

## 410-141-3420 Billing and Payment

(1) Providers shall submit all billings for CCO members in the following timeframes:

(a) Submit billings within 12 months of the date of service in the following cases:

(A) Pregnancy;

(B) Eligibility issues such as retroactive deletions or retroactive enrollments;

(C) Medicare is the primary payer, except where the CCO is responsible for the Medicare reimbursement;

(D) Other cases that could have delayed the initial billing to the CCO, which does not include failure of the provider to certify the member's eligibility; or

(E) Third Party Liability (TPL). Pursuant to 42 CFR 136.61, subpart G: Indian Health Services and the amended Public Law 93-638 under the Memorandum of Agreement that Indian Health Service and 638 Tribal Facilities are the payers of last resort and are not considered an alternative liability or TPL.

(b) Submit bills within four months of the date of service for all other cases.

(2) Providers shall be enrolled with the Division to be eligible for fee-for-service (FFS) payments. Mental health providers, except Federally Qualified Health Centers (FQHC), shall be approved by the Local Mental Health Authority (LMHA) and the Authority's Addictions and Mental Health (AMH) division before enrollment with the Authority or to be eligible for CCO payment for services. Providers may be retroactively enrolled in accordance with OAR 410-120-1260 (Provider Enrollment).

(3) Providers, including mental health providers, shall be enrolled with the Authority as a Medicaid provider or an encounter-only provider prior to submission of encounter data to ensure the encounter is accepted.

(4) Providers shall verify, before providing services, that the member is eligible for coordinated care services on the date of service. Providers shall use the Authority's tools and the CCO's tools, as applicable, to determine if the service to be provided is covered under the member's OHP benefit package. Providers shall also identify the party responsible for covering the intended service and seek preauthorizations from the appropriate payer before providing services. Before providing a non-covered service, the provider shall complete a DMAP 3165, or facsimile, signed by the client, as described in OAR 141-120-1280.

(5) CCOs shall pay for all covered coordinated care services. These services shall be billed directly to the CCO, unless the CCO or the Authority specifies otherwise. CCOs may require providers to obtain preauthorization to deliver certain coordinated care services.

(6) Payment by the CCO to participating providers for coordinated care services is a matter between the CCO and the participating provider except as follows:

(a) CCOs shall have written procedures for processing preauthorization requests received from any provider and written procedures for processing claims submitted from any source. The procedures shall specify time frames for:

(A) Date stamping preauthorization requests and claims when received;

(B) Determining within a specific number of days from receipt whether a preauthorization request or a claim is valid or non-valid;

(C) The specific number of days allowed for follow-up on pending preauthorization requests or pending claims to obtain additional information;

## 410-141-3420 Billing and Payment

(D) The specific number of days following receipt of the additional information that a redetermination shall be made;

(E) Providing services after office hours and on weekends that require preauthorization;

(F) Sending notice of the decision with appeal rights to the member when the determination is a denial of the requested service as specified in OAR 410-141-3263.

(b) CCOs shall make a determination on at least 95 percent of valid preauthorization requests within two working days of receipt of a preauthorization or reauthorization request related to urgent services, alcohol and drug services, or care required while in a skilled nursing facility. Preauthorization for prescription drugs shall be completed and the pharmacy notified within 24 hours. If a preauthorization for a prescription cannot be completed within the 24 hours, the CCO shall provide for the dispensing of at least a 72-hour supply if there is an immediate medical need for the drug. CCOs shall notify providers of the determination within two working days of receipt of the request;

(c) For expedited prior authorization requests in which the provider indicates or the CCO determines that following the standard timeframe could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function:

(A) The CCO shall make an expedited authorization decision and provide notice as expeditiously as the member's health or mental health condition requires and no later than three working days after receipt of the request for service;

(B) The CCO may extend the three working day time period no more than 14 calendar days if the member requests an extension or if the CCO justifies to the Authority a need for additional information and how the extension is in the member's best interest.

