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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: 10/22/2026 9:50 AM
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
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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:
Meeting ID: 165 867 1365
Passcode: 215425

NEED FOR THE RULE(S):

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

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

DOCUMENTS RELIED UPON, AND WHERE THEY ARE AVAILABLE:

None

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

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

FISCAL AND ECONOMIC IMPACT:

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

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

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

(2) Effect on Small Businesses:
None.

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

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

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

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

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

WAS AN ADMINISTRATIVE RULE ADVISORY COMMITTEE CONSULTED? YES

RULES PROPOSED:

410-147-0000, 410-147-0020, 410-147-0040, 410-147-0060, 410-147-0080, 410-147-0085, 410-147-0140, 410-147-0160, 410-147-0180, 410-147-0200, 410-147-0260, 410-147-0280, 410-147-0360, 410-147-0380, 410-147-0460, 410-174-0010, 410-174-0020, 410-174-0030

AMEND: 410-147-0000

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

CHANGES TO RULE:

410-147-0000
Foreword ¶

(1) The Division~~ of Medical Assistance Programs" (Division)~~ Federally Qualified Health Center (FQHC) and Rural Health Clinic (RHC) rules are designed to assist FQHCs and RHCs to deliver health care services and prepare health claims for ~~clients with Medical Assistance Program coverage~~Members.¶
(2) The FQHC and RHC rules contain important information including general program policy, provider enrollment, and maintenance of financial records, special programs, and billing information.¶
(3) It is the clinic's responsibility to understand and follow all Division rules that are in effect on the date services are provided.¶
(4) Typically rules are modified twice a year, April for technical changes and October for technical and/or program changes. Technical changes refer to operational information. All ~~p~~Provider rules can be found on the Division website.¶
(5) FQHCs and RHCs must use rules contained in the FQHC and RHC rules. Do not use other ~~p~~Provider rules unless specifically directed in rules contained in the FQHC and RHC rules. Division ~~G~~general ~~R~~rules (chapter 410, division 120) and the Oregon Health Plan (OHP) Administrative Rules (chapter 410, division 141) are intended to be used in conjunction with all program rules including the FQHC and RHC ~~p~~Provider rules.¶
(6) The ~~Health Services Commission's~~OHA Prioritized List of Health Services is found in ~~the OHP Administrative Rules (~~OAR 410-141-~~0520)~~3830 and defines the services covered under the Division.¶
(7) An FQHC is defined as a clinic that is recognized and certified by the Centers for Medicare and Medicaid Services (CMS) as meeting federal requirements as an FQHC.¶
(8) An RHC is defined as a clinic that is recognized and certified by CMS as meeting federal requirements for payment for RHC services.
Statutory/Other Authority: ORS 413.042, 414.065
Statutes/Other Implemented: ORS 414.065

AMEND: 410-147-0020

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

CHANGES TO RULE:

410-147-0020
Professional Ambulatory Services ¶

(1) Providers must use the following rules in conjunction with all individual program rules to determine service coverage and limitations for ~~Oregon Health Plan (OHP) client~~Members according to their ~~b~~Benefit ~~p~~Packages: Medical, EPSDT, Diagnostic, Dental, Vision, Physical Therapy, Occupational Therapy, Podiatry, Mental Health, Alcohol and Chemical Dependency, Maternity Case Management, Speech, Hearing, and Home Health services are governed by the Federally Qualified Health Center (FQHC) and Rural Health Clinic (RHC) rules (OAR 410 division 147), General Rules (410 division 120), OHP Administrative Rules (410-141-0480, 410-141-0500, and 410-141-0520), and the ~~Health Services Commission's (HSC)~~OHA Prioritized List of Health Services (OHA Prioritized List), and the Oregon Health Authority (Authority) rules related to ~~p~~Provider enrollment and claiming (943-120-0300 through 0380).¶
(2) Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) are eligible for reimbursement of covered professional services provided within the scope of the clinic and within the individual ~~p~~Practitioner's scope of license or certification. See also OAR 410-147-0120(6). For the purposes of this rule, a clinic's "scope" refers to authorization or certification to provide services if required:¶
(a) For FQHCs only, services must be provided in accordance with the FQHC's scope as approved by the Health Resources and Services Administration (HRSA) Notice of Grant Award Authorization; and¶
(b) Both FQHCs and RHCs must provide services within the scope of the Addictions and Mental Health Division (AMH) certification for the facility, if required. See OAR 410-147-0320(3) and (5).¶
(3) The ~~d~~Date of ~~s~~Service determines the appropriate version of the FQHC and RHC rules, ~~G~~general ~~R~~rules, and ~~HSC~~OHA Prioritized List to determine coverage.
Statutory/Other Authority: ORS 413.042, 414.065
Statutes/Other Implemented: ORS 414.065

AMEND: 410-147-0040

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

CHANGES TO RULE:

410-147-0040
ICD-10-CM Diagnosis and CPT/HCPCs Procedure Codes ¶

(1) The appropriate ICD-10-CM diagnosis code or codes from 001.0 through V99.9 must be used to identify:¶
(a) Diagnoses;¶
(b) Symptoms;¶
(c) Conditions;¶
(d) Problems;¶
(e) Complaints; or¶
(f) Other reasons for the encounter/visit.¶
(2) The Division~~ of Medical Assistance Program (DMAP)~~ requires diagnosis codes on all claims, including those submitted by independent laboratories and portable radiology, including nuclear medicine and diagnostic ultrasound providers. A clinic must always provide the ~~client~~Member's diagnosis to ancillary service providers when prescribing services, equipment, and supplies.¶
(3) Clinics must list the principal diagnosis in the first position on the claim. 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. Use a three-digit diagnosis code only if the diagnosis code is not further subdivided. Whenever fourth-digit or fifth-digit subcategories are provided, the ~~p~~Provider must report the diagnosis at that specificity. ~~DMAP~~The Division considers a diagnosis code invalid if it has not been coded to its highest specificity.¶
(5) ~~DMAP~~The Division requires ~~p~~Providers to use the standardized code sets required by the Health Insurance Portability and Accountability Act (HIPAA) and adopted by the Centers for Medicare and Medicaid Services (CMS). Unless otherwise directed in rule, ~~p~~Providers must accurately code claims according to the national standards in effect for the date the service(s) was provided:¶
(a) For dental services, use codes that are in effect for the date the service(s) was provided that are found in Dental Procedures and Nomenclature as maintained and distributed by the American Dental Association for dental services;¶
(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 service(s) 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 laboratory tests;¶
(E) Other medical diagnostic procedures;¶
(F) Hearing and vision services.¶
(6) ~~DMAP~~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 410-130-0670, Death with Dignity Services, for specific requirements.
Statutory/Other Authority: ORS 413.042, 414.065
Statutes/Other Implemented: ORS 414.065

AMEND: 410-147-0060

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

CHANGES TO RULE:

410-147-0060
Prior Authorization ¶

(1) Most Oregon Health Plan (OHP) ~~client~~Members have prepaid health services, contracted for by the Oregon Health Authority (Authority) through enrollment in a CCO or prepaid health plan (PHP). ~~client'~~Open Card Members who are not enrolled in a CCO or PHP, receive services ~~on an "open card" or "~~through the fee-for-service~~"~~ (FFS) ~~basis~~delivery system.¶
(2) It is the responsibility of the Provider to verify whether a PHP~~ or Division~~, CCO, or the Authority is responsible for reimbursement. Refer to OAR 410-120-1140 Verification of Eligibility.¶
(3) ~~If a client is enrolled in a PHP t~~There may be Prior Authorization (PA) requirements for some services that are provided t~~hrough the PHP~~o CCO Members. It is the Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC) responsibility to comply with the CCO or PHP's PA requirements or other policies necessary for reimbursement from the PHP or CCO before providing services to any ~~OHP client enrolled in a PHP~~CCO Member. The FQHC or RHC needs to contact the ~~client's PHP~~appropriate CCO for specific instructions.¶
(4) C~~lients who are enrolled in a PHP~~CO Members can receive family planning services, human immunodeficiency virus (HIV) and acquired immune deficiency syndrome (AIDS) prevention services (excludes any treatment for HIV or AIDS) through an FQHC or RHC without PA from the PHP or CCO as provided under the terms of Oregon's Section 1115 (CMS) Waiver. If the FQHC or RHC does not have a contract or other arrangements with a PHP or CCO, and the PHP or CCO denies payment, the Division~~ of Medical Assistance Programs (Division)~~ will reimburse for these services per a clinic's encounter rate (see OAR 410-147-0120(12)(b)).¶
(5) ~~If a client receives services on a FFS basi~~For Open Card Members, a PA may be required by the Division for certain ~~c~~Covered ~~s~~Services or items before the service can be provided or before payment will be made. An FQHC or RHC assumes full financial risk in providing services to a ~~FFS client~~Open Card Member prior to receiving authorization, or in providing services that are not in compliance with OARs. See OAR 410-120-1320 Authorization of Payment and any applicable program rules.¶
(6) If the service or item is subject to Prior Authorization, the FQHC or RHC 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, ~~m~~Medical ~~a~~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 those services provided; and¶
(d) The services are provided within the timeframe specified on the authorization of payment document.
Statutory/Other Authority: ORS 413.042
Statutes/Other Implemented: ORS 413.042, 414.065

AMEND: 410-147-0080

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

CHANGES TO RULE:

410-147-0080
Prepaid Health Plans (PHPs) ¶

(1) Most Oregon Health Plan (OHP) ~~client~~Members have prepaid health services, contracted for by the Oregon Health Authority (Authority) through enrollment in a prepaid health plan (PHP)~~. Clinics serving eligible OHP clients who are enrolled in a PHP~~ or Coordinated Care Organization (CCO). Clinics serving eligible CCO Members must secure authorization from the PHP or CCO prior to providing PHP~~-c~~ or CCO Covered ~~s~~Services or ~~c~~Case ~~m~~Management ~~s~~Services. Federally Qualified Health Centers (FQHC) and Rural Health Clinics (RHC) must request an authorization or ~~r~~Referral from the PHP or CCO before providing any services to ~~clients enrolled in a PHP~~CCO Members unless the FQHC or RHC have contracted with the PHP or CCO to provide PHP~~-c~~ or CCO Covered ~~s~~Services. If an FQHC or RHC has an arrangement or contract with a PHP or CCO, the clinic is responsible to follow PHP or CCO rules and ~~p~~Prior ~~a~~Authorization requirements. See OAR 410 division 141 for OHP Program Rules and; 410-147-0060, Prior Authorization.¶
(2) The Division~~ of Medical Assistance Programs (Division)~~ encourages FQHCs and RHCs to contact each PHP or CCO in their local service area for the purpose of requesting inclusion in their panel of ~~p~~Providers.¶
(3) PHPs or CCOs contracting with FQHCs or RHCs, for the provision of providing services to ~~their m~~CCO Members, are required by 42 USC 1396b(m)(2)(A)(ix) to provide payment to the FQHC or RHC that is not less than the level and amount of payment which the PHP or CCO would make for services furnished by a non-FQHC/RHC ~~p~~Provider.¶
(4) Payment for services provided to ~~PHP-enrolled clients (PHP m~~CCO Members~~)~~ is a matter between the FQHC or RHC and the PHP or CCO authorizing the services except as otherwise provided in OAR 410-141-0410, OHP primary care managers. If a PHP or CCO denies payment to an FQHC or RHC because arrangements were not made with the PHP or CCO prior to providing the service, the Division will not reimburse the FQHC or RHC under the encounter rate, except as outlined in ~~S~~section (5) of this rule (see OAR 410-141-0120, OHP PHP Provision of Health Care Services).¶
(5) FQHCs and RHCs can provide ~~f~~Family ~~p~~Planning ~~s~~Services or Human Immunodeficiency Virus (HIV) and Acquired Immune ~~d~~Deficiency Syndrome (AIDS) prevention services to eligible ~~PHP m~~CCO Members without authorization or a ~~r~~Referral from the PHP or CCO. The FQHC and RHC must bill the PHP or CCO first. If the PHP or CCO will not reimburse for the service, then the clinic may bill Division. Refer to ORS 414.153, Authorization for payment for certain point of contact services.¶
(6) PHPs or CCOs will execute agreements with publicly funded providers, unless cause can be demonstrated to Division's satisfaction why such an agreement is not feasible for authorization of payment for point of contact services in the following categories (refer to ORS 414.153):¶
(a) Immunizations;¶
(b) Sexually transmitted diseases; and¶
(c) Other communicable diseases.¶
(7) PHPs or CCOs are responsible to ensure the provision of qualified sign language and ~~oral~~spoken language interpreter services for covered medical, mental health or dental care visits, for their enrolled ~~PHP~~CCO Members w~~ith a~~ho are deaf, experience hearing impairment, or who are ~~non-English speaking~~LEP. Services must be sufficient for the FQHC or RHC provider to be able to understand the ~~PHP~~CCO Member's complaint; to make a diagnosis; respond to the ~~PHP~~CCO Member's questions and concerns; and to communicate instructions to the ~~PHP~~CCO Member. See OAR 410-141-0220(7), Oregon Health Plan prepaid health plan Accessibility.¶
(8) The ~~p~~Provider assumes full financial risk in serving a ~~person~~n individual not confirmed by the Division as eligible on the ~~d~~Date(s) of ~~s~~Service. It is the responsibility of the ~~p~~Provider to verify a ~~client~~Member's eligibility. Refer to OAR 410-120-1140 Verification of Eligibility:¶
(a) That the individual receiving ~~m~~Medical ~~s~~Services is eligible on the ~~d~~Date of ~~s~~Service for the service provided;¶
(b) Whether an OHP ~~client~~Member receives services on a fee-for-service ~~(o~~ basis (Open ~~c~~Card~~) basis~~ Member) or is enrolled with a PHP or CCO (CCO Member); and¶
(c) Whether the service is covered by a ~~t~~Third~~-p~~-Party ~~r~~Resource (TPR), a PHP, a CCO, or if the Division reimburses on a fee-for-service basis.¶
(9) The Division requires the following of a FQHC or RHC under contract with a PHP or CCO:¶
(a) Clinic must maintain reimbursement and documentation records that will permit calculation of supplemental

