are provided through the PHP. The IHCP shall contact the PHP prior to providing services to any:~~-~~¶
(a) Non-AI/AN OHP ~~client~~Members enrolled in a PHP and with whom the IHCP has a contract to comply with the PHP's PA requirements or other policies necessary for reimbursement from the PHP. The IHCP must contact the ~~client~~Member's PHP for specific instructions;~~-~~¶
(b) AI/AN OHP ~~client~~Member enrolled in a PHP with whom the IHCP does not have a contract to comply with PA requirements in these rules, the ~~G~~general ~~R~~rules (chapter 410, division 120), and applicable Division program rules.~~-~~¶
(5) If a~~-client receives services on a FFS basis~~n Open Card Member or ~~is~~ an AI/AN PHP-enrolled ~~client~~Member with whom the IHCP does not have a contract and plans to bill the Division directly on an FFS basis, a PA may be required from the Division for certain services. An IHCP assumes full financial risk in providing services to a ~~client~~Member prior to receiving authorization or in providing services that are not in compliance with Oregon Administrative Rules.~~-~~¶
(6) If the service or item is subject to PA, the IHCP must follow and comply with PA requirements in these rules, the ~~G~~general ~~R~~rules (chapter 410, division 120), and applicable program rules, including but not limited to:~~-~~¶
(a) The service is adequately documented (see OAR 410-120-1360, Requirements for Financial, Clinical and Other Records). Providers must maintain documentation in the ~~p~~Provider's files to adequately determine the type, medical appropriateness, or quantity of services provided;~~-~~¶
(b) The services provided are consistent with the information submitted when authorization was requested;~~-~~¶
(c) The services billed are consistent with the services provided; and~~-~~¶
(d) The services are provided within the timeframe specified on the authorization of payment document.
Statutory/Other Authority: ORS 413.042, ORS 414.065
Statutes/Other Implemented: ORS 414.065

AMEND: 410-146-0075

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

CHANGES TO RULE:

410-146-0075
~~Client~~Member Copayments ¶

(1) AI/AN ~~client~~Members who are members of a federally recognized Indian Tribe or Tribal Organization and receive ~~Medicaid c~~Covered ~~s~~Services rendered through an IHCP are exempt from copayments.~~Refer to OAR 410-120-1230 Client Copayment.~~¶
(2) IHCPs may not charge copayments to eligible non-AI/AN Division ~~client~~Members receiving care at their facility.
Statutory/Other Authority: ORS 413.042, ORS 414.065
Statutes/Other Implemented: ORS 414.065

AMEND: 410-146-0086

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

CHANGES TO RULE:

410-146-0086
Multiple Encounters ¶

(1) An "encounter" has the meaning given that term in OAR 410-146-0085.¶
(2) The following services may be considered as multiple ~~e~~Encounters when two or more service ~~e~~Encounters are provided on the same ~~d~~Date of ~~s~~Service with distinctly different diagnoses:¶
(a) Medical (~~section (3) of this rule and~~ OAR chapter 410, division 130 and section (3) of this rule);¶
(b) Dental (OAR 410-146-0380 and chapter 410, division 123);¶
(c) Behavioral Health. If a ~~client~~Member is also seen for a medical office visit and receives a behavioral health diagnosis, then the ~~client~~Member contacts are a single ~~e~~Encounter.¶
(d) Substance Use Disorder. If a ~~client~~Member is also seen for a medical office visit and receives an addiction diagnosis, then the ~~client~~Member's contacts are a single ~~e~~Encounter (refer to the Division for the appropriate OARs);¶
(e) Ophthalmology. Fitting and dispensing of eyeglasses are included in the encounter when the ~~p~~Practitioner performs a vision examination. (~~OAR~~ chapter 410, division 140);¶
(f) Maternity Case Management (MCM) (OAR 410-146-0120);¶
(g) Physical or ~~o~~Occupational ~~t~~Therapy (PT/OT). If this service is also performed on the same ~~d~~Date of ~~s~~Service as the medical ~~e~~Encounter that determined the need for PT/OT (initial referral), then it is considered a single ~~e~~Encounter (~~OAR~~ chapter 410, division 131);¶
(h) Immunizations. If no other medical office visit occurs on the same ~~d~~Date of ~~s~~Service; and¶
(i) Tobacco cessation. If no other medical, dental, ~~b~~Behavioral ~~h~~Health, or SUD service encounter occurs on the same ~~d~~Date of ~~s~~Service (OAR 410-130-0190).¶
(j) One or more prescriptions for pharmaceuticals and biologicals not generally provided during the clinic visit that are dispensed by an IHS or Tribal 638 Pharmacy to the same individual constitute multiple encounters when delivered in a single 24-hour period ending at midnight.¶
(3) Encounters with more than one health professional and multiple ~~e~~Encounters with the same health professional that take place on the same day and that share the same or like diagnoses constitute a single ~~e~~Encounter, except when one of the following conditions exist:¶
(a) After the first medical service ~~e~~Encounter, the patient suffers a distinctly different illness or injury requiring additional diagnosis or treatment. More than one office visit with a medical professional within a 24-hour period and receiving distinctly different diagnoses may be reported as two ~~e~~Encounters. This does not imply that if a ~~client~~Member is seen at a single office visit with multiple problems that the ~~p~~Provider can bill for multiple ~~e~~Encounters;¶
(b) The patient has two or more ~~e~~Encounters as described in section (2) of this rule.¶
(4) A ~~b~~Behavioral ~~h~~Health ~~e~~Encounter and a SUD ~~e~~Encounter provided to the same ~~client~~Member on the same ~~d~~Date of ~~s~~Service shall only count as multiple ~~e~~Encounters when provided by two separate health professionals and each encounter has a distinctly different diagnosis.¶
(5) Similar services even when provided by two different health care ~~p~~Practitioners are considered a single ~~e~~Encounter and not multiple ~~e~~Encounters. Services that would not be considered multiple ~~e~~Encounters provided on the same ~~d~~Date of ~~s~~Service include, but are not limited to:¶
(a) A well child check and an immunization;¶
(b) A well child check and fluoride varnish application in a medical setting;¶
(c) A ~~b~~Behavioral ~~h~~Health and SUD ~~e~~Encounter with similar diagnoses;¶
(d) A prenatal visit and a delivery procedure;¶
(e) A cesarean delivery and surgical assist; and¶
(f) Any time a ~~client~~Member receives only a partial service with one ~~p~~Provider and partial service from another ~~p~~Provider.¶
(6) A clinic may not develop clinic procedures that routinely involve multiple ~~e~~Encounters for a single ~~d~~Date of ~~s~~Service.¶
(7) Clinics may not "unbundle" services that are normally rendered during a single visit for the purpose of generating multiple ~~e~~Encounters:¶
(a) Clinics may not ask the patient to make repeated or multiple visits to complete what is considered a reasonable

and typical office visit, unless it is ~~m~~Medically ~~n~~Necessary to do so;~~.~~¶
(b) Medical ~~n~~Necessity must be clearly documented in the patient's record.
Statutory/Other Authority: ORS 413.042, ORS 414.065
Statutes/Other Implemented: ORS 414.065

