

Secretary of State  
**NOTICE OF PROPOSED RULEMAKING HEARING\***  
A Statement of Need and Fiscal Impact accompanies this form.

Oregon Health Authority, Division of Medical Assistance Programs (Division)	410	
Agency and Division	Administrative Rules Chapter Number	
Sandy Cafourek	500 Summer St Ne, Salem, OR 97301	503-945-6430
Rules Coordinator	Address	Telephone

**RULE CAPTION**

PHP and CCO Payment Methodologies for A & B Hospitals

**Not more than 15 words that reasonably identifies the subject matter of the agency's intended action.**

November 18, 2014	10:30 AM	500 Summer St NE, Salem, OR 97301, Room 137C	Sandy Cafourek
Hearing Date	Time	Location	Hearings Officer

*Auxiliary aids for persons with disabilities are available upon advance request.*

**RULEMAKING ACTION**

Secure approval of new rule numbers (Adopted or Renumbered rules) with the Administrative Rules Unit prior to filing.

**ADOPT:**

**AMEND:** OAR 410-141-0420 and OAR 410-141-3420

**REPEAL:** OAR 410-141-0420 (T) and OAR 410-141-3420 (T)

**RENUMBER:**

**AMEND & RENUMBER:**

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

Other Auth.: SB 204 and HB 3650

Stats. Implemented: ORS 414.065 and 414.610 through 414.685

**RULE SUMMARY**

The Division is amending these rules to comply with ORS 414.653. The statute requires Type A & B Hospitals to move to a new payment methodology. Type A & B hospitals that are found at financial risk will remain on the current methodology and will not have to change.

The Agency requests public comment on whether other options should be considered for achieving the rule's substantive goals while reducing the negative economic impact of the rule on business.

November 20, 2014 by 5 p.m. (Send comments to [dmap.rules@state.or.us](mailto:dmap.rules@state.or.us).)

**Last Day for Public Comment** (Last day to submit written comments to the Rules Coordinator)



Signature

Rhonda Busell

Printed name

10-8-14

Date

\*Hearing Notices published in the Oregon Bulletin must be submitted by 5:00 pm on the 15th day of the preceding month unless this deadline falls on a weekend or legal holiday, upon which the deadline is 5:00 pm the preceding workday. ARC 920-2005

**STATEMENT OF NEED AND FISCAL IMPACT**

A Notice of Proposed Rulemaking Hearing or a Notice of Proposed Rulemaking accompanies this form.

Oregon Health Authority, Division of Medical Assistance Programs

410

Agency and Division

Administrative Rules Chapter Number

PHP and CCO Payment Methodologies for A & B Hospitals

Rule Caption (Not more than 15 words that reasonably identifies the subject matter of the agency's intended action.)

In the Matter of: The amendment of OAR 410-141-0420 and OAR 410-141-3420 and the repeal of OAR 410-141-0420(T) and OAR 410-141-3420(T)

Statutory Authority: ORS 413.042, 414.065, 414.615, 414.625, 414.635, 414.651

Other Authority: SB 204 and HB 3650

Stats. Implemented: ORS 414.065 and 414.610 through 414.685

Need for the Rule(s): The Division needs to amend these rules to comply with ORS 414.653. Per HB 3650, hospitals meeting certain criteria currently under Cost-Based Reimbursement (CBR) for Medicaid will transition to an Alternative Payment Method (APM) effective CY 2015.

Documents Relied Upon, and where they are available: HB 3650; OHA Rural Health Reform Initiative "Summary of Methods and Outcomes of the Rural Health Reform Initiative Workgroup/Optimus Report, dated April 15, 2014; letter dated July 24, 2014 from Suzanne Hoffman, interim director of OHA, to Becky Pape, chair of the Small and Rural Hospital Committee, and Scott Ekblad, director of the Oregon Office of Rural Health, regarding the inclusion of the "frontier status as being an appropriate factor in the 'decision tree' related to cost-based reimbursement."

