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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: 10/15/2026 3:49 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: 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).
There is no expected economic impact.

(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:

410-124-0005, 410-124-0006, 410-124-0040, 410-125-0000, 410-125-0040, 410-125-0041, 410-125-0050, 410-125-0080, 410-125-0085, 410-125-0086, 410-125-0102, 410-125-0103, 410-125-0120, 410-125-0124, 410-125-0140, 410-125-0141, 410-125-0210, 410-125-0230, 410-125-0360, 410-125-0450, 410-125-0640, 410-125-1060, 410-125-1070

AMEND: 410-124-0005

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

CHANGES TO RULE:

410-124-0005
Donor Services ¶

(1) Living and cadaver donor search and procurement services are covered for ~~m~~Medically ~~n~~Necessary transplants.¶
(2) All living or cadaver donor services are payable under the ~~recipient~~Member's Medicaid identification number and not under the donor.¶
(3) For ~~Managed Care Entity(MCE) client~~CCO Members, contact the ~~client's MCE~~CCO for authorization requirements.
Statutory/Other Authority: ORS 413.042
Statutes/Other Implemented: ORS 414.065

AMEND: 410-124-0006

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

CHANGES TO RULE:

410-124-0006
Transplant Hospital Requirements And Reimbursement
Transplant services shall be reimbursed only when provided in a transplant ~~h~~Hospital that meets the Division requirements.~~-~~¶
(1) Medicare certified transplant facility.¶
(2) Must be an enrolled ~~p~~Provider with Oregon Health Authority, Health Systems Division outlined in OAR 410-120-1260.¶
(3) Selection of transplant ~~h~~Hospitals by geographic location: If the services are available in the state of Oregon, reimbursement shall not be made to out-of-state transplant ~~h~~Hospitals.¶
(4) Out-of-state transplant ~~h~~Hospitals shall be considered only if:¶
(a) The type of transplant required is not available in Oregon ~~and/~~or the type of transplant (for example, liver transplant) is available in Oregon but the Oregon transplant ~~h~~Hospital does not provide that type of transplant for all ~~client~~Members or all covered diagnoses, or both (e.g., pediatric transplants); and¶
(b) An in-state transplant ~~h~~Hospital requests the out-of-state transplant referral; and¶
(c) Be ~~c~~Cost ~~e~~Effective as determined by the Division. For example, if the transplant service is covered by the ~~client~~Member's ~~b~~Benefit ~~p~~Package and the ~~client~~Member's primary insurer (i.e., Medicare) requires the use of an out-of-state transplant hospital; or¶
(d) It is a contiguous, out-of-state transplant ~~h~~Hospital that has a contract or special agreement for reimbursement with the Division.¶
(5) Professional and other services shall be covered according to administrative rules in the applicable provider guides.¶
(6) Reimbursement for covered transplants and follow-up care for transplant services is as follows:¶
(a) For transplants for ~~fee-for-service client~~Open Card Members:¶
(A) Transplant facility services - by contract with the Division;¶
(B) Professional services - at the Division's maximum allowable rates.¶
(b) For emergency services, when no special agreement has been established, the rate shall be:¶
(A) 75~~%~~ percent of standard inpatient billed charge; and¶
(B) 50~~%~~ percent of standard outpatient billed charge.¶
(c) For ~~clients enrolled in Managed Care Entity (MCE)~~CCO Members, reimbursement for transplant services shall be by agreement between the ~~MCE~~CCO and the transplant ~~h~~Hospital.
Statutory/Other Authority: ORS 413.042
Statutes/Other Implemented: ORS 414.065

AMEND: 410-124-0040

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

CHANGES TO RULE:

410-124-0040
Emergency Transplants ¶

(1) An Emergency Transplant is one in which ~~m~~Medical ~~a~~Appropriateness requires that a transplant be performed less than five (5) days after determination of the need for a transplant.¶
(2) Emergency transplants are subject to post transplant review of the ~~client~~Member's medical records by the ~~Health Systems Division (Division) or Managed Care Entity (MCE)~~Division or CCO, to determine if the ~~client~~Member and the transplant ~~h~~Hospital met the criteria in these rules at the time of the transplant. Related charges, including ~~t~~Transportation, ~~p~~Physician's services, and donor charges shall be covered if payment is approved. The Division shall make payment as described in OAR 410-124 -0006 for covered transplants. ~~MCE~~The CCO shall make payment as described in their contract.
Statutory/Other Authority: ORS 413.042
Statutes/Other Implemented: ORS 414.065

AMEND: 410-125-0000

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

CHANGES TO RULE:

410-125-0000
Determining When the Patient Has Medical Assistance ¶

(1) The Medical Card gives the ~~client~~Member's name as listed with the Oregon Health Plan (OHP) and their alpha-numeric prime number.¶
(2) Eligibility may change on a monthly basis. In some instances, eligibility will change during the month. Eligibility should be verified each time services are provided in order to assure that the ~~client~~Member is eligible for ~~d~~Date(s) of ~~s~~Service. For ways to verify ~~client~~Member eligibility see ~~General Rule~~OAR 410-120-1140.
Statutory/Other Authority: ORS 413.042
Statutes/Other Implemented: ORS 413.042

AMEND: 410-125-0040

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

CHANGES TO RULE:

410-125-0040
Title XIX/Title XXI ~~Client~~Members ¶

(1) Title XIX-/Title XXI ~~client~~Members are eligible for medical assistance through programs established by the ~~F~~federal government and for which ~~the State~~Oregon receives federal assistance. Most Title XIX/Title XXI ~~client~~Members are eligible for the ~~P~~plus or ~~S~~standard Benefit ~~p~~Packages. See the ~~G~~general rules (chapter 410 division 120) for more information on eligibility, ~~b~~Benefit ~~p~~Package, and ~~c~~Covered ~~s~~Services. Most Title XIX/Title XXI ~~clients~~Member are enrolled in a FCHP, a MHO and a DCO. Some Title XIX ~~client~~Members are Medicare Beneficiaries.¶
(2) The Division ~~of Medical Assistance Programs (Division)~~ contracts with Prepaid Health Plans (PHPs): Fully-Capitated Health Plans (FCHPs), Mental Health Organizations (MHOs), and Dental Care Organizations (DCOs), to provide certain medical, mental health and dental services on a prepaid basis.¶
(a) FCHPs provide a comprehensive package of health care benefits including ~~h~~Hospital, ~~p~~Physician, ~~l~~Laboratory, X-ray and other diagnostic imaging, Medicheck (EPSDT), pharmacy, ~~p~~Physical ~~t~~Therapy, speech-language therapy, ~~o~~Occupational ~~t~~Therapy, case management, and other services;¶
(b) MHOs provide mental health services. They can be fully-capitated health plans, community mental health programs, private behavioral organizations or a combination thereof;¶
(c) DCOs provide dental care;¶
(d) If the ~~client~~Member is enrolled in a Prepaid Health Plan, the name, address and phone number of the plan will appear on the Medical Care Identification. Always check with the plan listed if there is a question about coverage;¶
(e) PHP ~~client~~Members receive most of their primary care services through the PHP or upon referral from the PHP. In emergency situations, all services may be provided without ~~p~~Prior ~~a~~Authorization or ~~r~~Referral. However, all claims for emergency services must be sent to the prepaid health plan. The ~~h~~Hospital must work with the ~~client~~Member's prepaid health plan to arrange for billing and payment for emergency and non-emergency services;¶
(f) Division will not reimburse for services that can be provided by the ~~client~~Member's PHP and are included in the PHP's contract as ~~c~~Covered ~~s~~Services. Reimbursement is between the service ~~p~~Provider and the PHP.¶
(3) Medicare ~~Client~~Members: Some Title XIX ~~client~~Members also have Medicare coverage. Most Medicare beneficiaries who are also eligible for Medicaid will have the full range of covered benefits for both Medicare and Medicaid. However, a few individuals who are Medicare eligible are eligible for only partial coverage through Medicaid. Refer to the ~~G~~general rules (chapter, 410 division 120) for information on eligibility.
Statutory/Other Authority: ORS 413.042
Statutes/Other Implemented: ORS 414.065

AMEND: 410-125-0041

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

CHANGES TO RULE:

410-125-0041
Non-Title XIX/XXI ~~Client~~Members ¶

(1) State-funded ~~clients are client~~Members are Members who have not qualified for medical assistance through a federal program but have access to medical benefits through state funded programs. There are two categories of ~~client~~Members who are in ~~S~~state-funded programs.¶
(2) Program General Assistance (GA) ~~client~~Members: Program GA ~~client~~Members are children in foster care, in Services to Children and Families (SCF) custody, who are not eligible for Title XIX/Title XXI programs. They have access to the full range of Medicaid ~~c~~Covered ~~s~~Services, but payment for services provided may be different from that for Title XIX/Title XXI ~~client~~Members. For additional reimbursement information see the Hospital Services Supplemental Information on the Division ~~of Medical Assistance Programs (Division~~) web site.¶
(3) Program SF ~~client~~Members: Program SF ~~client~~Members are individuals who are receiving treatment in a ~~s~~State ~~f~~Facility, such as Oregon State Hospital, or the Eastern Oregon Training Center. These ~~client~~Members may need to receive ~~h~~Hospital care outside the ~~s~~State ~~f~~Facility. They are entitled to the full range of Medicaid covered hospital services. These individuals will be referred by the ~~s~~State ~~f~~Facility for services. They do not have Medical Care Identification cards. They are not enrolled in a Fully Capitated Health Plan. The ~~s~~State ~~f~~Facility from which the ~~client~~Member is transferred will contact the ~~h~~Hospital regarding billing instructions for these ~~client~~Members.
Statutory/Other Authority: ORS 413.042
Statutes/Other Implemented: ORS 414.065

AMEND: 410-125-0050

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

CHANGES TO RULE:

410-125-0050
~~Client~~Member Copayments ¶

Copayments may be required for certain services ~~and/~~or ~~b~~Benefit ~~p~~Package(s), or both. See OAR 410-120-1230 for specific details.
Statutory/Other Authority: ORS 413.042
Statutes/Other Implemented: ORS 414.065

AMEND: 410-125-0080

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

CHANGES TO RULE:

410-125-0080
Inpatient Services ¶

(1) Elective (not urgent or emergent) ~~h~~Hospital admission:¶
(a) Coordinated Care Organization (CCO) and Mental Health Organization (MHO) ~~client~~Members: Contact the ~~client~~Member's CCO, or MHO. The health plan may have different ~~p~~Prior ~~a~~Authorization (PA) requirements than the Division;¶
(b) Medicare ~~client~~Members: The Division does not require PA for inpatient services provided to ~~client~~Members with Medicare Part A or B coverage;¶
(c) ~~Division client~~Medicaid Members: Oregon Health Plan (OHP) ~~client~~Members covered by the OHP Plus Benefit Package:¶
(A) For a list of medical and surgical procedures that require PA, see the Division's Medical-Surgical Services Program, rules OAR chapter 410, division 130, specifically OAR 410-130-0200, table 130-0200-1, unless they are urgent or emergent defined in OAR 410-125-0401;¶
(B) For PA, contact the Division unless otherwise indicated in the Medical-Surgical Service program rules, specifically OAR 410-130-0200, Table 130-0200-1.¶
(2) Transplant services:¶
(a) Complete rules for transplant services are in the Division's Transplant Services Program rules, OAR chapter 410, division 124;¶
(b) ~~Client~~Members are eligible for transplants covered by the Oregon Health Evidence Review Commission's Prioritized List of Health Services (Prioritized List). See the Transplant Services Program administrative rules for criteria.~~-~~¶
(3) Out-of-State non-contiguous ~~h~~Hospitals:¶
(a) All non-emergent and non-urgent services provided by hospitals more than 75 miles from the Oregon border require PA;¶
(b) Contact the Division's Medical Director's office for authorization for ~~client~~Members not enrolled in a Prepaid Health Plan (PHP). For ~~client~~Members enrolled in a PHP, contact the plan.¶
(4) Out-of-State contiguous ~~h~~Hospitals: The Division prior authorizes services provided by ~~c~~Contiguous-~~a~~Area ~~h~~Hospitals, less than 75 miles from the Oregon border, following the same rules and procedures governing in-state ~~p~~Providers.¶
(5) Transfers to another ~~h~~Hospital:¶
(a) Transfers for the purpose of providing a service listed in the Medical-Surgical Services program rules, specifically OAR 410-130-0200, Table 130-0200-1, e.g., inpatient physical rehabilitation care, require PA.~~-~~¶
(b) For transfers to a skilled ~~n~~Nursing ~~f~~Facility, intermediate care facility, or swing bed, contact Aging and People with Disabilities (APD). APD reimburses ~~n~~Nursing ~~f~~Facilities and swing beds through contracts with the facilities. For CCO ~~client~~Members, transfers require authorization and payment (for first 20 days) from the CCO;¶
(c) For transfers for the same or lesser level inpatient care to a general acute-care ~~h~~Hospital, the Division shall cover transfers, including back transfers that are primarily for the purpose of locating the patient closer to home and family, when the transfer is expected to result in significant social or psychological benefit to the patient:¶
(A) The assessment of significant benefit shall be based on the amount of continued care the patient is expected to need (at least seven days) and the extent to which the transfer locates the patient closer to familial support;¶
(B) Payment for transfers not meeting these guidelines may be denied on the basis of post-payment review.¶
(d) Exceptions:¶
(A) Emergency transfers do not require PA;¶
(B) In-state or contiguous non-emergency transfers for the purpose of providing care that is unavailable in the transferring ~~h~~Hospital do not require PA unless the planned service is listed in the Medical-Surgical Service Program rules, specifically OAR 410-130-0200, Table 130-0200-1;¶
(C) All non-urgent transfers to out-of-state, non-contiguous ~~h~~Hospitals require PA.¶
(6) Dental procedures provided in a ~~h~~Hospital setting:¶
(a) For ~~p~~Prior ~~a~~Authorization requirements, see the Division's Dental Services Program rules; specifically OAR 410-123-1260 and 410-123-1490;¶
(b) Emergency dental services do not require PA;¶

(c) For ~~p~~Prior ~~a~~Authorization for ~~fee-for-service client~~Open Card Members, contact the Division's Dental Services Program analyst. (See the Division's Dental Services Program Supplemental information, http://www.oregon.gov/OHA/HSD/OHP/Pages/Policy-Dental.aspx);¶
(d) For ~~clients enrolled in a CCO, contact the client's health plan~~CCO Members, contact the CCO.¶
(7) Long-term acute care (LTAC) hospital services authorization requirements:¶
(a) For an initial ~~thirty~~30-day stay:¶
(A) LTAC ~~p~~Provider must, before admitting the ~~client~~Member, submit a request for ~~p~~Prior ~~a~~Authorization to the Division;¶
(B) Include sufficient medical information to justify the requested initial stay;¶
(C) Meet the clinical criteria outlined in the LTAC Hospital guide at: http:www.oregon.gov/OHA/HSD/OHP/Pages/Policy-Hospital.aspx.¶
(b) Extension of stay:¶
(A) Submit request for ~~p~~Prior ~~a~~Authorization to the Division;¶
(B) Include sufficient medical justification for the extended stay.
Statutory/Other Authority: ORS 413.042
Statutes/Other Implemented: ORS 414.065

AMEND: 410-125-0085

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

CHANGES TO RULE:

410-125-0085
Outpatient Services ¶

(1) Outpatient services that may require ~~p~~Prior ~~a~~Authorization (PA) include (see the individual program in the ~~Authority's Health Systems Division (Division)~~Division) Oregon Administrative Rules:¶
(a) Physical Therapy (chapter 410, division 131);¶
(b) Occupational Therapy (chapter 410, division 131);¶
(c) Speech Therapy (chapter 410, division 129);¶
(d) Audiology (chapter 410, division 129);¶
(e) Hearing Aids (chapter 410, division 129);¶
(f) Dental Procedures (chapter 410, division 123);¶
(g) Drugs (chapter 410, division 121);¶
(h) Apnea monitors, services, and supplies (chapter 410, division 122);¶
(i) Home Parenteral/Enteral Therapy (chapter 410, division 148);¶
(j) Durable Medical Equipment and Medical supplies (chapter 410, division 122);¶
(k) Certain ~~h~~Hospital services.¶
(2) The National Drug Code (NDC) must be included on the electronic (837I) and paper (UB 04) claims for ~~p~~Physician administered drug codes required by the Deficit Reduction Act of 2005.¶
(3) Outpatient surgical procedures:¶
(a) For C~~oordinated Care Organization (CCO) m~~CO Members: Contact the CCO. The CCO may have different PA requirements than the Division. Some services are not covered under CCO contracts and require PA from the Division, or the Division's Dental Services program analyst;¶
(b) For Medicare ~~client~~Members enrolled in a CCO: These services must be authorized by the CCO even if Medicare is the primary payer. Without this authorization, the ~~p~~Provider may not be paid beyond any Medicare payments (see also OAR 410-125-0103);¶
(c) For ~~fee-for-service client~~Open Card Members on the OHP Plus ~~b~~Benefit ~~p~~Package:¶
(A) Surgical procedures listed in OAR 410-125-0080 require PA when performed in an outpatient or day surgery setting, unless they are urgent or emergent;¶
(B) Contact the Division for PA (unless indicated otherwise in OAR 410-125-0080).¶
(d) Out-of-State services: Outpatient services provided by ~~h~~Hospitals located less than 75 miles from the border of Oregon do not require PA unless specified in the Division's Hospital Services Program rules. All non-urgent or non-emergent services provided by ~~h~~Hospitals located more than 75 miles from the border of Oregon require PA. For ~~clients enrolled in a CCO~~CCO Members, contact the CCO for authorization. For ~~client~~Members not enrolled in a health plan, contact the Division's Provider Clinical Support Unit.¶
(4) Psychiatric Emergency Services (PES):¶
(a) Psychiatric emergency services as defined by OAR 309-023-0110 delivered in a PES facility as described in OAR 309-023-0120 shall be reimbursed for a maximum of 20 hours per admittance;¶
(b) Psychiatric emergency services shall be reimbursed with a bundled, hourly rate using a fee-for-service rate methodology that is based on rates paid for similar services, using similar ~~p~~Providers at a similar level-of-care.¶
(5) High-Cost Drug Carve-Out (HCDCO) products:~~-~~¶
(a) Drugs and biologics included in the HCDCO referenced in OAR 410-141-3855 will be carved out from the inpatient Diagnosis Related Grouper (DRG) and will be reimbursed on an outpatient claim when drugs are administered during an inpatient stay.~~-~~¶
(b) The A~~genc~~uthority will reimburse for HCDCO drugs and biologics billed on an outpatient claim at the actual ~~a~~Acquisition ~~c~~Cost according to invoice, up to Wholesale Acquisition Cost (WAC).~~-~~¶
(6) Long-Acting Reversible Contraceptives (LARCs):~~-~~¶
(a) LARCs will be carved out from the inpatient Diagnosis Related Grouper (DRG) and will be reimbursed on an outpatient claim when they are administered during an inpatient stay.~~-~~¶
(b) The A~~genc~~uthority will reimburse the LARCs billed on an outpatient claim at the Wholesale Acquisition Cost (WAC).
Statutory/Other Authority: ORS 413.042
Statutes/Other Implemented: ORS 414.065

AMEND: 410-125-0086

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

CHANGES TO RULE:

410-125-0086
Prior Authorization for FCHP/MHO ~~Client~~Members ¶

Most non-emergent inpatient and outpatient services require ~~p~~Prior ~~a~~Authorization by a Fully Capitated Health Plan (FCHP) or a Mental Health Organization (MHO). Emergency ~~h~~Hospital services must be covered by an FCHP or MHO without regard to ~~p~~Prior ~~a~~Authorization or the emergency care ~~p~~Provider's contractual relationship with the FCHP or MHO. Emergency ~~h~~Hospital services are defined as covered inpatient and outpatient services that are needed to evaluate or stabilize an emergency medical condition. Once a ~~client~~Member's condition is considered stabilized, or a medical screening examination has determined that the ~~client~~Member's medical condition is not emergent, an FCHP or MHO may require ~~p~~Prior ~~a~~Authorization for ~~h~~Hospital admission, follow-up care, or further treatment. Failure to obtain ~~p~~Prior ~~a~~Authorization from the FCHP or MHO may result in a denial of payment for services. Contact the ~~client~~Member's FCHP or MHO for further information on ~~p~~Prior ~~a~~Authorization.
Statutory/Other Authority: ORS 413.042
Statutes/Other Implemented: ORS 414.065

AMEND: 410-125-0102

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

CHANGES TO RULE:

410-125-0102
Medically Needy ~~Client~~Members ¶

(1) The QIO can give ~~p~~Prior ~~a~~Authorization for non-emergency inpatient services for ~~client~~Members who are in the Medically Needy Program but have not yet met their spend-down. Only Medically Needy Program ~~client~~Members under age 21 and pregnant ~~women~~individuals have coverage for inpatient services if enrolled in the Medically Needy Program.¶
(2) Prior ~~a~~Authorization cannot be granted for outpatient services, which require ~~p~~Prior ~~a~~Authorization. However, you may contact the Division Medical/ Dental Group once the ~~client~~Member has been made eligible and request retroactive authorization.
Statutory/Other Authority: ORS 413.042
Statutes/Other Implemented: ORS 414.065

AMEND: 410-125-0103

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

CHANGES TO RULE:

410-125-0103
Medicare ~~Client~~Members ¶

When Medicare is the primary payer, services provided in the inpatient or out-patient setting do not require ~~p~~Prior ~~a~~Authorization. However, if the Division is the primary payer because the service is not covered by Medicare; the ~~p~~Prior ~~a~~Authorization requirements listed in chapter 410 division 125 would apply.
Statutory/Other Authority: ORS 413.042
Statutes/Other Implemented: ORS 414.065

AMEND: 410-125-0120

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

CHANGES TO RULE:

410-125-0120
Transportation To and From Medical Services ¶

(1) Transportation to and from medical services, including ~~h~~Hospital services, is a ~~c~~Covered ~~s~~Service. However, all non-emergency transports require prior authorization in order for the transportation ~~p~~Provider to be paid.¶
(2) Interfacility transfers are defined as bed optimization and balancing resource management strategies for the purpose of patient movement across a health network system. The transfer of patients between ~~h~~Hospitals, f~~r~~om ~~h~~Hospitals to specialized care facilities, or bed to bed lateral transfers within the same health ~~p~~Provider network system.¶
(a) Interfacility transfers are not a ~~c~~Covered ~~s~~Service by the A~~genc~~uthority unless they meet ~~m~~Medically ~~n~~Necessary criteria.¶
(b) Interfacility transfers are considered ~~m~~Medically ~~n~~Necessary when one or more of the following criteria are met:¶
(A) The patient requires ~~m~~Medically ~~n~~Necessary diagnostic or therapeutic services that are not available at the originating facility; or¶
(B) The patient requires a higher-level of care which is not available at the originating facility; or¶
(C) The patient has received care at a prior facility for a condition that is not normally managed at the originating facility and the return to the prior facility is needed to diagnose, manage, or treat a complication or other ~~a~~Acute issue.¶
(3) The transportation must be the least expensive obtainable under existing conditions and appropriate to the ~~client~~Member's needs.¶
(4) Contact the Division-contracted regional Transportation Brokerage (Brokerage) for ~~p~~Prior ~~a~~Authorization for the transport or instruct the transportation ~~p~~Provider to contact the Brokerage. Brokerage map and contact information is available at
https://www.oregon.gov/oha/HSD/OHP/Tools/Transportation%20Brokerage%20Map.pdf¶
(5) Hospitals must follow the after~~-~~-hours procedures for the Brokerages and contact the appropriate after~~-~~-hours ~~p~~Providers for non-emergent transportation for ~~h~~Hospital discharges.¶
(6) No ~~p~~Prior ~~a~~Authorization is required when the ~~client~~Member's condition requires emergency transport.¶
(7) When a ~~h~~Hospital sends a patient to another facility or ~~p~~Provider during the course of an inpatient stay and the ~~client~~Member is returned to the admitting ~~h~~Hospital within 24 hours, the ~~h~~Hospital must arrange for and pay for the transportation. See billing instructions contained in the Hospital Supplemental Information on the Division website for additional information.
Statutory/Other Authority: ORS 413.042
Statutes/Other Implemented: ORS 414.065

AMEND: 410-125-0124

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

CHANGES TO RULE:

410-125-0124
Retroactive Authorization ¶

Retroactive authorization for payment can be granted after the service is provided only in the following circumstances:¶
(1) The ~~person~~individual was not yet eligible for Medicaid/CHIP at the time the services were provided. Payment can be made if the services are covered Medicaid/CHIP services and the ~~client~~Member's eligibility is extended back to the date the ~~h~~Hospital provided services. See~~:~~ the Hospital Services Supplemental Information on the Division ~~of Medical Assistance Programs (Division)~~ website for additional billing information.¶
(2) If another insurer denied the claim because the service is not covered by that insurer, and the ~~h~~Hospital did not seek ~~p~~Prior ~~a~~Authorization because it had good reason to believe the service was covered by the insurer. Payment can be made by the Division if the services are covered by Medicaid. See~~:~~ the Hospital Services Supplemental Information on the Division website for additional billing information.
Statutory/Other Authority: ORS 413.042
Statutes/Other Implemented: ORS 414.065

AMEND: 410-125-0140

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

CHANGES TO RULE:

410-125-0140
Prior Authorization Does Not Guarantee Payment ¶

(1) Prior ~~a~~Authorization (PA) is valid for the date range approved only as long as the ~~client~~Member remains eligible for services. For example, a ~~client~~Member may become ineligible after the PA has been granted but before the actual ~~d~~Date of ~~s~~Service, or a ~~client~~Member's ~~h~~Hospital benefit days may be used prior to the time the claim for the ~~p~~Prior ~~a~~Authorized service is submitted to the Division~~ of Medical Assistance Programs (Division)~~ for payment.¶
(2) All ~~p~~Prior ~~a~~Authorized treatment are subject to retrospective review. If the information provided to obtain PA cannot be validated in a retrospective review, payment shall be denied or recovered.¶
(3) Hospitals should develop their own internal monitoring system to determine if the admitting ~~p~~Physician has received PA for the service from the Division.¶
(4) For the Plus Benefit Package PA information refer to the PA chart in the Hospital Services Program OAR 410-125-0080.¶
(5) Hospitals may also verify PA requirements by calling the Division's Provider Services Unit or the RN Benefit Hotline (contact phone numbers are located on the Division's website).
Statutory/Other Authority: ORS 413.042
Statutes/Other Implemented: ORS 414.065

AMEND: 410-125-0141

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

CHANGES TO RULE:

410-125-0141
DRG Rate Methodology ¶

(1) Diagnosis Related Groups, (DRG):¶
(a) The DRG is a system of classification of diagnoses and procedures based on the International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM);¶
(b) The DRG classification methodology assigns a DRG category to each inpatient service, based on the patient's diagnoses, age, procedures performed, length of stay, and discharge status.¶
(2) Medicare Grouper: The Medicare Grouper is the software used to assign an individual claim to a DRG category. Medicare revises the Grouper program each year in October. The Agency uses the Medicare Grouper program in the assignment of inpatient ~~h~~Hospital claims. The most recent version of the Medicare grouper shall be installed each year within ~~ninety (~~90~~)~~ days of the date it is implemented by Medicare. Where better assignment of claims is achieved through changes to the grouper logic, the Agency may modify the logic of the grouper program. The Agency shall work with representatives of ~~h~~Hospitals that may be affected by grouper logic changes in reaching a cooperative decision regarding changes. The Agency DRG weight tables can be found on the Agency web site:¶
(a) Acute Care Hospitals larger than ~~fifty (~~50~~)~~ beds are considered DRG ~~h~~Hospitals and reimbursed using Medicare's MS-DRG grouper;¶
(b) Hospitals enrolled as ~~l~~Long-~~t~~Term ~~a~~Acute ~~c~~Care (LTAC) are reimbursed using Medicare's MS-LTC DRG grouper.¶
(c) Inpatient psychiatric adult and pediatric services are reimbursed using the most recent Medical Severity Diagnosis Related Groups, (MS-DRG), in Major Diagnosis Category, (MDC), MDC-19 and MDC-20 published by Medicare in the latest inpatient Prospective Payment System, (IPPS) final rule.¶
(3) DRG Relative Weights:¶
(a) Relative weights are a measure of the relative resources required in the treatment of the average case falling within a specific DRG category;¶
(b) For most DRGs, the Agency establishes a relative weight based on federal Medicare DRG weights. For state-specific Rehabilitation, and Neonate, Oregon Title XIX fee-for-service claims history is used. The Agency employs the following methodology to determine whether enough claims exist to establish a reasonable weight for each state-specific Rehabilitation, and Neonate, the Agency uses the following methodology: Using the formula N = ((Z * S)/ R)^2, where Z=1.15(a 75 percent confidence level), S is the standard deviation, and R = 10 percent of the mean. The Agency determines the minimum number of claims required to set a stable weight for each DRG (N must be at least 5). For state-specific Rehabilitation, and Neonate, lacking sufficient volume, the Agency sets a relative weight using:¶
(A) Agency non-Title XIX claims data; or¶
(B) Data from other sources expected to reflect a population similar to the Agency Title XIX caseload;¶
(c) When a test shows at the 90 percent confidence level that an externally derived weight is not representative of the average cost of services provided to the Agency Title XIX population in that DRG, the weight derived from the Agency Title XIX claims history is used instead of the externally derived weight for that DRG;¶
(d) Those relative weights based on Federal Medicare DRG weights shall be established when changes are made to the DRG Grouper logic. State-specific relative weights shall be adjusted, as needed, as determined by the Agency. When relative weights are recalculated, the overall Case Mix Index (CMI) shall be kept constant. Reweighing of DRGs or the addition or modification of the grouper logic shall not result in a reduction of overall payments or total relative weights.¶
(4) Case Mix Index: The hospital-specific case mix index is the total of all relative weights for all services provided by a ~~h~~Hospital during a period, divided by the number of discharges.¶
(5) Unit Value: Hospitals larger than ~~fifty~~50 beds or enrolled as a long-term acute care (LTAC) hospital are reimbursed using the DRG as described in section (2). Effective for services on or after:¶
(a) Effective October 1, 2009 the operating unit payment is 100 percent of the most recent version of the Medicare base payment rates. The Agency shall revise the base payment rates each year in October when Medicare posts the rates.¶
(b) DRG Payment: The DRG payment to each Oregon DRG ~~h~~Hospital or LTAC ~~h~~Hospital is calculated by adding the unit value to the capital amount, then multiplied by the claim assigned DRG relative weight (out-of-state hospitals