payments according to OAR 410-147-0460. According to OAR 410-141-0180, Oregon Health Plan prepaid health plan Record Keeping, a PHP's ~~p~~or CCO's Participating ~~p~~Providers shall maintain a clinical record keeping system with sufficient detail and clarity to permit internal and external clinical audit to validate encounter submissions and to assure Medically Appropriate services are provided consistent with the documented needs of the ~~PHP~~CCO Member. See also OAR 410-120-1360, Requirements for Financial, Clinical and Other Records;¶
(b) Clinics are subject to ongoing performance review by the PHP or CCO. According to OAR 410-141-0200, Oregon Health Plan prepaid health plan Quality Improvement (QI) System, PHPs and CCOs must maintain an effective process for monitoring, evaluating, and improving the access, quality and appropriateness of services provided to Division Members. The QI program must include QI projects that are designed to improve the access, quality and utilization of services;¶
(c) Clinics are subject to program review by Division, the Oregon Department of Human Services' Audit Unit, and the Department of Justice Medicaid Fraud Unit for the purposes of assuring program integrity and:¶
(A) Compliance with Oregon Revised Statutes, Oregon Administrative Rules and Federal laws and regulations;¶
(B) Use of accurate and complete encounter and fee-for-service claims data, and supporting clinical documentation, for calculating PHP or CCO supplemental payments and compensation for out-stationed outreach workers;¶
(C) Adequate records maintenance for cost reimbursed services to thoroughly explain how the amounts reported on the cost statement were determined. The records must be accurate and in sufficient detail to substantiate the data reported.
Statutory/Other Authority: ORS 413.042, 414.065
Statutes/Other Implemented: ORS 414.065

AMEND: 410-147-0085

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

CHANGES TO RULE:

410-147-0085
~~Client~~Member Copayments ¶

(1) The Division~~ of Medical Assistance Programs (Division)~~ Medical Care Identification will indicate which Oregon Health Plan (OHP) ~~client~~Members are responsible for copayments for services.¶
(2) Division requires copayments from ~~client~~Members with certain ~~b~~Benefit ~~p~~Packages. See OAR 410-120-1230, Client Copayment, and Table 120-1230-1 for specific details.¶
(3) A ~~client~~Member may owe more than one copayment during a 24-hour period. The Division may require copayments for each medical, dental, mental health or alcohol and chemical dependency encounter on the same date of service. Refer to OAR 410-147-0140, Multiple Encounters.
Statutory/Other Authority: ORS 413.042
Statutes/Other Implemented: ORS 414.025, 414.065

AMEND: 410-147-0140

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

CHANGES TO RULE:

410-147-0140
Multiple Encounters ¶

(1) An encounter is defined in OAR 410-147-0120.¶
(2) The following services may be considered as multiple encounters when two or more service encounters are provided on the same ~~d~~Date of ~~s~~Service with distinctly different diagnoses (see OAR 410-147-0120 and individual program rules listed below for specific service requirements and limitations):¶
(a) Medical section (3) of this rule and OAR chapter 410, division 130~~);~~;¶
(b) Dental (OAR 410-147-0125), and OAR chapter 410, division 123~~);~~;¶
(c) Mental Health - If a ~~client~~Member is also seen for a medical office visit and receives a mental health diagnosis, then the ~~client~~Member contacts are a single encounter (~~R~~refer to the ~~Division of Addictions and Ment~~OHA Behavioral Health ~~(AMH)~~Division for the appropriate OARs);¶
(d) Addiction and Alcohol and Chemical Dependency - If a ~~client~~Member is also seen for a medical office visit and receives an addiction diagnosis, then the ~~client~~Member contacts area single encounter (Refer to ~~AMH'~~Behavioral Health Divisions OARs);¶
(e) Ophthalmologic services - 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 410-147-0200);¶
(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 encounter that determined the need for PT/OT (initial referral), then it is considered a single 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, mental health or addiction service encounter occurs on the same ~~d~~Date of ~~s~~Service (refer to OAR 410-130-0190).¶
(3) Encounters with more than one health professional and multiple encounters with the same health professional that take place on the same day and that share the same or like diagnoses constitute a single encounter, except when one of the following conditions exist:¶
(a) After the first medical service 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 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 encounters;¶
(b) The patient has two or more encounters as described in section (2) of this rule.¶
(4) A mental health encounter and an addiction and alcohol and chemical dependency encounter provided to the same ~~client~~Member on the same ~~d~~Date of ~~s~~Service will only count as multiple 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 not considered multiple encounters. Situations that would not be considered multiple 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 mental health and addiction encounter with similar diagnoses;¶
(d) A prenatal visit and a delivery procedure;¶
(e) A cesarean delivery and surgical assist;¶
(f) Any time a ~~client~~Member receives only a partial service with one ~~p~~Provider and partial service from another ~~p~~Provider, this would be considered a single encounter.¶
(6) A clinic may not develop clinic procedures that routinely involve multiple encounters for a single ~~d~~Date of ~~s~~Service. A ~~recipient~~Member may obtain medical, dental or other health services from any ~~p~~Provider approved by the Division, ~~and/~~or contracts with the ~~recipient's PHP~~Member's CCO, if the Federally Qualified Health Center or Rural Health Clinic (FQHC/RHC) is not the ~~recipient~~Member's primary care manager.¶
(7) Clinics may not "unbundle" services that are normally rendered during a single visit for the purpose of generating multiple encounters:¶

(a) Clinics are prohibited from asking 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, 414.065
Statutes/Other Implemented: ORS 414.065

AMEND: 410-147-0160

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

CHANGES TO RULE:

410-147-0160
Modifiers ¶

(1) The Division ~~of Medical Assistance Programs (Division)~~ uses HIPAA compliant modifiers for many services.¶
(2) The following conditions require the use of a modifier for all codes:¶
(a) Family Planning Service - FP, Refer to OAR 410-130-0585 Family Planning Services¶
(b) Vaccine for Children - SL or 26, Refer to OAR 410-130-0255(4)¶
(3) When billing for services that are reimbursed outside a clinic's encounter rate, a clinic must use the required modifier(s) listed in the individual program ~~A~~administrative ~~R~~rules.¶
(a) Enhanced Care Services (including extended care) - HK, Refer to OAR 410-147-0120;¶
(b) Assist surgeon for cesarean deliveries for Citizenship Waived Medical (CWM) ~~client~~Members - 80, 81, 82 or AS.
Statutory/Other Authority: ORS 413.042, 414.065
Statutes/Other Implemented: ORS 414.065

AMEND: 410-147-0180

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

CHANGES TO RULE:

410-147-0180
Vaccines for Children (VFC) Program ¶

(1) The Division ~~of Medical Assistance Programs (Division) wi~~sha̲ll reimburse Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) for the administration of vaccines to eligible ~~client~~Member̲s.¶
(2) The VFC program supplies federally purchased free vaccines for immunizing eligible ~~client~~'Member̲s ages 0 through 18 at no cost to participating health care ~~p~~P̲roviders. For more information on how to enroll in the VFC program, contact the Oregon Health Authority (Authority) Immunization Program. Refer to the FQHC and RHC Supplemental Information for instructions.
Statutory/Other Authority: ORS 413.042, 414.065
Statutes/Other Implemented: ORS 414.065

AMEND: 410-147-0200

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

CHANGES TO RULE:

410-147-0200
Maternity Case Management Services ¶

(1) The Division ~~of Medical Assistance Programs (Division)~~ will reimburse ~~f~~Federally ~~q~~Qualified ~~h~~Health ~~c~~Centers (FQHCs) and rural health clinics (RHCs) for ~~m~~Maternity ~~c~~Case ~~m~~Management (MCM) services.¶
(2) MCM service is optional coverage for Prepaid Health Plans (PHPs) or CCOs. Before providing MCM services to a ~~client enrolled in a PHP~~CCO Member, determine if the PHP or CCO covers MCM services:¶
(a) If the PHP or CCO does not cover MCM services, the ~~p~~Provider can bill the Division directly per the clinic's Prospective Payment System (PPS) encounter rate. Prior ~~a~~Authorization is not required if the PHP or CCO does not provide coverage for MCM services;¶
(b) If the PHP or CCO does cover MCM services, the ~~p~~Provider needs to request the necessary authorizations from the PHP.~~¶~~
~~(3) Clients~~ or CCO.¶
(3) Member' records must clearly document all MCM services provided including all mandatory topics. Refer to OAR 410-130-0595, Maternity Case Management for specific requirements.¶
(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 cannot 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 the day before delivery;¶
(c) No other MCM service can 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 can qualify as two separate encounters when furnished on the same day only when the MCM service is:¶
(a) The initial evaluation to receive MCM service; or¶
(b) A nutritional counseling MCM service provided after the initial evaluation visit. See Section (7) of this rule for limitations.¶
(7) MCM services limitations:¶
(a) The Division reimburses the initial evaluation one time per pregnancy per ~~p~~Provider;¶
(b) The Division reimburses nutritional counseling one time per pregnancy if a ~~client~~Member meets the criteria in OAR 410-130-0595(14); and¶
(c) The Division will reimburse a maximum of ~~ten~~10 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 must not duplicate services for case management activities or direct services provided under the State Plan or the Oregon Health Plan (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 Maternity Case Management, and any Targeted Case Management (TCM) Programs outlined in OAR chapter 410, division 138.
Statutory/Other Authority: ORS 413.042, 414.065
Statutes/Other Implemented: ORS 414.065

AMEND: 410-147-0260

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

CHANGES TO RULE:

410-147-0260
Death With Dignity ¶

~~[Reserved]~~(1) Death with dignity is a Covered Service, except for those facilities limited by the Assisted Suicide Funding Restriction Act of 1997 (ASFRA), and is incorporated in the Comfort Care condition/treatment line on the OHA Prioritized List of Health Services.¶
(2) All claims for death with dignity services must be billed directly to the Division, even if the individual receiving services is a CCO Member. Death with dignity services are not part of the Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC) encounter rate.¶
(3) Follow criteria outlined in OAR 410-130-0670.
Statutory/Other Authority: ORS 413.042, 414.065
Statutes/Other Implemented: ORS 414.065

AMEND: 410-147-0280

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

CHANGES TO RULE:

410-147-0280
Drugs ¶

(1) As defined by the Division ~~of Medical Assistance Programs (Division)~~, a valid Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC) encounter excludes pharmaceutical or biologicals not generally provided during a clinic visit. Refer to OAR 41-147-0120 Division Encounter and Recognized Practitioners.¶
(a) Because the Division includes the costs of drugs or medication treatments administered by a clinic to treat a ~~client~~Member during an office visit in the PPS all-inclusive encounter rate for the office visit, ~~p~~Providers cannot bill separately for the costs of the drugs or treatments;¶
(b) Prescriptions are not included in the Prospective Payment System (PPS) encounter rate. To bill for filled prescriptions, the FQHC or RHC's qualified enrolled pharmacy must bill the Division using its pharmacy provider number.¶
(2) Clinics may directly bill the Division using their clinic provider number for contraceptive supplies and contraceptive medications only for:¶
(a) C~~lients enrolled in a prepaid health plan (PHP)~~CO Members: Clinics must bill the PHP or CCO first. If the PHP or CCO will not reimburse for the contraceptive supply or contraceptive medication, then the clinic can bill the Division's fee-for-service at the clinic's ~~a~~Acquisition ~~c~~Cost. See also OAR 410-130-0585, Family Planning Services;¶
(b) ~~Fee-for-service client~~Open Card Members: Clinics can directly bill the Division's 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 Rulebook for specific information.
Statutory/Other Authority: ORS 413.042, 414.065
Statutes/Other Implemented: ORS 414.065

AMEND: 410-147-0360

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

CHANGES TO RULE:

410-147-0360
Encounter Rate Determination ¶

(1) The Division ~~of Medical Assistance Programs (Division)~~ will coincide enrollment of a Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC) with the calculation of a clinic's Prospective Payment System (PPS) encounter rate:¶
(a) ~~DMAP~~The Division will enroll a clinic as an FQHC or RHC effective the date ~~DMAP~~the Division determines the clinic's PPS encounter rate. The encounter rate may be used to bill for services provided on or after the coinciding effective dates of enrollment as an FQHC or RHC with the Division and determination of the clinic's encounter rate.¶
(b) Consistent with OAR 410-120-1260, Provider Enrollment, only enrolled ~~p~~Providers can submit claims to the Division for providing specific care, item(s), or service(s) to Division ~~client~~Members. A clinic or individual ~~p~~Provider needs to bill fee-for-service for services provided prior to enrollment as an FQHC or RHC with ~~DMAP~~the Division, according to applicable service program's enrollment and billing Oregon Administrative Rules (OARs).¶
(2) To determine the PPS encounter rate(s), an FQHC must submit all financial documents listed in OAR 410-147-0320 for each Medical, Dental and Mental Health/Substance Use Disorder Services.¶
(a) Effective October 1, 2004, for FQHCs only, the Division will calculate three separate PPS encounter rates for clinics newly enrolling as an FQHC with the Division:¶
(~~i~~A) Medical;¶
(~~ii~~B) Dental; and¶
(~~iii~~C) Mental Health/Substance Use Disorder services.¶
(b) FQHCs enrolled with the Division prior to October 1, 2004, with a single PPS medical encounter rate, will have a separate encounter rate calculated if the clinic adds a service category listed in either ~~Section~~paragraphs (2)(a)(~~ii~~B) or (~~iii~~2)(a)(C) of this rule. Refer also to ~~S~~section (16) of this rule.¶
(3) To determine the PPS encounter rate, a RHC must submit all financial documents listed in OAR 410-147-0320.¶
(a) The Division will accept an uncertified Medicare Cost Report;¶
(b) If the clinic's Medicare Cost Report, provided to the Division, does not include all covered Medicaid costs provided by the clinic, the clinic must submit additional cost information. The Division will include these costs when determining the PPS encounter rate.¶
(c) The Division will remove the Medicare productivity screen and any other Medicare payment caps from the RHC's Medicare encounter rate;¶
(d) An RHC can submit the Division cost statement form 3027 as a substitute to the Medicare Cost Report.¶
(4) FQHCs or RHCs that have an additional clinic site(s) under the main FQHC or RHC designation, must file the required financial documentation for each clinic site unless specifically exempted in writing by the Division. If exempted from this requirement by the Division, an FQHC or RHC may file a consolidated cost report. See OAR 410-147-0340 regarding separate enrollment for multiple sites.¶
(5) FQHCs and RHCs cannot include costs associated with non-FQHC or non-RHC designated sites in the cost report.¶
(6) FQHCs and RHCs cannot include costs associated with ~~n~~Non-~~c~~Covered ~~Medicaid s~~Services. The Division does not allow the inclusion of indirect or direct costs for non-covered Medicaid services in the clinic's cost report/statement as allowed expenses. Refer to OAR 410-120-1200 Excluded Services and Limitations.¶
(7) An out-of-state FQHC or RHC will only include expenses associated with Medicaid ~~c~~Covered ~~s~~Services provided at clinic sites serving Division ~~client~~Members when completing the Cost Statement (DMAP 3027). For RHCs only, the Medicare Cost Report can only include financial documents for ~~Medicaid c~~Covered ~~s~~Services provided at clinic sites that see Division ~~client~~Members. Do not include costs associated with non-FQHC or RHC designated sites, or clinic sites that do not serve Division ~~client~~Members in the Cost Statements (DMAP 3027) or Medicare Cost Reports for RHCs.¶
(8) At any time, if the Division determines that the costs provided by the clinic for calculating the PPS encounter rate(s) were inflated, the Division may:¶
(a) Request corrected cost reports and any other financial documents in order to review and adjust the encounter rate(s); and¶