Fiscal and Economic Impact: See below.

Statement of Cost of Compliance:

1. Impact on state agencies, units of local government and the public (ORS 183.335(2)(b)(E)):

The Division does not anticipate fiscal impacts on other state agencies, units of local government, or the public.

2. Cost of compliance effect on small business (ORS 183.336):

a. Estimate the number of small businesses and types of business and industries with small businesses subject to the rule: The Division does not anticipate a direct or indirect impact on small businesses.

b. Projected reporting, recordkeeping and other administrative activities required for compliance, including costs of professional services: None.

c. Equipment, supplies, labor and increased administration required for compliance: None.

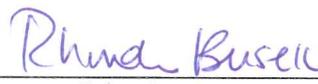
How were small businesses involved in the development of this rule? N/A This rule change will have no impact on small businesses.

Administrative Rule Advisory Committee consulted?: Yes. A RAC meeting was held on 9/15/2014.

If not, why?:



Signature



Printed name

10-7-14

Date

## 410-141-0420

### Managed Care Prepaid Health Plan Billing and Payment under the Oregon Health Plan

~~The Division of Medical Assistance Programs (Division) may have specific definitions for common terms. Please see OAR 410-141-0000, Definitions, in conjunction with this rule.~~

~~(1) Providers shall submit all billings for OHP members to Prepaid Health Plans (PHPs) and the Division within four months of the date of service, subject to other applicable Division billing rules. A billing submitted within four months of the date of service that was denied may be resubmitted within six months of the date of service. Providers shall submit billings to PHPs within the four month time frame except in the following cases in which providers shall submit billings to PHPs within 12 months of the date of service:~~

~~(a) Pregnancy;~~

~~(b) Eligibility issues such as retroactive deletions or retroactive enrollments;~~

~~(c) Medicare is the primary payer; \_\_\_\_\_~~

~~(d) Other cases that could have delayed the initial billing to the PHP (which does not include failure of provider to certify the Division Authority 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 payer of last resort and is not considered an alternative liability or TPL.~~

(1) Subject to other applicable Authority billing rules, providers shall submit all billings for OHP members following the timeframes in (a) and (b) below:

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

(A) Pregnancy;

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

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

(D) Other cases that could have delayed the initial billing to the MCO (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 of Medical Assistance Programs to be eligible for Division Authority 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 Division Authority or to be eligible for PHP 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 Division Authority either as a Medicaid provider or an encounter-only provider prior to submission of encounter data to ensure the encounter is accepted. ~~the servicing provider is not excluded per federal and state standard as defined in OAR 407-120-0300.~~

(4) Providers shall verify, before rendering providing services, that the member is eligible for the Division of Medical Assistance Programs on the date of service. Providers shall use the Division Authority tools and the PHP's tools, as applicable, and that to determine if the service to be rendered-provided is covered under the member's Oregon Health Plan Benefit Package of covered services. Providers shall also identify the party responsible for covering the intended service and seek preauthorizations from the appropriate payer before rendering-providing services. Before providing a non-covered services, the provider shall complete and have the member sign an Division Authority 3165, or facsimile signed by the client, as described in OAR 410-120-1280.

(5) PHPs shall pay for all capitated services. These services shall be billed directly to the PHP, unless the PHP or the Division Authority specifies otherwise. PHPs may require providers to obtain preauthorization to deliver certain capitated services.

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

(a) Preauthorizations:

(Aa) PHPs 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:

(iA) 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 pended preauthorization requests or pended claims to obtain additional information;

(#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 ~~made to deny a~~ denial of the requested service as specified in OAR 410-141-0263.

(Bb) PHPs 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 PHP shall provide for the dispensing of at least a 72-hour supply if the medical need for the drug is immediate. PHPs shall notify providers of such determination within two working days of receipt of the request;

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

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

(#B) The PHP may extend the three working days-time period by up to 14 calendar days if the member requests an extension or if the PHP justifies to the Division Authority a need for additional information and how the extension is in the member's interest.