(d) For all other preauthorization requests, CCOs shall notify providers of an approval, a denial, or the need for further information within 14 calendar days of receipt of the request as outlined in OAR 410-141-3263. CCOs shall make reasonable efforts to obtain the necessary information during the 14-day period. However, the CCO may use an additional 14 days to obtain follow-up information if the CCO justifies to the Authority, upon request, the need for additional information and how the delay is in the member's best interest. If the CCO extends the timeframe, it shall give the member written notice of the reason for the extension as outlined in 410-141-3263. The CCO shall make a determination as the member's health or mental health condition requires, but no later than the expiration of the extension;

(e) CCOs shall pay or deny at least 90 percent of valid claims within 45 calendar days of receipt and at least 99 percent of valid claims within 60 calendar days of receipt. CCOs shall make an initial determination on 99 percent of all claims submitted within 60 calendar days of receipt;

(f) CCOs shall provide written notification of CCO determinations when the determinations result in a denial of payment for services as outlined in OAR 410-141-3263;

(g) CCOs may not require providers to delay billing to the CCO;

(h) CCOs may not require Medicare be billed as the primary insurer for services or items not covered by Medicare or require non-Medicare approved providers to bill Medicare;

(i) CCOs may not deny payment of valid claims when the potential TPR is based only on a diagnosis, and no potential TPR has been documented in the member's clinical record;

(j) CCOs may not delay or deny payments because a co-payment was not collected at the time of service.

## 410-141-3420 Billing and Payment

(7) CCOs shall pay for Medicare coinsurances and deductibles up to the Medicare or CCOs allowable for covered services the member receives within the CCO for authorized referral care and urgent care services or emergency services the member receives from non-participating providers. CCOs may not pay for Medicare coinsurances and deductibles for non-urgent or non-emergent care members receive from non-participating providers.

(8) CCOs shall pay transportation, meals, and lodging costs for the member and any required attendant for services that the CCO has arranged and authorized when those services are not available within the state, unless otherwise approved by the Authority.

(9) CCOs shall pay for covered services provided by a non-participating provider that was not preauthorized if the following conditions exist:

(a) It can be verified that the participating provider ordered or directed the covered services to be delivered by a non-participating provider; and

(b) The covered service was delivered in good faith without the preauthorization; and

(c) It was a covered service that would have been preauthorized with a participating provider if the CCO's referral procedures had been followed;

(d) The CCO shall pay non-participating providers (providers enrolled with the Authority that do not have a contract with the CCO) for covered services that are subject to reimbursement from the CCO in the amount specified in OAR 410-120-1295. This rule does not apply to providers that are Type A or Type B hospitals;

(e) CCOs shall reimburse hospitals for services provided on or after January 1, 2012, using Medicare Severity DRG for inpatient services and Ambulatory Payment Classification (APC) for outpatient services or other alternative payment methods that incorporate the most recent Medicare payment methodologies for both inpatient and outpatient services established by CMS for hospital services and alternative payment methodologies, including but not limited to pay-for-performance, bundled payments, and capitation. An alternative payment methodology does not include reimbursement payment based on percentage of billed charges. This requirement does not apply to Type A or Type B hospitals as referenced in ORS 442.470. CCOs shall attest annually to the Authority in a manner to be prescribed to CCO's compliance with these requirements.

(10) For Type A or Type B hospitals transitioning from Cost-Based Reimbursement (CBR) to an Alternative Payment Methodology (APM):

(a) Sections (10)–(12) only apply to services provided by Type A or Type B hospitals to clients or members that are enrolled in a CCO;

(b) In accordance with ORS 414.653, the Authority may upon evaluation by an actuary retained by the Authority, on a case-by-case basis, require CCOs to continue to reimburse fully a rural Type A or Type B hospital determined to be at financial risk for the cost of covered services based on a cost-to-charge ratio;

(c) For those Type A or Type B hospitals transitioning from CBR to an APM, the Authority shall require hospitals and CCO's to enter into good faith negotiations for contracts to be effective by January 1, 2015. Dispute resolution during the contracting process shall be subject to OAR 410-141-3268 and 410-141-3269, as applicable;

(d) For monitoring purposes, CCOs shall submit to the Authority no later than November 30 of each year a list of those hospitals with which they have contracted for these purposes.

(11) Redetermination of which Type A or Type B hospitals shall transition off of CBR:

## 410-141-3420 Billing and Payment

(a) No later than April 30, 2015, the Authority shall update the algorithm for calculation of the CBR methodology with the most recent data available;

(b) After recalculation for each Type A and Type B hospital, any changes in a hospital's status from CBR to APM or from APM to CBR shall be effective January 1, 2016;

(c) The Authority shall recalculate the reimbursement methodology for each hospital every two years thereafter;

(d) Type A and Type B hospitals located in a county that is designated as "Frontier" will not be subject to redetermination via the algorithm and shall remain on CBR.