AMEND: 410-146-0100

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

CHANGES TO RULE:

410-146-0100
Vaccines for Children ¶

(1) The Vaccines for Children (VFC) program supplies federally purchased free vaccines for immunizing eligible ~~client~~Members ages 0 through 18 at no cost to participating health care ~~p~~Providers. For more information on how to enroll in the VFC program, contact the Oregon Health Authority (Authority) Immunization program. Refer to the AI/AN Supplemental Information for instructions and OAR 410-130-0255(4) VFC program.~~-~~¶
(2) The Division shall reimburse for the administration of vaccines to eligible ~~client~~Members according to the IHCP's IHS or cost-based rate.
Statutory/Other Authority: ORS 413.042, ORS 414.065
Statutes/Other Implemented: ORS 414.065

AMEND: 410-146-0120

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

CHANGES TO RULE:

410-146-0120
Maternity Case Management Services ¶

(1) The Division shall reimburse IHCP for MCM services according to their encounter rate.¶
(2) MCM service is optional coverage for Prepaid Health Plans (PHPs). Before providing MCM services to ~~client~~Members enrolled in a PHP, determine if the PHP covers MCM services:¶
(a) If the PHP does not cover MCM services, the ~~p~~Provider may bill the Division directly per the clinic's encounter rate. Prior ~~a~~Authorization is not required if the PHP does not provide coverage for MCM services;¶
(b) If the PHP does cover MCM services, and services were furnished to a:¶
(A) Non-AI/AN ~~client~~Member, the ~~p~~Provider needs to request the necessary authorizations from the PHP;¶
(B) AI/AN ~~client~~Member enrolled with a PHP with which the IHCP does not have an agreement, the IHCP may bill the Division directly.¶
(3) ~~Client~~Members' records must clearly document all MCM services provided including all mandatory topics. For specific requirements, refer to the Medical-Surgical Services program OAR 410-130-0595, Maternity Case Management.¶
(4) The primary purpose of the MCM program is to optimize pregnancy outcomes including the reduction of low birth weight babies. MCM services are intended to target pregnant ~~women~~individuals early during the prenatal period and can only be initiated when the ~~client~~Member is pregnant:¶
(a) MCM services may not be initiated the day of delivery, during postpartum, or for newborn evaluation;¶
(b) ~~Client~~Members are not eligible for MCM services if the ~~p~~Provider has not completed the MCM initial evaluation prior to the day of delivery;¶
(c) No other MCM service may be performed until an initial assessment has been completed.¶
(5) Multiple MCM contacts in a single day do not qualify as multiple encounters.¶
(6) A medical/prenatal visit encounter and an MCM encounter may qualify as two separate encounters when furnished on the same day only when the MCM service is:¶
(a) The initial evaluation to receive MCM services; or¶
(b) A nutritional counseling MCM service provided after the initial evaluation visit.¶
(7) MCM Services limitations:¶
(a) The Division shall reimburse the initial evaluation one time per pregnancy per ~~p~~Provider;¶
(b) The Division shall reimburse nutritional counseling one time per pregnancy if a ~~client~~Member meets the criteria in OAR 410-130-0595(14); and¶
(c) The Division shall reimburse a maximum of ten MCM services/visits in addition to subsections (a) and (b) above, providing visits/services are furnished in compliance with OAR 410-130-0595.¶
(8) Case ~~m~~Management ~~s~~Services may not duplicate services for case management activities or direct services provided under the State Plan or OHP through fee-for-service, managed care, or other contractual arrangement that meet the same need for the same ~~client~~Member at the same point in time. This includes the Division's Maternity Case Management program (~~OAR~~ chapter 410, division 130) and any Targeted Case Management (TCM) program outlined in OAR chapter 410, division 138.¶
(9) Community health representatives may be eligible to provide specific MCM services, with the exclusion of the initial assessment (G9001), while working under the supervision of a licensed health care ~~p~~Practitioner listed in OAR 410-130-0595(7)(a).
Statutory/Other Authority: ORS 413.042, ORS 414.065
Statutes/Other Implemented: ORS 414.065

AMEND: 410-146-0160

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

CHANGES TO RULE:

410-146-0160
Administrative Medical Examinations and Reports ¶

(1) The Division may not reimburse ~~a~~Administrative ~~m~~Medical ~~e~~Examinations and ~~r~~Reports at an IHCP's IHS encounter rate. Administrative ~~m~~Medical ~~e~~Examinations and ~~r~~Reports are not eligible under the Memorandum of Agreement (MOA). The Division shall reimburse ~~p~~Providers for Administrative Examinations and Reports on a fee-for-service basis outside the IHS or cost-based encounter rate.~~-~~¶
(2) AI/AN Health Care Facilities may be reimbursed for ~~a~~Administrative ~~m~~Medical ~~e~~Examinations and ~~r~~Reports when requested by a Oregon Department of Human Services branch office or approved by the Division. The branch office may request an Administrative Medical Examination/Report Authorization (OHP 729) to establish ~~client~~Member eligibility for an assistance program or casework planning.~~-~~¶
(3) Refer to OAR 410 division 150, Administrative Examination and Report Billing Services, for specific requirements. See Administrative Exams Supplemental Information guide for more detailed information on procedure codes and descriptions.
Statutory/Other Authority: ORS 413.042, ORS 414.065
Statutes/Other Implemented: ORS 414.065

AMEND: 410-146-0200

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

CHANGES TO RULE:

410-146-0200
Pharmacy ¶

(1) A valid encounter excludes pharmaceutical or biologicals not generally provided during a clinic visit:-¶
(a) An IHS or Tribal 638 Pharmacy may select whether to be reimbursed by the Division for prescriptions, including dispensing services, at the appropriate 340(B) or Federal Supply Schedule Acquisition Rate (refer to OAR 410-121-0160) plus the dispensing fee as determined by the state, or at the All-Inclusive Rate (AIR) published annually by the IHS, inclusive of dispensing fees;¶
(b) An IHS or Tribal 638 Pharmacy may request to change from the appropriate 340(B) or Federal Supply Schedule Acquisition Rate plus a dispensing fee methodology, to the IHS All-Inclusive Rate (AIR) methodology, or from the IHS AIR methodology to the appropriate 340(B) or Federal Supply Schedule Acquisition Rate (AAC) plus dispensing fee methodology, but no more frequently than four times in a calendar year. Requests must be submitted at least 30 days in advance and shall be effective at the start of the following quarter. If an IHS or Tribal 638 Pharmacy experiences circumstances requiring a methodology change, the 30 day advance notice may be waived and the process.¶
(2) IHCPs may bill directly the Division only for contraceptive supplies and contraceptive medications outside of the pharmacy program:-¶
(a) For ~~client~~Members enrolled with a PHP, IHCPs must bill the PHP first. If the PHP will not reimburse for the contraceptive supply or contraceptive medication, then the clinic may bill the Division fee-for-service at the clinic's ~~a~~Acquisition ~~c~~Cost. See also OAR 410-130-0585, Family Planning Services;-¶
(b) For ~~client~~Members not enrolled with a PHP, IHCPs may bill directly the Division fee-for-service at the clinic's ~~a~~Acquisition ~~c~~Cost for contraceptive supplies and contraceptive medications. See also OAR 410-130-0585, Family Planning Services.-¶
(3) Refer to OAR 410 division 121, Pharmaceutical Services program for specific information.
Statutory/Other Authority: ORS 413.042, ORS 414.065
Statutes/Other Implemented: ORS 414.065

AMEND: 410-146-0240

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

CHANGES TO RULE:

410-146-0240
Transportation ¶

(1) The Division may reimburse IHCP for ~~m~~Medically ~~a~~Appropriate sedan car or wheelchair van ~~t~~Transportation services provided to OHP AI/AN ~~client~~Members who receive medical services through an IHCP. (Refer to ~~OAR~~chapter 410 ~~D~~division 136, Medical Transportation.)-¶
(2) Federal regulations in 42 CFR 431.53 require the state to ensure necessary ~~t~~Transportation for Medicaid recipients to and from ~~p~~Providers. The IHCP must ensure that:-¶
(a) The service to be provided is the most ~~c~~Cost-~~e~~ Effective method that meets the medical needs of the ~~client~~Member; and-¶
(b) The service to be provided at the point of origin and destination is a Division Medicaid-~~c~~ Covered ~~s~~Service according to a ~~client~~Member's OHP ~~b~~Benefit ~~p~~Package;-¶
(c) In addition, AI/AN OHP ~~client~~Members may be transported to the nearest Tribal Health facility and are not restricted to the nearest (non-tribal) facility able to meet the ~~client~~Member's medical needs.-¶
(3) For the purpose of this rule, the most "cost effective" method is a transportation service that cannot, in the judgment of the Division, be provided through a less expensive alternative while meeting the medical needs of the ~~client~~Member. Reimbursement by the Division to an IHCP may not exceed the most ~~c~~Cost-~~e~~ Effective method and is the lesser of:-¶
(a) The ~~p~~Providers' costs for furnishing ~~t~~Transportation services; or-¶
(b) The amount reimbursed by the Division to ~~n~~Non-~~e~~Emergency ~~t~~Transportation ~~p~~Providers under ~~OAR~~chapter 410-~~D~~, division 136 Medical Transportation Program.-¶
(4) The Division shall reimburse transportation services fee-for-service, and outside of the IHS encounter rate, when the IHCP meets the following conditions:-¶
(a) The IHCP owns or leases the sedan car or wheelchair van; and-¶
(b) The individual providing the service is an employee of the IHCP.-¶
(5) IHCPs do not need to enroll separately as a ~~t~~Transportation ~~p~~Provider if they furnish either sedan car or wheelchair van transportation. As used in this rule, ~~t~~Transportation services by IHCPs are defined as follows:-¶
(a) Transportation provided by a 4-door sedan or mini-van motor vehicle having a seating capacity of not less than four and not more than seven passengers;-¶
(b) Transportation provided by a wheelchair lift equipped vehicle for a ~~client~~Member who uses a wheelchair. Transportation is generally a "door to door" service. At times, an individual being transported must be picked up inside their residence and taken inside their destination (escort by the driver).-¶
(6) Under the following conditions, an IHCP is required to separately enroll with the Division as a ~~p~~Provider of medical ~~t~~Transportation services:-¶
(a) The IHCP serves all ~~client~~Members as a whole and does not limit services to the AI/AN community (e.g., Native American ~~client~~Members);-¶
(b) The IHCP owns and operates a taxi service; or-¶
(c) The IHCP owns and operates an ambulance service.-¶
(7) Non-emergency ambulance, air ambulance, commercial air, bus, or train are not reimbursed under this rule to IHCPs and requires advance arrangement and ~~p~~Prior ~~a~~Authorization (PA) through the local Aging and People with Disabilities ~~Division~~ (APD) or Self Sufficiency Programs (SSP) branch office.-¶
(8) For all claims submitted to the Division, the ~~p~~Provider records must contain completed documentation (pertinent to the service provided) that includes but is not limited to:-¶
(a) Trip information including:-¶
(A) Date of ~~s~~Service;-¶
(B) If one way, round trip, or three-way and if transportation needs are ongoing;-¶
(C) Physical address of the point of origin, e.g., ~~client~~Member address, nursing home name and address, etc.;¶
(D) Number of actual patient miles traveled; and-¶
(E) Physical address and name of the destination point, e.g., hospital name, doctor name, address, etc.-¶
(b) ~~Client~~Member information including:-¶
(A) ~~Client~~Member name;-¶
(B) ID number; and-¶