(Dd) For all other preauthorization requests, PHPs shall notify providers of an approval, denial, or need for further information within 14 calendar days of receipt of the request as outlined in OAR 410-141-0263. PHPs shall make reasonable efforts to obtain the necessary information during the 14-day period. However, the PHP may use an additional 14 days to obtain follow-up information if the PHP justifies (to the Division Authority upon request) the need for additional information and how the delay is in the member's interest. If the PHP extends the timeframe, it shall give the member written notice of the reason for the extension as outlined in OAR 410-141-0263. The

PHP shall make a determination as the member's health condition requires but no later than the expiration of the extension.

~~(b) Claims payment:~~

~~(A) PHPs shall have written procedures for processing claims submitted for payment from any source. The procedures shall specify time frames for:~~

~~(i) Date stamping claims when received;~~

~~(ii) Determining within a specific number of days from receipt whether a claim is valid or non-valid;~~

~~(iii) The specific number of days allowed for follow up of pended claims to obtain additional information;~~

~~(iv) The specific number of days following receipt of additional information that a determination shall be made; and~~

~~(v) Sending notice of the decision with appeal rights to the member when the determination is made to deny the claim.~~

~~(Be)~~ PHPs 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. PHPs shall make an initial determination on 99 percent of all claims submitted within 60 calendar days of receipt;

~~(Cf)~~ PHPs shall provide written notification of PHP determinations when the determinations result in a denial of payment for services as outlined in OAR 410-141-0263.

~~(Dg)~~ PHPs may not require providers to delay billing to the PHP;

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

~~(Fi)~~ PHPs shall 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;

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

~~(e7)~~ FCHPs, PCOs, and MHOs shall pay for Medicare coinsurances and deductibles up to the Medicare or PHP's allowable for covered services the member receives within the

PHP for authorized referral care and for urgent care services or emergency services the member receives from non-participating providers. FCHPs, PCOs, and MHOs ~~are not responsible shall not pay~~ for Medicare coinsurances and deductibles for non-urgent or non-emergent care members receive from non-participating providers;

~~(d8) FCHPs and PCOs shall pay transportation, meals, and lodging costs for the member and any required attendant for services that the PHP has arranged and authorized when those services are not available within the state, unless otherwise approved by the Authority. out-of-state services (that the FCHP and PCO have arranged and authorized when those services are available within the state, unless otherwise approved by the Division);~~

(e9) PHPs shall pay for covered services provided by a non-participating provider that were not preauthorized if the following conditions exist:

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

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

(Cc) It was a covered service that would have been preauthorized with a participating provider if the PHP's referral protocols had been followed;

~~(Dd) The PHP shall make payment to non-participating providers pay non-participating providers (providers enrolled with the Division Authority that do not have a contract with the PHP) for covered services that are subject to reimbursement from the PHP, the amount specified in OAR 410-120-1295. This rule does not apply to providers that are Type A or Type B hospitals, as they are paid in accordance with ORS 414.727.~~

~~(Z10) For Type A or Type B hospitals transitioning from Cost-Based Reimbursement (CBR) to an Alternative Payment Methodology (APM):~~

~~(a) These sections (Z10) – (Z12) only, apply to services provided by Type A or Type B hospitals to clients /or members that are enrolled in a CCOPHP;~~

~~(b) In accordance with ORS 414.653, the Authority may upon evaluation by an actuary retained by Authority, on a case-by-case basis, require CCOPHPs 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 these 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 will be subject to OAR 410-141-3268 and/or 410-141-3269, as applicable.~~

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

(§11) Re-determination of which Type A or Type B hospitals will transition off of CBR:

(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 will be effective January 1, 2016;