(b) Impose sanctions as defined in OARs 410-120-1400 Provider Sanctions, 410-120-1460 Type and Conditions of Sanctions; and 943-120-0360 Consequences of Non-Compliance and Provider Sanctions.¶
(9) Effective January 1, 2001, ~~DMAP~~the Division determines FQHC and RHC encounter rates in compliance with 42 USC 1396a(bb). In general, the PPS encounter rate is calculated by dividing total costs of Medicaid ~~c~~Covered ~~s~~Services furnished by the FQHC/RHC during fiscal years 1999 and 2000 by the total number of clinic encounters during the two fiscal years.¶
(10) Clinics existing in 1999 and 2000, and enrolled with the Division as a FQHC or RHC as of January 1, 2001, receive payment from the Division for services rendered to Medicaid-eligible OHP ~~client~~Members per an all-inclusive PPS encounter rate (calculated on a per visit basis) that is equal to 100 percent of the average of the costs of the clinic for furnishing such services during fiscal years 1999 and 2000 which are reasonable and related to the cost of furnishing such services, or based on such other tests of reasonableness.¶
(11) Clinics first qualifying as an FQHC or RHC after fiscal year 2000, will receive payment from the Division for services rendered to Medicaid-eligible OHP ~~client~~Members per an all-inclusive PPS encounter rate (calculated on a per visit basis) that is equal to 100 percent of the average of the costs of the clinic for furnishing such services during the fiscal year the clinic first qualifies as an FQHC or RHC. Coinciding with enrollment as an FQHC or RHC with the Division, a clinic will have a PPS encounter rate:¶
(a) Established by reference to payments to other clinics located in the same or adjacent areas, and of similar caseload; or¶
(b) In the absence of such clinic, through cost reporting methods based on tests of reasonableness.¶
(12) Beginning in fiscal year 2002, and for each fiscal year thereafter, each FQHC/RHC is entitled to the PPS encounter rate(s) payment amount to which the clinic was entitled under Section 42 USC 1396a(bb) in the previous fiscal year, increased by the percentage increase in the Medicare Economic Index (MEI).¶
(13) For established, enrolled clinics with a change of ownership, the new owner can submit:¶
(a) A Cost Statement (DMAP 3027) or Medicare Cost Report within 30 days from the date of change of ownership for review by the Division to determine if a new PPS encounter rate will be calculated as otherwise described in this rule; or¶
(b) In writing, a letter advising adoption of the PPS encounter rate calculated under the former ownership, including notice if there is a change to the clinic's tax identification number;¶
(c) Failure to submit a cost statement (DMAP 3027) or Medicare Cost Report within 30 days of the change of ownership, will forfeit the opportunity for calculation of a PPS encounter rate(s) at a later date. The PPS encounter rate(s) calculated under the former ownership will be reassigned to the new ownership.¶
(14) The Centers for Medicare and Medicaid Services (CMS) defines a change in scope of services as one that affects the type, intensity, duration, and amount of services. Clinics must submit a request for change in scope to the Division for review.¶
(15) The Division may establish a separate PPS encounter rate if a FQHC adds Dental or Mental Health/Substance Use Disorder services. A separate PPS encounter rate will be calculated by the Division for the added service element if:¶
(a) Costs associated with the added service element were not included on the original cost statements for the initial PPS encounter rate determination;¶
(b) The addition of the service element has been approved by the Health Resources and Services Administration (HRSA) and is included in the notice of grant award issued by HRSA;¶
(c) The FQHC is certified by the ~~Addictions and Ment~~Behavioral Health Division (~~AMH~~BHD) to provide mental health services (if mental health services are provided by un-licensed providers), or has a letter or licensure of approval by ~~Addictions and Ment~~Behavioral Health Division (~~AMH~~BHD) former ~~Office of~~Addictions and Mental Health ~~and Addictions Services~~Division (~~O~~AMH~~AS~~) to provide ~~s~~Substance ~~u~~Use ~~d~~Disorder ~~s~~Services;¶
(~~i~~A) Certification by ~~AMH~~BHD of an FQHC's outpatient mental health program is required if mental health services are provided by non-licensed ~~p~~Providers. Refer to OAR 410-147-0320(3)(i) and (5)(h) for certification requirements¶
(~~iii~~B) A letter of licensure or approval by ~~AMH~~BHD is required for FQHCs providing substance use disorder services. Refer to OAR 410-147-0320 (3)(j) and (5)(i);¶
(16) If an FQHC meets the criteria as outlined in ~~S~~section (15) of this rule for the addition of ~~D~~dental or ~~Ment~~Behavioral Health/Substance Use Disorder ~~s~~Services, after the initial encounter rate determination, the Division will determine the PPS encounter rate for the newly added service element using the date the scope change was approved by HRSA. For example: the clinic submitted 1999 & 2000 cost reports. In 2001 the clinic added a dental clinic. The cost report would be from 2001 (the most appropriate months) with the MEI adjusted for 2002, 2003 and 2004.¶
(17) When an FQHC shares the same space for multiple services, then the Division will use square footage to determine the percent of the indirect cost associated with each encounter rate.¶
(18) A clinic may be exempt from this requirement if an FQHC has minimal utilization for a particular service such