(C) Medical assistance needs (e.g., requires wheelchair, walker, cane, needs assistance, requires portable oxygen, etc.); and-¶
(c) Justification for extra attendant beyond one if wheelchair van.-¶
(9) All required documentation must be retained in the ~~p~~Provider files for the period of time specified in the ~~G~~general ~~R~~rules (~~OAR~~chapter 410-~~D~~, division 120).-¶
(10) Medical ~~t~~Transportation services must be billed in the professional claim format using the billing instructions and procedure codes in this rule and in conjunction with OAR 410 division 136 Medical Transportation Program.-¶
(11) If two or more Me~~dicaid client~~mbers are transported by the same mode (e.g., wheelchair van) at the same time, the Division shall reimburse at the full base rate for the first ~~client~~Member and one-half the appropriate base rate for each additional ~~client~~Member. If two or more Division ~~client~~Members are transported by mixed mode (e.g., wheelchair van and ambulatory) at the same time, the Division shall reimburse at the full base rate for the highest mode for the first ~~client~~Member and one-half the base rate of the appropriate mode for each additional ~~client~~Member. Reimbursement may not be made for duplicated miles traveled. If more than one ~~client~~Member is transported from a single pickup point to different destinations or from different pickup points to the final destination, the total mileage may be billed. The first ~~ten~~10 miles is included in the base rate and should be included in the total number of miles on the CMS-1500 (OAR 410-136-0080, Additional Client Transport).-¶
(12) Tribal facility owned/leased sedan car:-¶
(a) S0215 -- Non-~~e~~Emergency ~~t~~Transportation; mileage, per mile;-¶
(b) Not eligible for base rate or extra attendant reimbursement.-¶
(13) Tribal facility owned/leased wheelchair car/van. The Division's reimbursement of the first ~~ten~~10 miles of a transport is included in the payment for the base rate. A service from point of origin to point of destination (one-way) is considered a "transport."-¶
(14) Tribal facility owned/leased wheelchair van:-¶
(a) If a ~~client~~Member is able to transfer from wheelchair to car/van, the Division may not make payment for wheelchair services for transportation of ambulatory (capable of walking) ~~client~~Members (e.g., base rate, extra attendant);-¶
(b) Wheelchair van -- Bill using the following procedure codes:-¶
(A) A0130 -- Non-~~e~~Emergency ~~t~~Transportation, wheelchair car/van base rate;-¶
(B) S0209 -- Wheelchair van, ground mileage, per statute mile;-¶
(C) T2001 -- Extra attendant (each).-¶
(15) When billing ~~t~~Transportation services, use the appropriate place of service (POS) codes and modifiers as listed in the Medical Transportation Services Supplemental Information guidebook to indicate the type of ~~t~~Transportation service and point of origin and destination.-¶
(16) The Division may recoup such payments if, on subsequent review, it is found that the ~~p~~Provider did not comply with the Division's administrative rules. Non-compliance includes, but is not limited to, failure to adequately document the service and the need for the service.
Statutory/Other Authority: ORS 413.042, ORS 414.065
Statutes/Other Implemented: ORS 414.065

AMEND: 410-146-0440

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

CHANGES TO RULE:

410-146-0440
Prepaid Health Plan Supplemental Payments ¶

(1) Effective January 1, 2001, the Division is required by 42 USC 1396a(bb) to make supplemental payments to eligible Federally Qualified Health Centers (FQHC) and Rural Health Clinics (RHC) that contract with Prepaid Health Plans (PHP). American Indian/Alaska Native (AI/AN) program ~~p~~Providers that are not FQHCs and that elect to receive payment under Title XIX and XXI according to the Indian Health Services (IHS) rate under the Memorandum of Agreement (MOA) effective July 11, 1996 will also be eligible to receive supplemental payments in the same manner as an FQHC under 1902(bb)(5).~~-~~¶
(2) IHCPs reimbursed according to a cost-based rate under the Prospective Payment System (PPS) are directed to Oregon administrative rule (OAR) 410-147-0460, Prepaid Health Plan Supplemental Payments.~~-~~¶
(3) The PHP supplemental payment represents the difference, if any, between the payment received by the IHCP from the PHP for treating the PHP enrollee and the payment to which the IHCP would be entitled if they had billed the Division directly for these encounters according to the clinic's IHS rate.~~-~~¶
(4) In accordance with federal regulations, the ~~p~~Provider must take all reasonable measures to ensure that in most instances, with the exception of IHS or designated Tribal funds, Medicaid shall be the payer of last resort. Providers must make reasonable efforts to obtain payment first from other resources before submitting claims to the PHP (refer to OAR 410-120-1140, Verification of Eligibility).~~-~~¶
(5) When any other coverage is known to the ~~p~~Provider, the ~~p~~Provider must bill the other resource prior to billing the PHP. When a ~~p~~Provider receives a payment from any source prior to the submission of a claim to the PHP, the amount of the payment must be shown as a credit on the claim in the appropriate field (see OAR 410-120-1280, Billing and 410-120-1340, Payment).~~-~~¶
(6) Supplemental payment by the Division for encounters submitted by IIHCPs for purposes of this rule is reduced by any and all payments received by the IHCP from outside resources, including Medicare, private insurance, or any other coverage. IHCPs are required to report all payments received on the Managed Care Data Submission Worksheet, including:~~-~~¶
(a) Medicaid PHPs;~~-~~¶
(b) Medicare Advantage Managed Care Organizations (MCO);~~-~~¶
(c) Medicare, including Medicare MCO supplemental payments; and~~-~~¶
(d) Any ~~t~~Third ~~p~~-Party ~~r~~Resources (TPR).~~-~~¶
(7) The Division shall calculate the PHP supplemental payment in the aggregate of the difference between total payments received by the IHCP to include payments as listed in section (6) of this rule and the payment to which the IHCP would have been eligible to claim as an encounter if they had billed the Division directly according to the IHS encounter rate.~~-~~¶
(8) IHCPs must submit their clinic's data using the Managed Care Data Submission Template developed by the Division to report all PHP encounter and payment activity.~~-~~¶
(9) To facilitate the Division processing PHP supplemental payments, the IHCP must submit the following:~~-~~¶
(a) To PHPs:~~-~~¶
(A) Claims within the required timelines outlined in the contract with the PHP and in OAR 410-141-0420, Oregon Health Plan Prepaid Health Plan Billing Payment under the OHP;~~-~~¶
(B) The AI/AN National Provider Identifier (NPI) number and applicable associated taxonomy code registered with the Division for the health center must be used when submitting all claims to the PHPs.~~-~~¶
(b) To the Division:~~-~~¶
(A) Report total payments for all services submitted to the PHP:~~-~~¶
(i) Including laboratory, radiology, nuclear medicine, and diagnostic ultrasound; and~~-~~¶
(ii) Excluding any bonus or incentive payments.~~-~~¶
(B) Report total payments for each category listed in the "Amounts Received during the Settlement Period" section of the Managed Care Data Submission Template coversheet;~~-~~¶
(C) Payments must be reported at the detail line level on the Managed Care Data Submission Template worksheet, except for capitated payments, or per ~~m~~Member per month and risk pool payments received from the PHP;~~-~~¶
(D) The total number of actual encounters. An encounter represents all services for a like service element (medical, dental, mental health, or alcohol and chemical dependency) provided to an individual ~~client~~Member on a single