(12) Non-contracted Type A or Type B hospital rates for those transitioning off of CBR:

(a) Charges shall be discounted for both inpatient and outpatient services. The initial reimbursement rate effective January 1, 2015 shall be based on the individual hospital's most recently filed Medicare cost report adjusted to reflect the hospital's Medicaid/OHP mix of services;

(b) Reimbursement rates effective for the calendar year beginning January 1, 2016 shall be based on the hospital's most recently filed Medicare cost report adjusted to reflect the hospital's Medicaid/OHP mix of services and further adjusted by the Actuarial Services Unit (ASU) based on the individual hospital's annual price increases during FY 2014 – FY 2015 and the Authority's global budget rate increase as defined by the CMS 1115 waiver, using the following formula:  $\text{Current Reimbursement Rate} \times (1 + \text{Global Budget Increase}) / (1 + \text{Hospital Price Increase})$ ;

(c) Subsequent year reimbursement rates shall be adjusted and calculated by the Actuarial Services Unit (ASU) based on the individual hospital's annual price increase and the Authority's global budget rate increase as defined by the CMS 1115 waiver, using the following formula:  $\text{Current Reimbursement Rate} \times (1 + \text{Global Budget Increase}) / (1 + \text{Hospital Price Increase})$ ;

(d) ASU shall contact hospitals regarding price increases during March of each year;

(e) Inpatient and outpatient reimbursement rates shall be calculated separately;

(f) A volume adjustment shall be applied. ASU shall develop a risk corridor on the volume adjustment on a hospital specific basis. The Authority shall determine when the volume adjustment might sunset on a hospital specific basis;

(g) Non-contracted Type A or Type B hospital reimbursement rates for those transitioning off of CBR can be found in the Rate Table section at the following: <http://www.oregon.gov/oha/healthplan/Pages/hospital.aspx>.

(13) Members may receive certain services on a Fee-for-Service (FFS) basis:

(a) Certain services shall be authorized by the CCO or the Community Mental Health Program (CMHP) for some mental health services, even though the services are then paid by the Authority on a FFS basis. Before providing services, providers shall verify a member's eligibility using the web portal or AVR;

(b) Services authorized by the CCO or CMHP are subject to the Authority's administrative rules and supplemental information including rates and billing instructions;

(c) Providers shall bill the Authority directly for FFS services in accordance with billing instructions contained in the Authority administrative rules and supplemental information;

(d) The Authority shall pay at the Medicaid FFS rate in effect on the date the service is provided subject to the Authority's administrative rules, contracts, and billing instructions;

## 410-141-3420 Billing and Payment

(e) The Authority may not pay a provider for providing services for which a CCO has received a CCO payment unless otherwise provided for in rule;

(f) When an item or service is included in the rate paid to a medical institution, a residential facility, or foster home, provision of that item or service is not the responsibility of the Authority or a CCO except as provided in Authority administrative rules and supplemental information (e.g., coordinated care services that are not included in the nursing facility all-inclusive rate);

(g) CCOs that contract with FQHCs and RHCs shall negotiate a rate of reimbursement that is not less than the level and amount of payment that the CCO would pay for the same service furnished by a provider who is not an FQHC nor RHC, consistent with the requirements of BBA 4712(b)(2).

(14) Coverage of services through the OHP benefit package of covered services is limited by OAR 410-141-0500 (Excluded Services and Limitations for OHP Clients).

Stat. Auth.: ORS 413.042, 414.065, 414.615, 414.625, 414.635 & 414.651

Stats. Implemented: ORS 414.065 & 414.610 - 414.685

Hist.: DMAP 16-2012(Temp), f. & cert. ef. 3-26-12 thru 9-21-12; DMAP 37-2012, f. & cert. ef. 8-1-12; DMAP 38-2013(Temp), f. 7-8-13, cert. ef. 7-9-13 thru 1-5-14; DMAP 60-2013, f. & cert. ef. 10-31-13; DMAP 65-2013, f. & cert. ef. 11-29-13; DMAP 34-2014(Temp), f. 6-25-14, cert. ef. 7-1-14 thru 12-27-14; DMAP 66-2014(Temp), f. 11-13-14, cert. ef. 12-28-14 thru 6-25-15; DMAP 71-2014, f. 12-8-14, cert. ef. 1-1-15