(c) The reimbursement methodology for each hospital will be recalculated 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 re-determination via the algorithm and will 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 will 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 will 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 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 will be adjusted and calculated by 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 will contact hospitals regarding price increases during March of each year;

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

(f) A volume adjustment will also be applied. ASU will develop a risk corridor on the volume adjustment on a hospital specific basis. The Authority will 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>

~~(7) Other services:~~

~~(a13) Members enrolled with PHPs may receive certain services on an DivisionAuthority FFS basis. These services are referred to as non-capitated services;~~

~~(ba) Certain services shall be authorized by the PHP or the Community Mental Health Program (CMHP) for some mental health services, even though the services are then paid by the DivisionAuthority on a Division-FFS basis. Before providing services, providers ~~should~~ shall verify a member's eligibility via the web portal or AVR. For some mental health services, providers will need to contact the CMHP directly. In addition, the provider may call the PHP to obtain information about coverage for a particular service or preauthorization requirements;~~

~~(eb) Services authorized by the PHP or CMHP are subject to the rules and limitations of the appropriate DivisionAuthority administrative rules and supplemental information including rates and billing instructions;~~

~~(dc) Providers shall bill the DivisionAuthority directly for non-capitated FFS services in accordance with billing instructions contained in the DivisionAuthority administrative rules and supplemental information;~~

~~(ed) The DivisionAuthority shall pay at the Medicaid FFS rate in effect on the date the service is provided subject to the rules and limitations described in the relevant rules, contracts, billing instructions, and Division administrative rules and supplemental information;~~

~~(fe) The DivisionAuthority may not pay a provider for provision of services for which a PHP has received a capitation payment unless otherwise provided for in OAR 410-141-0120 rule;~~

~~(gf) 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 DivisionAuthority, AMH, or PHP except as provided for in DivisionAuthority administrative rules and supplemental information (e.g., capitated services that are not included in the nursing facility all-inclusive rate); and~~

(hg) FCHPs and PCOs 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 FCHP or PCO would make for the same service furnished by a provider who is not an FQHC nor RHC, consistent with the requirements of BBA 4712(b)(2).

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

(915) OHP clients enrolled with a PCM receive services on a FFS basis:

(a) PCMs are paid a per client-per month payment to provide PCM ~~s~~Services in accordance with OAR 410-141-0410, PCM Medical Management;

(b) PCMs provide primary care access and management services for preventive services, primary care services, referrals for specialty services, limited inpatient hospital services, and outpatient hospital services. The ~~Division~~Authority payment for these PCM managed services is contingent upon PCM authorization;

(c) All PCM managed services are covered services that shall be billed directly to the ~~Division~~Authority in accordance with billing instructions contained in the ~~Division~~Authority administrative rules and supplemental information;

(d) The ~~Division~~Authority shall pay at the FFS rate in effect on the date the service is provided subject to the rules and limitations described in the appropriate ~~Division~~Authority administrative rules and supplemental information.

(4016) All OHP members enrolled with a PCO receive inpatient hospital services on a FFS basis:

(a) May receive services directly from any appropriately enrolled provider;

(b) All services shall be billed directly to the ~~Division~~Authority in accordance with FFS billing instructions contained in the ~~Division~~Authority administrative rules and supplemental information;

(c) The ~~Division~~Authority shall pay at the FFS rate in effect on the date the service is provided subject to the rules and limitations described in the appropriate ~~Division~~Authority administrative rules and supplemental information.

(4117) OHP clients not enrolled with a PHP receive services on a FFS basis:

(a) Services may be received directly from any appropriately enrolled provider;

(b) All services shall be billed directly to the Division Authority in accordance with billing instructions contained in the Division Authority administrative rules and supplemental information;

(c) The Division Authority shall pay at the FFS rate in effect on the date the service is provided subject to the rules and limitations described in the appropriate Division Authority administrative rules and supplemental information.