~~d~~Date of ~~s~~Service. The total number of encounters is not the total number of ~~client~~Members assigned to the IHS or Tribal 638 facility or the total detail lines submitted on the Managed Care Data Submission Template worksheet;-¶
(E) A list of individual practitioners with active Division enrollment including names, legacy Division ~~p~~Provider number, and NPI number assigned to ~~p~~Practitioners associated with the IHS or Tribal 638 facility. "Associated" refers to a practitioner who is either subcontracted or employed by the IHCP;-¶
(F) A current list of all PHP contracts. An updated list of all PHP contracts must be submitted annually to the Division no later than October 31 of each year.-¶
(10) PHP supplemental payment process:-¶
(a) The Division processes PHP supplemental payments on a quarterly basis. The quarterly settlement includes a final reconciliation for the reported time period;-¶
(b) Upon processing a clinic's data and the PHP supplemental payment, the Division shall:-¶
(A) Send a check to the IHCP for PHP supplemental payment calculated from clinic data the Division was able to process;-¶
(B) Provide a cover letter and summary of the payment calculation; and-¶
(C) Return data that is incomplete, unmatched, or cannot otherwise be processed by the Division.-¶
(c) The IHCP is responsible for reviewing the data the Division was unable to process for accuracy and completeness. The clinic has 30 days from the date of the Division's cover letter under section (9) of this rule to make any corrections to the data and resubmit to the Division for processing. Documentation supporting any and all changes must accompany the resubmitted data. A request for extension must be received by the Division prior to expiration of the 30 days and must:-¶
(A) Be in writing;-¶
(B) Be accompanied by a cover letter fully explaining the reason for the late submission; and-¶
(C) Provide an anticipated date for providing the Division the clinic's resubmitted data and supporting documentation.-¶
(d) Within 30 days of the Division's receipt of the re-submitted data, the Division shall:-¶
(A) Review the data and issue a check for all encounters the Division verifies to be valid; and-¶
(B) For quarterly data submissions, send a letter outlining the final quarterly settlement including any other pertinent information to accompany the check.-¶
(e) The IHCP must submit data to the Division within the timelines provided by the Division.-¶
(11) Clinics must carefully review in a timely fashion the data that the Division was unable to process and returns to the IHCP. If clinics do not bring any incomplete, inaccurate, or missing data to the Division's attention within the time frames outlined, Division may not process an adjustment.-¶
(12) The Division encourages IHCPs to request PHP supplemental payment in a timely manner.-¶
(13) Clinics must exclude from a clinic's data submission for PHP supplemental payment services provided to a PHP-enrolled non-AI/AN ~~client~~Member denied by the PHP because the clinic does not have a contract or agreement with the PHP. This may not apply to ~~f~~Family ~~p~~Planning ~~s~~Services or HIV/ AIDS prevention services. Family planning and HIV/AIDS prevention services provided to a PHP-enrolled ~~client~~Member when a clinic does not have a contract or agreement with the PHP:-¶
(a) Must be reported in the clinic's data submission for PHP supplemental payment if the clinic receives payment from the PHP;-¶
(b) May not be reported in the clinic's data submission for PHP supplemental payment if the clinic is denied payment by the PHP. If the PHP denies payment to the clinic, the clinic may bill these services directly to the Division.-¶
(14) If a PHP denies payment to a contracted IHCP for all services, items, and supplies provided to a ~~client~~Member on a single ~~d~~Date of ~~s~~Service and meeting the definition of an "encounter" as defined in OAR 410-146-0085 for the reason that all services, items, and supplies are ~~n~~Non-~~c~~Covered by the plan, the Division may or may not make a supplemental payment to the clinic. The following examples are excluded from the provision of this rule:-¶
(a) Encounters that will later be billed to the PHP as a covered global procedure (e.g., Obstetrics Global Encounter);-¶
(b) If payment received by Medicare and any other ~~t~~Third-~~p~~-Party ~~r~~Resource does not exceed the payment the PHP would have made, the PHP would make payment;-¶
(c) At least one of the detail lines reported for all services, items and supplies provided to a ~~client~~Member on a single ~~d~~Date of ~~s~~Service and represents an "encounter," has a reported payment amount by the PHP.-¶
(15) The Division may not reimburse some ~~Medicaid-c~~Covered ~~s~~Services that are only reimbursed by PHPs and are not reimbursed by the Division. The Division may not make PHP supplemental payment for these services, as the Division does not reimburse these services when billed directly to the Division.-¶
(16) It is the responsibility of the IHCP to refer PHP-enrolled non-AI/AN ~~client~~Members back to their PHP if the IHCP does not have a contract with the PHP, and the service to be provided is not family planning or HIV/AIDS prevention. The provider assumes full financial risk in serving a person not confirmed by the Division as eligible on

the ~~d~~Date of ~~s~~Service. See OAR 410-120-1140, Verification of Eligibility. The provider must verify:~~-~~¶
(a) That the individual receiving medical services is eligible on the ~~d~~Date of ~~s~~Service for the service provided; and~~-~~¶
(b) Whether a~~ client is enrolled with a PHP or receives services~~n individual is a CCO Member o~~n~~r an "~~o~~Open ~~c~~Card"~~ or fee-for-service basis~~ Member.
Statutory/Other Authority: ORS 413.042, ORS 414.065
Statutes/Other Implemented: ORS 414.065