do not receive the capital amount).¶
(c) Effective January 1, 2025; the Agency shall establish separate unit values for inpatient psychiatric adult and pediatric services. The unit values shall apply to the DRGs published in the most recent Major Diagnostic Category (MDC) group 19 and 20 and be multiplied by the claim-assigned DRG relative weight. The adult and pediatric psychiatric unit values for each ~~h~~Hospital have been established as a percentage of the estimated Medicaid costs for inpatient hospital psychiatric services based on calendar year 2021 and 2022 Oregon inpatient hospital claims and the applicable Medicare cost reports.¶
(6) The unit values for inpatient psychiatric adult and pediatric services are adjusted for the location of the ~~h~~Hospital. The calculated labor portion of unit values are multiplied by the wage index as identified in the Medicare Inpatient Prospective Payment System Final Rule (IPPS Final Rule) to determine the location adjusted labor portion and the capital portion of the unit values are multiplied by the geographic adjustment factor as outlined in the IPPS Final Rule.~~-~~The total unit value for each hospital equals the sum of the wage-adjusted labor portion, the non-labor portion and geographic-adjusted capital portion shall be rebased every two (2) years or at the discretion of the Agency.~~-~~During non-rebase years, the adult and pediatric psychiatric unit values shall be updated using the Medicare increases in the Medicare market basket increases from the IPPS Final Rule effective October 1st of the non-rebase year.¶
(7) DRG Hospital Cost Outlier Payments:¶
(a) Cost outlier payments are an additional payment made to in-state and contiguous ~~h~~Hospitals for exceptionally costly services or exceptionally long lengths of stay provided to Title XIX and SF (State Facility) ~~client~~Members. As of January 1, 2025, outlier payments for inpatient hospital psychiatric services follow the methodology outlines in Section (10);¶
(b) The calculation to determine the cost outlier payment for Oregon DRG ~~h~~Hospitals is as follows:¶
(A) Non-~~c~~Covered ~~s~~Services (such as ~~a~~Ambulance charges) are deducted from billed charges;¶
(B) The remaining billed charges are converted to hospital-specific costs using the ~~h~~Hospital's cost-to-charge ratio derived from the most recent audited Medicare cost report and adjusted to the Medicaid caseload;¶
(C) If the hospital's net costs as determined above are greater than 270 percent of the DRG payment for the admission and are greater than $25,000, an additional cost outlier payment is made;¶
(D) Costs which exceed the threshold ($25,000 or 270 percent of the DRG payment, whichever is greater) are reimbursed using the following formula:¶
(i) Billed charges less non-covered charges, multiplied by;¶
(ii) Hospital-specific cost-to-charge ratio equals;¶
(iii) Net Costs, minus;¶
(iv) 270 percent of the DRG or $25,000 (whichever is greater), equals;¶
(v) Outlier Costs, multiplied by;¶
(vi) Cost Outlier Percentage, (cost outlier percentage is 50 percent), equals;¶
(vii) Cost Outlier Payment;¶
(E) Third-~~-~~party reimbursements are deducted from the Agency calculation of the payable amount;¶
(F) When ~~h~~Hospital cost reports are audited during the cost settlement process, an adjustment shall be made to cost outlier payments to reflect the actual Medicaid hospital-specific cost-to-charge ratio during the time cost outlier claims were incurred. The cost-to-charge ratio in effect for that period of time shall be determined from the audited Medicare Cost Report and cost statement template, adjusted to reflect the Medicaid mix of services.¶
(8) LTAC Short Stay Outliers: Occurs when a covered length of stay is between one day and up to and including 5/6ths of the average length of stay for the LTC-DRG grouping. The Short Stay Outlier payment for the hospital shall be the lesser of:¶
(a) Per Diem for Short Stay Outlier Calculation:¶
(A) MS-LTC DRG payment, divided by;¶
(B) Geometric Length of Stay (GLOS,) multiplied by;¶
(C) Actual length of stay, multiplied by;¶
(D) 120 percent equals;¶
(E) Per Diem payment;¶
(b) Full MS-LTC DRG payment.¶
(9) LTAC High Cost Outliers: Are an additional payment when the estimated cost of a claim exceeds the outlier threshold (LTC DRG payment plus a fixed loss amount):¶
(a) The fixed loss amount is published annually by Medicare;¶
(b) If the estimated cost of a claim is greater than the outlier threshold, an additional payment is added to the LTC DRG payment;¶
(c) The outlier payment is 80 percent of the difference between the estimated cost of the claim and the outlier threshold (LTC DRG payment plus the fixed loss amount);¶
(d) The estimated cost of the claim is calculated by multiplying the Agency's allowable charge on the claim by the

~~h~~Hospital's cost-to-charge ratio.¶
(10) Inpatient psychiatric adult and pediatric services day outlier payment:¶
(a) Effective for services on or after January 1, 2025; a day outlier shall be applied to inpatient psychiatric adult and pediatric services when the outlier threshold is met. The outlier threshold is a sliding scale starting at a length of stay ~~thirty (~~30~~)~~ days. The sliding scale determines the adjustment percentage for the calculation.¶
(b) Adjustment percentage sliding scale effective on or after January 1, 2025:¶
(A) Percentage scale for days of service 30-89 is 70 percent¶
(B) Percentage scale for days of service 90 plus is 50 percent¶
(11) Day outlier formula calculation effective on or after January 1, 2025:¶
(a) Unit value as defined in subsection (5)(c);¶
(b) Multiplied by the DRG weight equals DRG base payment;¶
(c) Divide DRG base payment by the arithmetic length of stay (ALOS), equals DRG per diem;¶
(d) DRG per diem multiplied by days over the 30-day threshold, equals DRG outlier;¶
(e) DRG day outlier times the DRG Day Outlier Percentage equals allowable DRG outlier.¶
(f) Formula, unit value (70 percent of Medicare) X DRG weight=DRG base payment/ DRG ALOS= DRG per diem X days over 30-day threshold= DRG outlier X DRG day outlier percentage= allowable DRG outlier.¶
(12) Capital:¶
(a) The capital payment is a reimbursement to in-state hospitals for capital costs associated with the delivery of services to Title XIX, non-Medicare persons. The Agency uses the Medicare definition and calculation of capital costs. These costs are taken from the Hospital Statement of Reimbursable Cost (Medicare Report); capital cost per discharge is calculated as follows:¶
(b) The capital cost per discharge is 100 percent of the current year Medicare capital rate for non-psychiatric services and updated every October thereafter, see section (5) of this rule. The capital cost is added to the Unit Value and paid per discharge for non-psychiatric services.¶
(c) There is no separate cost reimbursement for capital cost for adult and pediatric inpatient psychiatric services as it is captured in the unit value per subsection (5)(c).¶
(13) Direct Medical Education:¶
(a) The direct medical education payment is a reimbursement to in-state ~~h~~Hospitals for direct medical education costs associated with the delivery of services to Title XIX eligible persons. The Agency uses the Medicare definition and calculation of direct medical education costs. These costs are taken from the Hospital Statement of Reimbursable Cost (Medicare Report);¶
(b) Direct medical education cost per discharge is calculated as follows:¶
(A) The direct medical education cost proportional to the number of Title XIX non-Medicare discharges during the period from July 1, 1986, through June 30, 1987, are divided by the number of Title XIX non-Medicare discharges. This is the Title XIX direct medical education cost per discharge;¶
(B) The Title XIX direct medical education cost per discharge for this period is inflated forward to January 1, 1992, using the compounded HCFA-DRI market basket adjustment;¶
(c) Direct medical education payment per discharge:¶
(A) The number of Title XIX non-Medicare discharges from each hospital for the quarterly period is multiplied by the inflated Title XIX cost per discharge. This determines the current quarter's Direct Medical Education costs. This amount is then multiplied by 85 percent. Payment is made within ~~thirty~~30 days of the end of the quarter;¶
(B) The Direct Medical Education Payment per Discharge shall be adjusted at an inflation factor determined by the Department in consideration of inflationary trends, ~~h~~Hospital productivity, and other relevant factors.¶
(C) Notwithstanding section (9) of this rule, this subsection becomes effective for ~~d~~Dates of ~~s~~Service:¶
(i) On July 1, 2006, and thereafter direct medical education payments shall not be made to ~~h~~Hospitals; and¶
(ii) On July 1, 2008,and thereafter direct medical education payments shall be made to ~~h~~Hospitals.¶
(14) Indirect Medical Education:¶
(a) The indirect medical education payment is a reimbursement made to in-state hospitals for indirect medical education costs associated with the delivery of services to Title XIX non-Medicare ~~client~~Members;¶
(b) Indirect medical education costs are those indirect costs identified by Medicare as resulting from the effect of teaching activity on operating costs;¶
(c) Indirect medical education payments are made to in-state ~~h~~Hospitals determined by Medicare to be eligible for such payments. The indirect medical education factor in use by Medicare for each of these eligible ~~h~~Hospitals at the beginning of the state's fiscal year is the Agency indirect medical education factor. This factor is used for the entire Oregon Fiscal Year;¶
(d) For ~~d~~Dates of ~~s~~Service on and after March 1, 2004, the calculation for the Indirect Medical Education quarterly payment is as follows: Total paid discharges during the quarter multiplied by the Case Mix Index, multiplied by the hospital-specific February 29, 2004, Unit Value, multiplied by the Indirect Factor, equals the Indirect Medical Education Payment;¶

(e) Effective October 1, 2009, the calculation of the Indirect Medical Education quarterly payment is as follows: Total paid discharges during the quarter multiplied by the Case Mix Index, multiplied by the ~~h~~Hospital unit value, see subsection (5)(c) of this rule, multiplied by the indirect factor, equals the Indirect Medical Education Payment;¶
(f) This determines the current quarter's Indirect Medical Education Payment. Indirect medical education payments are made quarterly to each eligible ~~h~~Hospital. Payment for indirect medical education costs shall be made within ~~thirty (~~30~~)~~ days of the end of the quarter;¶
(g) Notwithstanding section (10) of this rule, this subsection becomes effective for ~~d~~Dates of ~~s~~Service:¶
(A) On July 1, 2006, and thereafter Indirect Medical Education payment shall not be made to ~~h~~Hospitals; and¶
(B) On July 1, 2008, and thereafter Indirect Medical Education payments shall be made to ~~h~~Hospitals.¶
[Publications: Publications referenced are available from the agency.]
Statutory/Other Authority: ORS 413.042
Statutes/Other Implemented: ORS 414.065

AMEND: 410-125-0210

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

CHANGES TO RULE:

410-125-0210
Third-Party Resources and Reimbursement ¶

(1) The Division ~~of Medical Assistance Programs (Division)~~ establishes maximum allowable reimbursements for all services. When ~~client~~Members have other ~~t~~Third-~~p~~Party ~~p~~Payers, the payment made by that payer is deducted from the Division's maximum allowable payment.¶
(2) The Division will not make any additional reimbursement when a ~~t~~Third-~~p~~Party pays an amount equal to or greater than the Division's reimbursement. The Division will not make any additional reimbursement when a ~~t~~Third-~~p~~Party pays 100 percent of the billed charges, except when Medicare Part A is the primary payer.¶
(3) When Medicare is ~~P~~primary:¶
(a) The Division's calculates the reimbursement for these claims in the same manner as described in the Inpatient and Outpatient Rates Calculations Sections above;¶
(b) Payment is the Division allowable payment, less the Medicare payment, up to the amount of the deductible ~~and/~~or coinsurance due. For ~~client~~Members who are Qualified Medicare Beneficiaries the Division does not make any reimbursement for a service that is not covered by Medicare. For ~~client~~Members who are Qualified Medicare/Medicaid Beneficiaries Division payment is the Division's allowable, less the Part A payment up to the amount of the deductible due for services by either Medicare or Medicaid.¶
(4) When Medicare is ~~S~~secondary:¶
(a) An individual admitted to a ~~h~~Hospital may have Medicare Part B, but not Part A. The Division calculates the reimbursement for these claims in the same manner as described in the Inpatient Rates Calculations section above. Payment is the Division's allowable payment, less the Medicare Part B payment;¶
(b) An individual receiving services in the outpatient setting may have most services covered by Medicare Part B. The Division payment is the Division's allowable payment, less the Part B payment, up to the amount of the coinsurance and deductible due. For services provided in the outpatient setting which are not covered by Medicare, (for example, Take Home Drugs), the Division payment is the Division's allowable payment as calculated in the Outpatient Rates Calculation section above;¶
(c) Most Medicare-Medicaid ~~client~~Members have Medicare Part A, Part B, and full Medicaid coverage. The Division refers to these ~~client~~Members as Qualified Medicare-Medicaid Beneficiaries (QMM). However, a few individuals have Medicare coverage and only limited additional coverage through Medicaid. ~~t~~The Division refers to these ~~client~~Members as Qualified Medicare Beneficiaries (QMB). For QMB ~~client~~Members, the Division does not make reimbursement for a service that is ~~a~~ not a covered service for Medicare.¶
(d) ~~Client~~Members who are Qualified Medicare-Medicaid Beneficiaries will have coverage for services that are not covered by Medicare if those services are covered by the Division.¶
(5) For ~~client~~Members with Physician Care Organization (PCO) or Prepaid Health Plan (PHP) Coverage, Division payment is limited to those services that are not the responsibility of the PCO or PHP. Payment is made at Division rates.¶
(6) Other Insurance:¶
(a) The Division pays the maximum allowable payment as described in the Inpatient and Outpatient Rates Calculations, less any ~~t~~Third-~~p~~Party payments;¶
(b) The Division will not make additional reimbursements when a ~~t~~Third-~~p~~Party ~~p~~Pay~~e~~er (other than Medicare) pays an amount equal to or greater than the Division reimbursement, or 100 percent of billed charges.¶
(7) Medically Needy with Spend-Down. Reimbursement is the Division's maximum allowable payment for ~~c~~Covered ~~s~~Services less the amount of the spend-down due.
Statutory/Other Authority: ORS 413.042
Statutes/Other Implemented: ORS 414.065

AMEND: 410-125-0230

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

CHANGES TO RULE:

410-125-0230
Qualified Directed Payments
Qualified Directed Payments (QDP) are payments made by the Oregon Health Authority (Authority) to Coordinated Care Organizations (CCOs) from three Quality and Access pools for distinct ~~p~~Provider classes as follows: (i) Rural Type A and Type B hospitals,~~-~~(ii) Public Academic Health Centers and (iii) DRG hospitals. Each provider class is defined in §438.6(c) Preprint forms approved by the U.S. Department of health and Human Services Centers for Medicare and Medicaid Services. QDPs are tied to inpatient and outpatient encounters with Medicaid and Children's Health Insurance Program (CHIP) ~~m~~CCO Members ~~enrolled in Coordinated Care Organizations~~. However, the Authority does not make Qualified Directed Payments for encounters with ~~m~~Members who received Citizenship Waived Medical (CWM) or CWM Plus Benefit Packages.¶
(1) Type A and Type B hospitals:¶
(a) The Authority shall make a qualified directed payment only if the Type A or Type B ~~h~~Hospital meets criteria established by the Authority for the Type A or Type B ~~h~~Hospital Quality and Access program in accordance with applicable federal requirements, which may be updated as needed.¶
(b) The Authority shall make a qualified directed payment for each inpatient and outpatient encounter; one encounter per ~~m~~CCO Member, per day, per facility;¶
(c) QDP amounts shall be at two separate rates; one for inpatient encounters and one for outpatient encounters;¶
(d) Payment rates shall be set by the Authority and may be adjusted based on actual utilization and available Quality and Access Funds;¶
(e) The Authority shall create a monthly report to assist CCOs in distributing funds to the appropriate ~~h~~Hospital. The report shall be distributed to each CCO and each Type A and Type B ~~h~~Hospital;¶
(f) Within five (5) business days after receipt of the monthly report, the CCO shall submit an electronic payment to an account established by the ~~h~~Hospital for the amount indicated on the report;¶
(g) Adjustments shall be processed weekly through the Medicaid payment system and included in the monthly report.¶
(2) Public Academic Health Centers:¶
(a) The Authority shall make a qualified directed payment only if the public academic medical center meets criteria established by the Authority for the Public Academic Medical Center Quality and Access program in accordance with applicable federal requirements, which may be updated as needed.¶
(b) The Authority shall make a qualified directed payment for each inpatient and outpatient encounter; one encounter per ~~m~~CCO Member, per day, per facility;¶
(c) QDP amounts shall be at two separate rates. One for inpatient encounters and one for outpatient encounters;¶
(d) Payment rates shall be set by the Authority and may be adjusted based on actual utilization and available Quality and Access Funds;¶
(e) The Authority shall combine the weekly encounters into a monthly report to assist CCOs in distributing the funds to the appropriate ~~h~~Hospital. The report shall be distributed to each CCO and public academic health center;¶
(f) Within five (5) business days after receipt of the monthly report, the CCO shall submit an electronic payment to an account established by each public health center for the amount indicated on the report;¶
(g) Adjustments shall be processed weekly through the Medicaid payment system and included in the monthly report.¶
(3) Diagnosis Related Grouper (DRG) Hospitals:¶
(a) The Authority shall make a qualified directed payment only if the DRG Hospital meets criteria established by the Authority for the DRG Hospital Quality and Access Pool program in accordance with applicable federal requirements, which may be updated as needed.¶
(b) The Authority shall make a qualified directed payment for each inpatient and outpatient encounter; one encounter per ~~m~~CCO Member, per day, per facility;¶
(c) QDP amounts shall be at two separate rates. One for inpatient encounters and one for outpatient encounters;¶
(d) Payment rates shall be set by the Authority and may be adjusted based on actual utilization and available Quality and Access Funds;¶
(e) The Authority shall create a monthly report to assist CCOs in distributing funds to the appropriate ~~h~~Hospital. The report shall be distributed to each CCO and each DRG ~~h~~Hospital;¶

(f) Within five (5) business days after receipt of the monthly report, the CCO shall submit an electronic payment to an account established by the ~~h~~Hospital for the amount indicated on the report;¶
(g) Adjustments shall be processed weekly through the Medicaid payment system and included in the monthly report.¶
(4) If an error is identified in the monthly report, the CCO shall make the payment based on the original amount provided in the report. The Authority shall identify separately the correction in the following month's report and adjust the total payment amount to account for the error.
Statutory/Other Authority: ORS 413.042, ORS 414.869
Statutes/Other Implemented: ORS 414.869

AMEND: 410-125-0360

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

CHANGES TO RULE:

410-125-0360
Definitions and Billing Requirements ¶

(1) Total days on an inpatient claim must equal the number of accommodation days. Do not count the day of discharge when calculating the number of accommodation days.¶
(2) Inpatient services are reimbursed based on the admission date and discharge diagnosis.¶
(3) Inpatient services are services to patients who typically are admitted to the ~~h~~Hospital before midnight and listed on the following day's census, with the following exceptions:¶
(a) A patient admitted and transferred to another ~~a~~Acute care ~~h~~Hospital on the same day is considered an inpatient;¶
(b) A patient who expires on the day of admission is an inpatient; and¶
(c) Births.¶
(4) Outpatient services:¶
(a) Outpatient services are services to patients who are treated and released the same day;¶
(b) Outpatient services also include services provided prior to midnight and continuing into the next day if the patient was admitted for ambulatory surgery, admitted to a birthing center, a treatment or observation room, or a short term stay bed;¶
(c) Outpatient observation services are services provided by a ~~h~~Hospital, including the use of a bed and periodic monitoring by ~~h~~Hospital nursing or other staff for the purpose of evaluation of a patient's medical condition. A maximum of 48 hours of outpatient observation shall be reimbursed. An outpatient observation stay that exceeds 48 hours shall be billed as inpatient; and¶
(d) Outpatient observation services do not include the following:¶
(A) Services provided for the convenience of the patient, patient's family or ~~p~~Physician but that are not ~~m~~Medically ~~n~~Necessary;¶
(B) Standard recovery period; and¶
(C) Routine preparation services and recovery for diagnostic services provided in a ~~h~~Hospital outpatient department.¶
(5) Outpatient and inpatient services provided on the same day: If a patient receives services in the emergency room or in any outpatient setting and is admitted to an ~~a~~Acute care bed in the same ~~h~~Hospital on the same day, combine the emergency room and other outpatient charges related to that admission with the inpatient charges. Bill on a single UB-04 for both inpatient and outpatient services provided under these circumstances:¶
(a) If on the day of discharge, the ~~client~~Member uses outpatient services at the same ~~h~~Hospital, these shall be billed on the UB-04 along with other inpatient charges, regardless of the type of service provided or the diagnosis of the ~~client~~Member. Prescription medications provided to a patient being discharged from the ~~h~~Hospital may be billed separately as outpatient Take Home Drugs if the patient receives more than a three-day supply;¶
(b) Inpatient and outpatient services provided to a ~~client~~Member on the same day by two different ~~h~~Hospitals shall be reimbursed separately. Each ~~h~~Hospital shall bill for the services provided by that ~~h~~Hospital;¶
(c) Inpatient and psychiatric emergency services (PES) as defined in OAR 309-023-0110 provided to the patient on the same day, whether in the same ~~h~~Hospital or two different ~~h~~Hospitals, shall be reimbursed separately.¶
(6) Outpatient procedures that result in an inpatient admission: If, during the course of an outpatient procedure, an emergency develops requiring an inpatient stay, place a "1" in the Type of Admission field. The principal diagnosis should be the condition or complication that caused the admission. Bill charges for the outpatient and inpatient services together.¶
[ED. NOTE: Forms referenced are available from the agency.]
Statutory/Other Authority: ORS 413.042
Statutes/Other Implemented: ORS 414.065

AMEND: 410-125-0450

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

CHANGES TO RULE:

410-125-0450
Provider Preventable Conditions ¶

(1) Health Care-Acquired Conditions (HCAC):¶
(a) Formally known as Medicare's list of "hospital acquired conditions" (HAC) that apply to inpatient ~~h~~Hospital settings with dates of admission on or after January 1, 2011 except those ~~h~~Hospitals exempt from the reporting requirements.¶
(b) For inpatient ~~h~~Hospital admissions on or after July 1, 2012, all in-state, contiguous and non-contiguous ~~h~~Hospitals must report health care-acquired conditions.¶
(A) A HCAC is a condition that is reasonably preventable and was not present or identified at the ~~h~~Hospital admission.¶
(B) A "present on admission" (POA) indicator is a status code the ~~h~~Hospital uses on an inpatient claim that indicates if a condition was present at the time the order for inpatient admission occurs. A POA indicator can also identify a condition that developed during an outpatient encounter. This includes, but is not limited to the emergency department, observation, and outpatient surgery.¶
(C) The Division~~ of Medical Assistance Program (Division)~~ shall use the most recent list of conditions identified as non-payable by Medicare. The Division may revise through addition or deletion the selected conditions at any time during the fiscal year.¶
(D) Diagnosis-related groups (DRG) and percentage paid ~~h~~Hospitals must submit a POA indicator for the principal diagnosis and every secondary ~~d~~Diagnosis ~~c~~Code. A valid POA indicator must be included all inpatient ~~h~~Hospital claims. Claims without a valid POA indicator shall be denied.¶
(E) Critical Access Hospitals (CAH) must implement the POA reporting requirements by September 1, 2013.¶
(F) For a complete list of HCACs and billing instructions please see the hospital supplemental guide.¶
(2) Other Provider-Preventable Conditions (OPPC):¶
(a) Applies to any health care setting, including but not limited to inpatient and outpatient ~~h~~Hospital settings.¶
(b) Effective July 1, 2012 the Agency shall no longer cover the following conditions identified by the National Coverage Determinations (NCD):¶
(A) Wrong surgical or other invasive procedure performed on a patient;¶
(B) Surgical or other invasive procedure performed on the wrong body part;¶
(C) Surgical or other invasive procedure performed on the wrong patient.¶
(c) To protect the access to care the Division requires:¶
(A) No reduction in payment for a Provider Preventable Conditions (PPC) will be imposed on a ~~p~~Provider when an identified PPC for a ~~client~~Member existed prior to the initiation of treatment for that ~~client~~Member by that ~~p~~Provider.¶
(B) Reductions in ~~p~~Provider payment may be limited to the extent that the identified PPC would otherwise result in an increase in payment; and the Division reasonably isolate for nonpayment the portion of the payment directly related to treatment for, and related to the PPC.¶
(3) For ~~client~~Members with both Medicare and Medicaid (duals) the agency may not act as secondary payer for Medicare non-payment of HCAC.
Statutory/Other Authority: ORS 413.042
Statutes/Other Implemented: ORS 414.065

AMEND: 410-125-0640

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

CHANGES TO RULE:

410-125-0640
Third-Party Payers - Other Resources, ~~Client~~Member Responsibility and Liability ¶

(1) For Medicare~~: D~~, do not send claims to the Division ~~of Medical Assistance Programs (Division)~~ until the~~y~~ claim ha~~ve~~s been billed to and adjudicated by Medicare:¶
(a) ~~E~~The exception~~: T~~ to this section are take home drugs and other services, which are not covered by Medicare, and may be billed directly to the Division without billing Medicare first;¶
(b) ~~See: b~~Billing instructions are available in the Hospital Services Supplemental Information on the Division's website for additional information on billing Medicare claims.¶
(2) ~~O~~For other ~~I~~insurance~~. W~~, with the exception of services described in the ~~G~~general ~~R~~rules (OARs chapter 410, division 120), bill all other insurance first before billing the Division. Report the payments made by the other insurers.¶
(3) Motor vehicle accident fund:¶
(a) Enter 01 (Auto Accident) in the Occurrence Code Block and give the date of the accident;¶
(b) For all other ~~client~~Members, bill all other resources before billing the Division. Do not bill the Motor Vehicle Accident Fund.¶
(4) Employment Related Injuries: Enter 04 (Employment Related Accident) in the Occurrence Code Block and give the date of the injury.¶
(5) Liability:¶
(a) Liability refers to insurance that provides payment based on legal liability for injuries or illness or damages to property. It includes, but is not limited to, automobile liability insurance, uninsured and underinsured motorist insurance, homeowners' liability insurance, malpractice insurance, product liability insurance and general casualty insurance. It also includes payments under state "wrongful death" statutes that provide payment for medical damages;¶
(b) The ~~p~~Provider may bill the insurer for liability prior to billing the Division. The ~~p~~Provider may not bill both the Division and the insurer;¶
(c) The ~~p~~Provider may bill the Division after receiving a payment denial from the insurer; however, the Division billing must be within 12 months of ~~d~~Date of ~~s~~Service. Payment accepted from Division is payment in full;¶
(d) The ~~p~~Provider may bill the Division without billing the liability insurer. However, payment accepted from the Division is payment in full. The payment made by the Division may not later be returned in order to pursue payment from the liability insurer. When the ~~p~~Provider bills the Division, the ~~p~~Provider agrees not to place any lien against the ~~client~~Member's liability settlement;¶
(e) The ~~p~~Provider has 12 months from the ~~d~~Date of ~~s~~Service to bill the Division. No payment will be made by Division under any circumstances once the one-year limit has passed if no billing has been received within that time.¶
(6) ~~A~~For adoption agreements~~. A~~, adopting parents and~~/or an~~ adoption agency~~y~~ies may be considered a prior resource. In some instances, the Division makes reimbursement to ~~h~~Hospitals and other ~~p~~Providers for services provided to a ~~mother~~n individual whose baby is to be adopted. The Division may also make reimbursement for services provided to the infant. Some adoption agreements, however, stipulate that the adoptive parents will make payment for part or all of the medical costs for the ~~mother and/or~~individual, the child, or both. In these instances, the adoptive parent(s) ~~and/or agency~~, agency, or both, are a third-party resource and should be billed before billing the Division for this service.¶
(7) Veteran's Administration benefits:¶
(a) Some ~~client~~Members have limited benefits through the Veterans' Administration. Hospitals must bill the Veterans' Administration for VA ~~c~~Covered ~~s~~Services before billing the Division;¶
(b) The Veterans' Administration requires notification within 72 hours of an emergency admission to a non-VA hospital.¶
(8) ~~T~~For trust funds~~. S~~, some individuals will have trust funds that will pay for medical expenses. Occasionally a special trust fund will be set up to pay for extraordinary medical expenses, such as a transplant. These, and other trusts which pay medical expenses, are considered a prior resource. Bill the trust fund prior to billing the Division for services that are covered by the trust fund.¶
(9) ~~Billing the client.~~ A ~~p~~Provider may bill the ~~client~~Member or any financially responsible relative or