as "Look Alike" clinics and is located in an isolated area. Submit an exemption request with appropriate documentation to the Division FQHC Program Manager for consideration.¶
(19) For an FQHC approved by the Division to participate in an Alternate Payment Methodology (APM) pilot, the following will apply:¶
(a) APM converts the clinics current PPS rate into an equivalent per member per month (PMPM) rate using the clinic's historical patient utilization and the clinic's PPS cost base rate. The purpose of APM is to reimburse clinics an amount no less than what the clinic would have received if paid with PPS. The Division shall process quarterly reconciliations and if the APM issued is less than what the clinic would have received if paid using PPS, the Division shall reimburse the clinic the difference. The Division will perform a final annual reconciliation and remit payment within 120 days after the close of the calendar year.¶
(b) The Division shall have a memorandum of understanding to establish an effective date with each participating clinic.¶
(c) A clinic may request to return to its PPS rate by submitting written request to the Division. The Division shall return the clinic to their PPS rate within 30 business days after a clinics request has been received.
Statutory/Other Authority: ORS 413.042, 414.065
Statutes/Other Implemented: ORS 414.065

AMEND: 410-147-0380

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

CHANGES TO RULE:

410-147-0380
Accounting and Record Keeping ¶

(1) General Requirements:¶
(a) The following rules and regulations apply to clinics reimbursed under the Federally Qualified Health Center (FQHC) and Rural Health Clinic Program;¶
(b) In cases of conflict between the rules contained in section (2) and (3) of this rule, section (2) will prevail over section (3);¶
(c) FQHCs and RHCs must use the cost principles contained in Office of Management and Budget (OMB) Circular A-87 or A-122 to determine reasonable costs. Use the circular appropriate to your clinic; and¶
(d) Must adhere to acceptable accounting standards.¶
(2) Rules and ~~R~~regulations:¶
(a) FQHC and RHC ~~A~~administrative ~~R~~rules;¶
(b) The Division ~~of Medical Assistance Programs (Division) General Rules~~general rules (chapter 410, division 120);¶
(c) Oregon Health Plan (OHP) ~~A~~administrative ~~R~~rules (chapter 410, division 141);¶
(d) All other applicable Division ~~p~~Provider rules.¶
(3) Cost Principles for State and Local Governments, OMB Circular A-87 and A-122.¶
(4) Each FQHC and RHC shall:¶
(a) Maintain internal control over and accountability for all funds, property and other assets;¶
(b) Maintain complete ~~client~~Member documentation;¶
(c) Adequately safeguard from duplicate billings or other routine billing errors;¶
(d) Adequately safeguard all such assets and assure that they are used solely for authorized purposes;¶
(e) Prepare Cost Statements (Division 3027) or Medicare Cost Reports for RHCs in conformance with:¶
(A) Generally accepted accounting principles;¶
(B) The provisions of the FQHC and RHC ~~A~~administrative ~~R~~rules; and¶
(C) All other applicable rules listed in sections (2) and (3).¶
(f) Maintain for a period of not less than five (5) years from the end of the fiscal the year:¶
(A) Cost Statement (Division 3027) or Medicare Cost Report for RHCs;¶
(B) Cost Statement Worksheet (Division 3032);¶
(C) A copy of the clinic's trial balance;¶
(D) Audited financial statements;¶
(E) Depreciation schedules;¶
(F) Overhead cost allocation schedules; and¶
(G) Financial and clinical records for the period covered by the Cost Statement (Division 3027) or Medicare Cost Report for RHCs.¶
(g) Maintain adequate records to thoroughly explain how the amounts reported on the Cost Statement (Division 3027) were determined. If there are unresolved audit questions at the end of the five-year period, the records must be maintained until the questions are resolved;¶
(h) Adequately document expenses reported as allowable costs in the records of the clinic or they will be disallowed. Documentation for travel and education expenses must include a summary of costs for each employee stating the purpose of the trip or activity, the dates, name of the employee, and a detailed breakdown of expenses. Receipts must be attached for expenses over $25;¶
(i) Prepare special work papers or reports to support or explain data reported on the Cost Statement (Division 3027) or Medicare Cost Report for RHCs for current or previous periods at Division's request. These work papers/reports must be completed within 30 days of the Division request. An extension of up to 30 days may be granted if the request is made before the end of the original 30 day period. Extensions must be requested in writing;¶
(j) Ensure that the Cost Statement (Division 3027) or Medicare Cost Report for RHCs is reconcilable to the audited financial records and encounters must be reconcilable to the Uniform Data Set (UDS) form or other reasonable data the Division may request. If the Cost Statement (Division 3027) or Medicare Cost Report for RHCs cannot be reconciled, the UDS numbers will be used or other appropriate data sets as determined by the Division;¶

(k) Do not submit financial documentation to Division for FQHC or RHC sites that:¶
(A) Are not designated as an FQHC or RHC~~,~~; and~~/or,~~¶
(B) Do not serve Me~~dical Assistance Program client~~mbers.
Statutory/Other Authority: ORS 413.042, 414.065
Statutes/Other Implemented: ORS 414.065

AMEND: 410-147-0460

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

CHANGES TO RULE:

410-147-0460
Prepaid Health Plan Supplemental Payments ¶

(1) Effective January 1, 2001, the Division ~~of Medical Assistance Programs (Division)~~ is required by 42 USC 1396a(bb), to make supplemental payments to eligible ~~f~~Federally ~~q~~Qualified ~~h~~Health ~~c~~Centers (FQHC) and rural health clinics (RHC) that contract with Prepaid Health Plans (PHP) or CCOs.¶
(2) The ~~PHP S~~ supplemental ~~P~~payment represents the difference, if any, between the payment received by the FQHC/RHC from the PHP~~(s)~~ or CCO for treating the ~~PHP enrollee~~CCO Member and the payment to which the FQHC/RHC would be entitled if they had billed Division directly for these encounters according to the clinic's Medicaid Prospective Payment System (PPS) encounter rate. Refer to OAR 410-147-0360.¶
(3) In accordance with federal regulations the Provider must take all reasonable measures to ensure that in most instances Medicaid will be the payer of last resort. Providers must make reasonable efforts to obtain payment first from other resources before submitting claims to the PHP or CCO. Refer to OAR 410-147-0120(14).¶
(4) When any other coverage is known to the ~~p~~Provider, the ~~p~~Provider must bill the other resource(s) prior to billing the PHP or CCO. When a Provider receives a payment from any source prior to the submission of a claim to the PHP or CCO, the amount of the payment must be shown as a credit on the claim in the appropriate field. See also OAR 410-120-1280 Billing and 410-120-1340 Payment.¶
(5) Supplemental payment by Division for encounters submitted by FQHC/RHCs for purposes of this rule is reduced by any and all payments received by the FQHC/RHC from outside resources, including Medicare, private insurance or any other coverage. Therefore, FQHC/RHCs are required to report all payments received on the Managed Care Data Submission Worksheet, including:¶
(a) Medicaid PHPs or CCOs;¶
(b) Medicare Advantage Managed Care Organizations (MCO);¶
(c) Medicare, including Medicare MCO supplemental payments; and¶
(d) Any Third-~~-~~Party Resource(s) (TPR).¶
(6) The Division will calculate the ~~PHP S~~supplemental ~~P~~payment in the aggregate of the difference between total payments received by the FQHC/RHC, to include payments as listed in ~~S~~section (5) of this rule and the payment to which the FQHC/RHC would have been eligible to claim as an encounter if they had billed Division directly per their PPS encounter rate.¶
(7) Effective July 1, 2006, FQHC/RHCs must submit their clinic's data beginning with ~~d~~Dates of ~~s~~Service January 1, 2006 and after, using the Managed Care Data Submission Template developed by Division to report all ~~PHP~~CCO encounter and payment activity.¶
(8) To facilitate Division processing ~~PHP~~ supplemental payments, the FQHC or RHC must submit the following:¶
(a) To PHPs or CCOs:¶
(A) Claims within the required timelines outlined in the contract with the PHP or CCO and in OAR 410-141-0420, Oregon Health Plan Prepaid Health Plan Billing Payment Under the Oregon Health Plan;¶
(B) The National Provider Identifier (NPI) number and associated taxonomy code, registered by the FQHC or RHC clinic with Division must be used when submitting all claims to the PHPs or CCOs;¶
(b) To the Division:¶
(A) Report total payments for all services submitted to the PHP or CCO:¶
(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 ~~M~~managed ~~C~~care ~~D~~data ~~S~~submission ~~T~~template ~~C~~coversheet;¶
(C) Payments are to be reported at the detail line level on the ~~M~~managed ~~C~~care ~~D~~data ~~S~~submission ~~T~~template ~~W~~worksheet, except for capitated payments, or per ~~m~~Member per month and risk pool payments received from the PHP or CCO;¶
(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 FQHC or RHC or the total detail lines submitted on the ~~M~~managed ~~C~~care ~~D~~data ~~S~~submission ~~T~~template ~~W~~worksheet;¶
(E) All individual NPI numbers and taxonomy codes assigned to ~~p~~Practitioners associated with the FQHC or RHC. A

~~p~~Practitioner associated with an FQHC or RHC can only retain individual active enrollment with Division in limited situations. Refer to OAR 410-147-0340(3).¶
(F) A current list of all PHP or CCO contracts. An updated list of all PHP or CCO contracts must be submitted annually to Division no later than October 31 of each year.¶
(9) ~~PHP~~ Supplemental ~~P~~payment process:¶
(a) Division will process ~~PHP S~~supplemental ~~P~~payments on a quarterly basis:¶
(A) Quarterly processing of ~~PHP S~~supplemental ~~P~~payments includes a final reconciliation for the reported time period;¶
(B) For an FQHC or RHC approved by Division to participate in a pilot project, ~~PHP S~~supplemental ~~P~~payments will be processed at the discretion of the Division in collaboration with health centers;¶
(b) Upon processing a clinic's data and the ~~PHP S~~supplemental ~~P~~payment, the Division ~~will~~may:¶
(A) Send a check to the clinic for ~~PHP S~~supplemental ~~P~~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 FQHC or RHC 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 ~~S~~subsection (9)(b) 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 requested in writing;¶
(B) 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 ~~will~~may:¶
(A) Review the data and issue a check for all encounters 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 FQHC or RHC should submit data to the Division within the timelines provided by the Division.¶
(10) Clinics must carefully review in a timely fashion the data that Division was unable to process and returns to the FQHC or RHC. If clinics do not bring any incomplete, inaccurate or missing data to the Division's attention within the time frames outlined, the Division will not process an adjustment.¶
(11) The Division encourages FQHCs and RHCs to request ~~PHP S~~supplemental ~~P~~payment in a timely manner.¶
(12) Clinics must exclude from a clinic's data submission for ~~PHP~~ supplemental payment, clinic services provided to a ~~PHP-enrolled client~~CCO Member when the clinic does not have a contract or agreement with the ~~PHP~~CCO. This may not apply to ~~f~~Family ~~p~~Planning ~~s~~Services, or Human Immunodeficiency Virus and Acquired Immune Deficiency Syndrome (HIV/AIDS) prevention services. Family Planning and HIV/AIDS prevention services provided to a ~~PHP-enrolled client~~CCO Member when a clinic does not have a contract or agreement with the ~~PHP~~CCO:¶
(a) Must be reported in the clinic's data submission for ~~PHP S~~supplemental ~~P~~payment if the clinic receives payment from the ~~PHP~~CCO;¶
(b) Cannot be reported in the clinic's data submission for ~~PHP S~~supplemental ~~P~~payment if the clinic is denied payment by the ~~PHP~~CCO. If the ~~PHP~~CCO denies payment to the clinic, the clinic can bill these services directly to the Division. (See also OAR 410-147-0060).¶
(13) If a ~~PHP~~CCO denies payment to an FQHC or RHC for all services, items and supplies provided to a ~~client~~CCO Member on a single ~~d~~Date of ~~s~~Service and meeting the definition of an "encounter" as defined in OAR 410-147-0120, for the reason that all services, items and supplies are non-covered by the plan, the Division is not required to 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~~CCO as a covered global procedure (e.g. Obstetrics Global Encounter);¶
(b) Had payment received by Medicare, and any other ~~t~~Third ~~p~~-Party ~~r~~Resource not have exceeded the payment the ~~PHP~~CCO would have made, the ~~PHP~~CCO would have made payment;¶
(c) At least one of the detail lines reported for all services, items and supplies provided to a ~~client~~CCO Member on a single ~~d~~Date of ~~s~~Service and represents an "encounter," has a reported payment amount by the ~~PHP~~CCO.¶
(14) If an FQHC or RHC has been denied payment by a ~~PHP~~CCO because the clinic does not have a contract or agreement with the ~~PHP,~~CCO, the Division is not required to make a supplemental payment to the clinic. The Division is only required to make a ~~PHP~~ supplement payment when the FQHC or RHC has a contract with a ~~PHP~~CCO.¶
(15) The Division will not reimburse some Medicaid ~~c~~Covered ~~s~~Services that are only reimbursed by ~~PHP~~CCOs,

and are not reimbursed by the Division. The Division will 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 FQHC or RHC to refer ~~PHP-enrolled client~~CCO Members back to their ~~PHP~~CCO if the FQHC or RHC does not have a contract with the ~~PHP~~CCO, and the service to be provided is not ~~f~~Family ~~p~~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(s) of ~~s~~Service. See OAR 410-120-1140. It is the responsibility of the Provider to verify:¶
(a) That the individual receiving ~~m~~Medical ~~s~~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, 414.065
Statutes/Other Implemented: ORS 414.065

AMEND: 410-174-0010

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

CHANGES TO RULE:

410-174-0010
Culturally and Linguistically Specific Services Organization
(1) In order to qualify for enhanced payments for culturally and linguistically specific services provided by traditional health workers as an organization, the organization must:¶
(a) Be enrolled as a ~~p~~Provider and reimbursed through OHP's fee schedule for physical health services;¶
(b) Submit a complete Traditional Health Worker Culturally and Linguistically Specific Services application to OHA;¶
(c) Demonstrate the ability to serve a minoritized cultural community; and¶
(d) Have traditional health workers working with or being immersed in the same distinct minoritized community being served; or¶
(e) Have a history of at least one year experience primarily serving the specified minoritized cultural community being served.¶
(2) To demonstrate the ability to serve a minoritized cultural community under subsection (1)(c) of this rule, an organization must provide information that shows the following:¶
(a) Comprehensive knowledge of diverse lived experiences held by the minoritized cultural community being served including, but not limited to, their experiences of structural and individual racism, minoritization or discrimination that may have an impact on the community's collective health and wellbeing.¶
(b) Knowledge of specific health inequities documented in the minoritized cultural community being served, which may be addressed by the organization.¶
(c) A practice of supporting and affirming cultural and language practices for the community being served, such as but not limited to:¶
(A) Health and safety beliefs, or practices;¶
(B) Positive cultural identity, pride, or resilience;¶
(C) Immigration dynamics; or¶
(D) Sacred beliefs.¶
(d) A demonstrated ability to support and affirm ~~client~~Members experiencing intersectional oppression in the provision of services. The ability to support and affirm the unique needs of ~~client~~Members experiencing intersectional oppression may be evidenced through details of the organization's established collaboration with other culturally specific providers, details of dedicated spaces or groups provided for ~~client~~Members experiencing intersectional oppression, or any other supporting information.¶
(3) The information required to be provided under subsections (1)(b) through (1)(e) and section (2) of this rule must include documentation of the organization's culturally specific focus demonstrated in a mission statement, vision statement, or other public-facing document. Supporting information can also include but is not limited to:¶
(a) Documentation detailing policies and procedures.¶
(b) Documentation of staff training requirements and any resulting certifications.¶
(c) A narrative that details the organization or program's strategic plan or history and experience, including specific examples, without identifying any individual ~~client~~Members.
Statutory/Other Authority: ORS 413.042, ORS 414.065
Statutes/Other Implemented: ORS 414.065

AMEND: 410-174-0020

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

CHANGES TO RULE:

410-174-0020
Culturally and Linguistically Specific Services Program Qualifications
(1) In order to qualify for enhanced payments for culturally and linguistically specific services provided by traditional health workers as a program, the program must:¶
(a) Be enrolled as a ~~p~~Provider and reimbursed through OHP's fee schedule for physical health services;¶
(b) Submit a complete Culturally and Linguistically Specific Services Traditional Health Worker application to OHA.¶
(c) Demonstrate the ability to serve a minoritized cultural community; and¶
(d) Have traditional health worker staff working with or being immersed in the same minoritized community being served; or¶
(e) Ensure traditional health worker staff have a history of at least one year experience primarily serving the specified cultural community being served.¶
(2) To demonstrate the ability to serve a minoritized cultural community under subsection (1)(c) of this rule, a program must provide information that shows the following:¶
(a) Comprehensive knowledge of diverse lived experiences held by the minoritized cultural community being served including, but not limited to, their experiences of structural and individual racism, minoritization or discrimination that may have an impact on the community's collective health and wellbeing.¶
(b) Knowledge of specific health inequities documented in the minoritized cultural community being served, which may be addressed by the program.¶
(c) A practice of supporting and affirming cultural and language practices of the minoritized cultural community being served, such as but not limited to:¶
(A) Health and safety beliefs, or practices;¶
(B) Positive cultural identity, pride, or resilience;¶
(C) Immigration dynamics; or¶
(D) Sacred beliefs.¶
(d) A demonstrated ability to support and affirm ~~client~~Members experiencing intersectional disparities in the provision of services. The ability to support and affirm the unique needs of ~~client~~Members experiencing intersectional oppression may be evidenced through details of the program's established collaboration with other culturally specific ~~p~~Providers, details of dedicated spaces or groups provided for ~~client~~Members experiencing intersectional oppression, or any other supporting information.¶
(3) The information required to be provided under subsection (1)(b) through (1)(e) and section (2) of this rule must include documentation of the program's culturally specific focus demonstrated in a mission statement, vision statement, or other public-facing document. Supporting information can also include but is not limited to:¶
(a) Documentation detailing policies and procedures~~.~~;¶
(b) Documentation of staff training requirements and any resulting certifications~~.~~; or¶
(c) A narrative that details the program's strategic plan or history and experience, including specific examples, without identifying any individual ~~client~~Members.
Statutory/Other Authority: ORS 413.042, ORS 414.065
Statutes/Other Implemented: ORS 414.065

AMEND: 410-174-0030

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

CHANGES TO RULE:

410-174-0030
Culturally and Linguistically Specific Services Individual Traditional Health Worker Qualifications
(1) In order to qualify for enhanced payments for culturally and linguistically specific traditional health worker services, an individual must:¶
(a) Be enrolled as a ~~p~~Provider and reimbursed through OHP's fee schedule for physical health services~~.~~:¶
(b) Be a Traditional Health Worker~~.~~:¶
(c) Submit a complete Traditional Health Worker Culturally and Linguistically Specific Services application~~.~~; and¶
(d) Demonstrate the ability to serve a minoritized cultural community.¶
(2) To demonstrate the ability to serve a particular minoritized community under subsection (1)~~(c~~(d) of this rule, an individual must provide information that shows the following:~~-~~¶
(a) Comprehensive knowledge of diverse lived experiences held by the minoritized cultural community being served including, but not limited to, their experiences of structural and individual racism, minoritization or discrimination that may have an impact on the community's collective health and wellbeing~~.~~:¶
(b) Knowledge of specific social/physical health inequities documented in the minoritized cultural community being served, which may be addressed by the culturally and linguistically specific services of the individual;¶
(c) A practice of supporting and affirming cultural and language practices for the minoritized cultural community being served, such as but not limited to:¶
(A) Health and safety beliefs or practices;¶
(B) Positive cultural identity, pride, or resilience;¶
(C) Immigration dynamics; or¶
(D) Sacred beliefs.¶
(d) A demonstrated ability to support and affirm ~~client~~Members experiencing intersectional oppression in the provision of services. The ability to support and affirm the unique needs of ~~client~~Members experiencing intersectional oppression may be evidenced through details of the individual's established collaboration with other culturally specific ~~p~~Providers, details of dedicated spaces or groups provided for ~~client~~Members experiencing intersectional oppression, or any other supporting information; and¶
(e) Have extensive experience working with or being immersed in the same minoritized cultural community being served; or~~-~~¶
(f) Have a history of at least one year of experience primarily serving a specified minoritized cultural community.~~-~~¶
(3) The information required to be provided under subsections (1)(~~b~~c) and (~~c~~d) and section (2) of this rule can include, but is not limited to:¶
(a) A resume or curriculum vitae detailing academic credentials, relevant course work, work history, or certifications; or¶
(b) A narrative that details the individual's professional history and experience, including specific examples, without identifying ~~client~~Members.
Statutory/Other Authority: ORS 413.042, ORS 414.065
Statutes/Other Implemented: ORS 414.065