AMEND: 410-146-0470

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

CHANGES TO RULE:

410-146-0470
Traditional Health Care Practices
(1) Definitions:¶
(a) "Indian Health Care Provider (IHCP)" means a health care program operated by the Indian Health Service (IHS) or by an Indian Tribe, Tribal Organization, or Urban Indian Organization (otherwise known as an I/T/U) as those terms are defined in section 4 of the Indian Health Care Improvement Act (25 U.S.C. § 1603).¶
(b) "Medicaid Management Information System (MMIS)" means the automated claims processing and information retrieval system for handling all Medicaid transactions. The objectives of the system include verifying ~~p~~Provider enrollment and ~~client~~Member eligibility, managing health care ~~p~~Provider claims and ~~b~~Benefit ~~p~~Package maintenance, and addressing a variety of Medicaid business needs.¶
(c) "National Provider Identifier" means a unique 10-digit number that is issued by the Centers for Medicare and Medicaid and is used to identify health care ~~p~~Providers throughout the health care industry.¶
(d) "Prospective Payment System" means the method of reimbursement in which payment is made based on a pre-determined, fixed amount.¶
(e) "IHCP Prospective Payment Rates (PPS)" means payments made to an IHCP that is based on a clinic-specific, cost-based rate, calculated according to each IHCP's reported costs and volume of patient encounters.¶
(f) "Tribal-Based Practices" means those practices that are based on cultural principles that have been traditionally used in tribal communities since time immemorial. Tribal-Based Practices are culturally validated utilizing the process that has been established and been approved by the review panel of tribal representatives. Not all Tribal-based practices are eligible for Medicaid reimbursement.¶
(g) "Traditional Health Care Practices" means those Tribal-based practices that have been determined to be eligible for Medicaid reimbursement.¶
(h) "Tribal Based Practices Review Panel" means the panel comprised of tribal representatives who have been elected by representatives from the Nine Federally Recognized Tribes of Oregon. The Tribal Based Practices Review Panel is responsible for accepting, reviewing, and approving Tribal ~~b~~-Based ~~p~~Practices that have been proposed and submitted to the Tribal Based Practices Review Panel for review and approval when evidence, based on research, practice, and culture-based knowledge, shows the Tribal-~~b~~Based ~~p~~Practice to be effective. The Tribal Based Practices Review Panel may also provide technical assistance on an ongoing basis to the Tribes and Tribal Organizations regarding Tribal Based Practices. The panel meets on an as-needed basis. Review panel membership is determined by tribal representatives from the Nine Federally Recognized Tribes of Oregon.¶
(i) "Traditional Knowledge Keeper(s)" means the individual(s) responsible for providing the Tribal Based Practices. Traditional Knowledge Keepers have gained the traditional knowledge according to their Tribal community that is necessary to implement Tribal Based Practices in a meaningful, respectful, and purposeful way. Examples of Traditional Knowledge Keepers may include elders, cultural or spiritual advisors, traditional foods providers, medicines gatherers, sweat lodge leaders, Tribal singers, dancers, artists, and more. These individuals must meet the qualifications in Section (5) of this rule and are authorized to provide Tribal Based Practices as an employee or contractor of an IHCP.¶
(j) "Urban Indian Health Program (UIHP)" means an urban Indian organization as defined in section 1603 of Title 25 that has an IHS Title V contract as described in Section 1653 of Title 25.¶
(2) Eligibility to Receive Tribal-Based Practices: To be eligible to receive one or more Tribal-Based Practice(s), an individual must meet the following criteria:¶
(a) Is enrolled in Medicaid or CHIP; and,¶
(b) Is able to receive services delivered by an Indian Health Care Provider (IHCP), as determined by the IHCP.¶
(3) Delivery of Traditional Health Care Practices to Qualifying Individuals¶
(a) The IHCP shall provide Traditional Health Care Practices to qualifying Medicaid or CHIP Members through employed or contracted Traditional Knowledge Keepers.¶
(b) The Tribal Based Practices Review Panel shall review and maintain a list of available Tribal-Based Practices and the scope of each service. This list will identify the Tribal-Based Practices that are also approved as Traditional Health Care Practices and covered by Medicaid.¶
(c) The IHCP shall determine the list and scope of each Traditional Health Care Practices that will be offered to qualifying Medicaid and CHIP Members at each IHCP.¶
(d) Traditional Health Care Practices shall not be subject to ~~OHP's~~the OHA Prioritized List of Health Services as