#### **410-141-3420**

### **Billing and Payment**

(1) Subject to other applicable Division Authority billing rules, providers must submit all billings for CCO members following the timeframes in (a) and (b) below:

(a) Submit billings within twelve 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 ~~must~~ shall be enrolled with the Division of Medical Assistance Programs to be eligible for Authority fee-for-service (FFS) payments. Mental health providers, except Federally Qualified Health Centers (FQHC), ~~must~~ shall be approved by the Local Mental Health Authority (LMHA) and the Authority's Addictions and Mental Health (AMH) ~~Division~~ 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, ~~must~~ 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 tools and the CCO's tools, as applicable, to determine if the service to be provided is covered under the member's Oregon Health Plan ~~benefit~~ Benefit package ~~Package~~ of covered services. 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 services~~, the provider ~~must~~ 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 ~~must~~ 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~~ follow-up on pended preauthorization requests or pended claims to obtain additional information;

(D) The specific number of days following receipt of the additional information that a redetermination ~~must~~ 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 ~~must~~ 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 ~~must~~ 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 must 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 410-141-3263. CCOs ~~must~~ 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 interest of the member. If the CCO extends the timeframe, it shall give the member written notice of the reason for the extension as outlined in OAR 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.

~~(7) CCOs shall have written procedures for processing payment claims submitted from any source. The procedures shall specify time frames for:~~

~~(a) Date stamping claims when received;~~

~~(b) Determining within a specific number of days from receipt whether a claim is valid or non-valid;~~

~~(c) The specific number of days allowed for follow up of pending claims to obtain additional information;~~

~~(d) The specific number of days following receipt of additional information that a determination must be made; and~~

~~(e) Sending notice of the decision with appeal rights to the member when the determination is made to deny the claim;~~

~~(f) 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;~~

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

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

(ih) 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;

(ji) 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;

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

(87) 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.

(98) 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.

(109) 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.

(4410) For Type A or Type B hospitals transitioning from Cost-Based Reimbursement (CBR) to an Alternative Payment Methodology (APM):

(a) These sections (4410) – (123) only apply to services provided by Type A or Type B hospitals to clients/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 will be subject to OAR 410-141-3268 and/or 410-141-3269, as applicable.

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

(4211) Re-determination of which Type A or Type B hospitals will transition off of CBR:

(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 will be effective January 1, 2016;

(c) The reimbursement methodology for each hospital will be recalculated 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 re-determination via the algorithm and will remain on CBR.

(4312) 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, will 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, will 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 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: Current Reimbursement Rate x (1+Global Budget Increase) / (1+Hospital Price Increase);

(c) Subsequent year reimbursement rates will be adjusted and calculated by 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: Current Reimbursement Rate x (1+Global Budget Increase) / (1+Hospital Price Increase);

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

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

(f) A volume adjustment will also be applied. ASU will develop a risk corridor on the volume adjustment on a hospital specific basis. The Authority will 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>.

(1413) Members may receive certain services on an Authority Fee for Service (FFS) basis:

(a) Certain services ~~must~~ 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 ~~must~~ shall verify a member's eligibility using the web portal or AVR;

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

~~(c) Providers shall bill the Authority directly for~~ The Authority shall pay at the Medicaid FFS rate in effect on the date the services is provided in accordance with the rules and limitations described in the relevant rules, contracts, 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 rules and limitations described in the relevant rules, contracts, and billing instructions;

(e) The Authority may not pay a provider for provision of 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, AMH 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).

~~(1514)~~ Coverage of services through the Oregon Health Plan ~~benefit~~ Benefit package Package of covered services is limited by OAR 410-141-0500, excluded services and limitations for OHP clients.

Stat. Auth.: ORS 414.032, 414.615, 414.625, 414.635, 414.651

Stats. Implemented: ORS 414.610 – 685 OL 2011, Ch 602 Sec. 13, 14, 16, 17, 62, 64 (2), 65, HB 3650