~~r~~Representative of that individual only as allowed in OAR 410-120-1~~28~~350.¶
(10) The ~~h~~Hospital may not bill the ~~client~~Member under the following circumstances:¶
(a) For services which are covered by the Division;¶
(b) For services for which the Division has made payment;¶
(c) For services billed to the Division for which no payment is made because third~~-~~-party reimbursement exceeds the Division maximum allowed amount;¶
(d) For any deductible, coinsurance or co-pay amount; or¶
(e) For services for which the Division has denied payment to the ~~h~~Hospital as a result of one of the following:¶
(A) The hospital failed to supply the correct information to the Division to allow processing of the claim in a timely manner as described in these rules and the ~~G~~general ~~R~~rules (OARs chapter 410, division 120);¶
(B) The ~~h~~Hospital failed to obtain ~~p~~Prior ~~a~~Authorization as described in these rules;¶
(C) The service provided by the ~~h~~Hospital was determined by or the Division not to be ~~m~~Medically ~~a~~Appropriate; or¶
(D) The service provided by the ~~h~~Hospital was determined by the QIO not to be ~~m~~Medically ~~a~~Appropriate, necessary, or reasonable.
Statutory/Other Authority: ORS 413.042
Statutes/Other Implemented: ORS 414.065

AMEND: 410-125-1060

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

CHANGES TO RULE:

410-125-1060
Fiscal Audits ¶

(1) Year-end fiscal audits will include retrospective examination and verification of claims and the determination of allowable charges and costs of ~~h~~Hospital services provided to Division ~~client~~Members.¶
(2) The principal source document for the fiscal audit of Title XIX/Title XXI and General Assistance patient billings and payments for a given fiscal period is the Division's data processing printout. This printout includes all transactions for the audit period. Using gross totals from this printout and applying other information from Division records, information received from the ~~h~~Hospital, and other sources, the Division will compile detailed schedules of adjustments and revise the gross totals. A revised Calculation of Reasonable Cost Statement (DMAP 42) will be prepared using revised totals and information from the Medicare report.¶
(3) Cost Settlements: The Division will send the ~~h~~Hospital a letter stating the amount of underpayment or ~~o~~Overpayment calculated by the Division for the fiscal year examined. The letter will also state the ~~h~~Hospital's inpatient/outpatient interim reimbursement rate for the period from the effective date of the change until the next fiscal year's audit is completed. Payment of the cost-settlement amount is due and payable within 30 days from the date of the letter.¶
(4) The Division, at its discretion, may grant a ~~thirty-day (30)~~30-day extension for the purpose of reviewing the cost settlement upon a written request by the ~~h~~Hospital. If a ~~thirty-day (30)~~30-day extension is granted, payment of the cost settlement amount is due within ~~sixty (~~60~~)~~ days from the date of the letter. If the ~~p~~Provider chooses to appeal the decision or rate, a written request for an administrative review, or contested case must be received by the Division within ~~thirty (~~30~~)~~ days of the date of the letter notifying the ~~h~~Hospital of the settlement amount and interim rate, or within ~~sixty (~~60~~)~~ days if the Division has granted a ~~thirty (~~30~~)~~ day extension, not withstanding the time limits in OAR 410-120-1580(3) or 410-120-1660(1). Upon receipt of the request, the Division will attempt to resolve any differences informally with the ~~p~~Provider before scheduling the administrative review or hearing.¶
(5) Under extraordinary circumstances, the Division, at its discretion, may negotiate a repayment schedule with a ~~h~~Hospital. The ~~h~~Hospital may be required to submit additional information to support the ~~h~~Hospital's request for a repayment schedule. The ~~h~~Hospital will be required to pay interest associated with extended payments granted by the Division.¶
(6) The revised Calculation of Reasonable Cost, copies of adjustment schedules, and a copy of the printout are available to the ~~h~~Hospital upon request. For Type A ~~r~~Rural ~~h~~Hospitals the Calculation of Reasonable Cost Statement will reflect the difference between payment at 100% of costs and payment for ~~d~~Dates-of-~~s~~Services on or after January 1, 2006 under the fee schedule for clinical laboratory services provided by the ~~h~~Hospital. An adjustment to the Cost Settlement will be made to reimburse a Type A ~~h~~Hospital at 100% of costs for laboratory and radiology services provided to Medical Assistance Program ~~client~~Members during the period the ~~h~~Hospital was designated a Type A ~~h~~Hospital. Settlements to Type B and Critical Access ~~h~~Hospitals will be made within the legislative appropriation.¶
(7) The adjusted Professional Component Cost-to-Charge ratio(s) will be applied to all corresponding revenue code charges as listed on the Hospital Claim Detail Reports for cost settlements finalized on or after October 1, 1999.¶
(8) Hospital Based Rural Health Clinics shall be subject to the rules in the Hospital Services for the Oregon Health Plan Guide for Type A and B Hospitals. Hospital Based Rural Health Clinics cost settlements for dates of service from January 1, 2001 shall be finalized to cost.¶
(9) No interim settlements will be made. No settlements will be made until after receipt and review of the audited Medicare cost report.
Statutory/Other Authority: ORS 413.042
Statutes/Other Implemented: ORS 414.065

AMEND: 410-125-1070

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

CHANGES TO RULE:

410-125-1070
Type A and Type B Hospitals ¶

(1) Type A and Type B ~~h~~Hospitals must submit the following information to the Division:¶
(a) The aggregate percent increase in patient charges and the effective date of the increase within 30 days following the end of their fiscal year for increases in the preceding year. Aggregate percent increase in patient charges is defined as the percent increase in patient revenues due to charge increases; and¶
(b) The amount of payment received by the ~~h~~Hospital, from each Division-contracted managed care plan and ~~t~~Third-~~p~~Party ~~p~~Payers, for inpatient and outpatient ~~h~~Hospital services provided to ~~managed care m~~CCO Members, within the ~~h~~Hospital's fiscal year.¶
(2) When a ~~h~~Hospital is contracted with a Prepaid Health Plan (PHP), within ~~thirty (~~30~~)~~ days of the Division's request the ~~h~~Hospital will supply the Division the following information:¶
(a) The name of the contracting PHP; and¶
(b) The dates for which the contract will be effective; and¶
(c) The contracted services and reimbursement rates.¶
(3) The hospital and PHP must coordinate payment information to verify and return the PHP payment data file sent by the Division within ~~ninety (~~90~~)~~ days from date the data file is received by the ~~h~~Hospital.¶
(4) Failure to supply the requested information within timelines stated may result in a discretionary sanction or fine (see OAR 410-120-1440). No ~~s~~Sanction or fine will be imposed if the Division determines, at its sole discretion, that the ~~h~~Hospital was unable to coordinate payment information with the PHP through no fault of the ~~h~~Hospital's own.
Statutory/Other Authority: ORS 413.042
Statutes/Other Implemented: ORS 414.065