described in OAR 410-141-3830.[KG1] [DC2] ¶
(e) The IHCP shall maintain internal supporting documentation relating to the provision of the service for the OHP enrolled Member in accordance with OAR 410-120-1360.¶
(4) Reimbursement for the Delivery of Tribal Based Practices¶
(a) The IHCP shall be permitted to seek Medicaid reimbursement for expenditures on any Traditional Health Care Practice following the requirements outlined in this section.¶
(b) The IHCP shall ensure that all Medicaid claims, even those claims that are for Traditional Health Care Practices provided to ~~OHP~~CCO Members ~~enrolled in Coordinated Care Organizations (CCOs),~~ are submitted to the Authority directly with the applicable information that identifies the IHCP as the Billing Provider, and the Traditional Knowledge Keeper identified as the Rendering Provider. The IHCP shall not submit Medicaid claims relating to the provision of Traditional Health Care Practices to CCOs.¶
(c) The IHCP shall ensure that diagnosis code Z7689 and procedure code H0051 are used for the reimbursement of all Tribal-Based Practices claims.¶
(d) The Authority shall process all Traditional Health Care Practices claims at the IHCP's chosen specified encounter rate (Indian Health Service (IHS) or Prospective Payment System Rates (PPS)).¶
(e) The Authority shall not provide Traditional Health Care Practice reimbursement for the following items or services:¶
(A) Construction costs (including building modification and building rehabilitation);¶
(B) Room and board;¶
(C) Capital investments; and¶
(D) Research grants and expenditures not related to monitoring and evaluation.¶
(f) Payment for permissible claims submitted for the provision of Traditional Health Care Practices shall be contingent on the availability of federal funding.¶
(5) Provider Qualifications for Traditional Knowledge Keepers¶
(a) The IHCP shall be responsible for confirming that all contracted and employed Traditional Knowledge Keepers meet the qualifications described in this Section 5.¶
(b) In order to receive OHP reimbursement for the provision of Traditional Health Care Practices, a Traditional Knowledge Keeper must be, at the time the practice was performed:¶
(A) Be employed or contracted with an IHCP.¶
(B) Meet Traditional Knowledge Keeper qualifications, as determined by the IHCP.¶
(C) Have the necessary experience and appropriate training to serve as a Traditional Knowledge Keeper, as determined by the IHCP.¶
(c) Each IHCP shall ensure the following for all the delivery of Tribal-Based Practices:¶
(A) Establish methods for determining whether its employees or contractors are qualified to serve as Traditional Knowledge Keepers.¶
(B) Bill the Authority for Traditional Health Care Practices furnished only by Traditional Knowledge Keepers who are qualified to provide them, as determined by the IHCP.¶
(d) Each IHCP shall send the Authority a list of employed or contracted Traditional Knowledge Keepers, which must be updated as changes occur. Each IHCP must provide the Authority with copies of any updated list as they occur.¶
(e) Each Traditional Knowledge Keeper on the list described in (5)(d) shall enroll with Oregon Health Plan (OHP) Open Card by submitting the necessary ~~p~~Provider forms to OHA.¶
(A) An IHCP shall not submit any claim for payment for the provision of any Traditional Health Care Practice by a Traditional Knowledge Keeper if such Traditional Knowledge Keeper was not enrolled with the Authority as required under this subsection at the time the practice was performed.¶
(B) Traditional Knowledge Keepers shall not be required to have a National Provider Identifier (NPI) number.¶
(f) The Authority shall verify that the Traditional Knowledge Keeper is on the list provided by each IHCP, as described in (5)(d) of this rule¶
(g) Once verified, the Authority shall enroll the Traditional Knowledge Keeper in Medicaid Management Information System (MMIS).
Statutory/Other Authority: 25 U.S.C. § 1603
Statutes/Other Implemented: 25 U.S.C. § 1603

AMEND: 410-146-5000

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

CHANGES TO RULE:

410-146-5000
Indian Managed Care Entities
(1) Definitions. The definitions in OAR 410-141-3500 apply to this rule unless context dictates otherwise. In addition, for purposes of this rule:¶
(a) "~~The~~ Authority" means the Oregon Health Authority;¶
(b) "Contract" means an agreement between the State of Oregon and an Indian Managed Care Entity to provide Primary Care Case Management services to eligible ~~m~~Members;¶
(c) "Indian Managed Care Entity (IMCE)" means a ~~m~~Managed ~~c~~Care ~~e~~Entity that is controlled by the Indian Health Service, a Tribe, Tribal Organization, or Urban Indian Organization, or a consortium thereof, as described in 42 U.S.C. § 1396u-2(h)(4)(B) and 42 C.F.R. § 438.14(a);¶
(d) "~~Client~~Member" means an Oregon Health Plan ~~client~~Member who is American Indian or Alaska Native (AI/AN) as defined at 25 USC 1603(13), 1603(28), or 1679(a), or who has been determined eligible as an Indian, under 42 CFR 136.12; or as defined under 42 CFR 438.14(a).;¶
(e) "CCO Member" means a ~~client~~Member enrolled with an IMCE;¶
(f) "Primary Care Case Management (PCCM) Services" means the location, coordination and monitoring of primary health care services for members. PCCM services may include:¶
(A) The provision of intensive telephonic or face-to-face case management, including operation of a nurse triage advice line;¶
(B) The development of enrollee care plans;¶
(C) The execution of contracts with, or oversight responsibilities for, the activities of ~~f~~Fee-for-~~s~~Service (FFS) ~~p~~Providers in the FFS program;¶
(D) The provision of payments to FFS ~~p~~Providers on behalf of the State;¶
(E) The provision of enrollee outreach and education activities;¶
(F) The operation of a customer service call center;¶
(G) Review of ~~p~~Provider claims, utilization, and practice patterns to conduct ~~p~~Provider profiling or practice improvement;¶
(H) Implementation of quality improvement activities, including administering enrollee satisfaction surveys or collecting data necessary for performance measurement of ~~p~~Providers;¶
(I) Coordination with ~~b~~Behavioral ~~h~~Health systems/~~p~~Providers; and¶
(J) Coordination with ~~l~~Long-~~t~~Term ~~s~~Services and ~~s~~Supports systems/~~p~~Providers.¶
(2) IMCE PCCM Services: General Standard. The Authority will reimburse an IMCE for PCCM services furnished to eligible ~~m~~CCO Members in accordance with a duly executed IMCE contract. The Authority shall ensure that:¶
(a) All necessary federal approvals are obtained in order to ensure the availability of federal financial participation for PCCM services furnished by IMCEs;¶
(b) IMCE contracts are executed in accordance with, and require IMCEs to comply with:¶
(A) Applicable federal law, including 42 U.S.C. § 1396u-2(h) and 42 C.F.R. Part 438; and¶
(B) Applicable state law, including this rule.¶
(3) Reimbursement. An IMCE will receive a Per Member Per Month payment, calculated by the Authority in accordance with the contract. This payment will be prorated for any ~~m~~CCO Member who is enrolled for less than a full month.¶
(a) IMCE payments will be generated on a monthly basis.¶
(b) Should the Authority identify an overpayment (due to, for example, member disenrollment or ineligibility), the overpayment will be recouped from subsequent IMCE payments.¶
(4) Member Attribution: IMCEs Operated by a Tribe or Tribal Organization.¶
(a) An individual is potentially eligible to enroll in a Tribal IMCE if the individual:¶
(A) Is an American Indian or Alaska Native, as defined at 25 USC 1603(13), 1603(28), or 1679(a), or who has been determined eligible as an Indian, under 42 CFR 136.12; or as defined under 42 CFR 438.14(a)¶
(B) May reside within the Tribe's purchased and referred care service delivery area (PRCDA);¶
(C) Is enrolled in the OHP; and¶
(D) Is not currently enrolled with another IMCE or a Coordinated Care Organization (CCO).¶
(b) A Tribal IMCE has the discretion to decide which eligible individuals to enroll and how many eligible individuals to enroll, subject to compliance with:¶

(A) Any applicable contract provisions; and¶
(B) Applicable state and federal laws that prohibit discrimination based on disability and other protected traits.¶
(c) The IMCE will, on a monthly basis, submit to the Authority a patient attribution form listing the IMCE's enrolled ~~m~~Members, as specified in the contract. The Authority will confirm the eligibility of all ~~m~~Members before processing IMCE payments.¶
(5) Member Attribution: IMCEs Operated by an Urban Indian Organization.¶
(a) An individual is potentially eligible to enroll in an Urban Indian IMCE if the individual:¶
(A) Is an American Indian or Alaska Native, as defined in OAR 410-141-3500;¶
(B) Resides within the service area designated in the contract;¶
(C) Is enrolled in the OHP; and¶
(D) Is not currently enrolled with another IMCE or a CCO.¶
(b) In accordance with the contract, the Authority will periodically generate and submit to the Urban Indian IMCE a list of individuals that meet the eligibility criteria under subsection (5)(a).¶
(c) An Urban Indian IMCE has the discretion to decide which eligible individuals to enroll and how many eligible individuals to enroll, subject to compliance with:¶
(A) Any applicable contract provisions; and¶
(B) Applicable state and federal laws that prohibit discrimination based on disability and other protected traits.¶
(6) Enrollment. IMCEs shall comply with applicable contract provisions regarding ~~m~~Member enrollment and communication with new ~~m~~Members.¶
(7) Disenrollment. IMCEs are responsible for processing, and notifying the Authority of, ~~m~~Member disenrollments, in accordance with applicable contract provisions.¶
(a) Disenrollments initiated by ~~m~~Members. Members have a right to request disenrollment from an IMCE at any time.¶
(b) Disenrollments initiated by the IMCE.¶
(A) An IMCE must disenroll any ~~m~~Member who is no longer eligible for IMCE PCCM services.¶
(B) An IMCE may disenroll any ~~m~~Member at any time, subject to compliance with subparagraph (7)(b)(C) and any applicable contract provisions.¶
(C) An IMCE may not select ~~m~~Members for disenrollment based on factors that would violate applicable state and federal laws that prohibit discrimination based on disability and other protected traits. In addition, consistent with 42 C.F.R. § 438.56(b)(2), an IMCE may not disenroll a ~~m~~Member solely due to:¶
(i) An adverse change in the ~~m~~Member's health status;¶
(ii) The ~~m~~Member's utilization of medical services;¶
(iii) The ~~m~~Member's diminished mental capacity; or¶
(iv) The ~~m~~Member's uncooperative or disruptive behavior resulting from special needs (except when the member's continued enrollment seriously impairs the IMCE's ability to furnish services to either this particular ~~m~~Member or other ~~m~~Members).¶
(8) IMCE Member Rights & Responsibilities. An IMCE shall, in accordance with the contract, develop written policies defining ~~m~~Member rights and responsibilities, ensuring that ~~m~~Members are aware of those rights and responsibilities, and enabling ~~m~~Members to exercise their rights.¶
(a) At a minimum, ~~m~~Members have the right to:¶
(A) Be treated with dignity and respect;¶
(B) Have choice of one or more friends, family members, ~~m~~Member representatives, and/or advocate present during communications with IMCE staff;¶
(C) Be actively involved in the development of their care plan;¶
(D) Receive written materials describing rights, responsibilities, benefits available, how to access services, and what to do in an emergency in language, format, and presentation methods appropriate for effective communication according to the needs and abilities of the individual and, as applicable, the legal ~~r~~Representative or authorized representative of the individual;¶
(E) Have written materials explained in a manner that is understandable to the ~~m~~Member and be educated about the PCCM model;¶
(F) Have a clinical record maintained that documents conditions, services received, and referrals made;¶
(G) Have access to one's own ~~c~~Clinical ~~r~~Record, unless restricted by federal regulations or state statute;¶
(H) Transfer of a copy of the ~~c~~Clinical ~~r~~Record to another ~~p~~Provider; and¶
(I) Be able to make a complaint ("grievance") with the IMCE and receive a response.¶
(b) At a minimum, ~~m~~Members have the responsibility to:¶
(A) Treat the IMCE staff members with respect;¶
(B) Give accurate information for inclusion in the clinical record;¶
(C) Help the ~~p~~Provider or clinic obtain ~~c~~Clinical ~~r~~Records from other ~~p~~Providers that may include signing an authorization for release of information;¶

(D) Ask questions about conditions, treatments, and other issues related to care that is not understood;¶
(E) Help in the creation of a care plan;¶
(F) Inform the IMCE or the Authority of a change of address or phone number; and¶
(G) Bring issues or complaints or grievances to the attention of the IMCE.¶
(9) Grievance System. An IMCE must establish a system for ~~m~~Member grievances that complies with OAR 410-141-3875 through 410-141-3880, OAR 410-141-3915, and any applicable contract provisions. (An IMCE that does not make service authorization decisions is not required to establish processes for ~~m~~Member ~~a~~Appeals or ~~c~~Contested ~~c~~Case ~~h~~Hearings.)¶
(10) Application of Oregon Health Plan Regulations. Subject to the scope of the IMCE contract and to the definitions in subsection (1) above, the following rules apply to IMCEs as though, in these rules, all instances of the term "MCE" were replaced with "IMCE":¶
(a) OAR 410-120-0000 (Acronyms and Definitions);¶
(b) OAR 410-141-3530 (Definitions);¶
(c) OAR 410-141-3501 (Administration of Oregon Integrated and Coordinated Health Care Delivery System Regulation; Rule Precedence);¶
(d) OAR 410-141-3505 (Use of Subcontractors);¶
(e) Sections (9) through (13) of OAR 410-141-3520 (Record Keeping and Use of Health Information Technology);¶
(f) OAR 410-141-3530 (Sanctions);¶
(g) OAR 410-141-3550 (Resolving Disputes with OHA);¶
(h) OAR 410-141-3575 (Member Relations, Marketing);¶
(i) OAR 410-141-3580 (Potential Member Information);¶
(j) OAR 410-141-3585 (Member Relations: Education and Information); and¶
(k) Sections (1) through (10) of OAR 410-141-3710 (Contract Termination and Close-Out Requirements).
Statutory/Other Authority: ORS 413.042, 42 U.S. Code § 1396u-2, 42 CFR § 438.14
Statutes/Other Implemented: ORS 413.042