

Secretary of State
NOTICE OF PROPOSED RULEMAKING HEARING*

A Statement of Need and Fiscal Impact accompanies this form.

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|--|-------------------------------------|
| Oregon Health Authority, Division of Medical Assistance Programs | 410 |
| Agency and Division | Administrative Rules Chapter Number |
| Cheryl Peters, 500 Summer St Ne, Salem, OR 97301 | 503-945-6527 |
| Rules Coordinator | Address Telephone |

RULE CAPTION

Patient-Centered Primary Care Home program revisions and clarifications

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

| | | | |
|----------------|-------|--|------------------|
| March 19, 2012 | 10:00 | 500 Summer St NE, Salem, OR 97301, Room 137C | Cheryl Peters |
| 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.

AMEND: OAR 410-141-0860, 410-147-0362, 410-146-0020
SUSPEND: OAR 410-141-0860(T), 410-147-0362(T), 410-146-0020(T)
Repeal 415112

Stat. Auth. : ORS 413.042, 414.065 and 413.032

Other Auth.:

Stats. Implemented: ORS 414.065, 413.032, and 413.042

RULE SUMMARY

The Division will permanently amend OAR 410-141-0860 to modify the Oregon Health Plan Primary Care Manager provider qualification and enrollment criteria to include Patient Centered Primary Care Homes. The Division also will permanently amend OAR 410-146-0020 in the American Indian/Alaska Native Program and OAR 410-147-0362 in the Federally Qualified Health Clinics/Rural Health Clinics Program, filed in conjunction with and referencing the more detailed OAR 410-141-0860.

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.

March 21, 2012
Last Day for Public Comment (Last day to submit written comments to the Rules Coordinator)

| | | |
|---|-----------------|---------|
|  | JEAN S. DONOVAN | 2-15-12 |
| Signature | Printed name | 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

Secretary of State
STATEMENT OF NEED AND FISCAL IMPACT

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

Oregon Health Authority (Authority), Division of Medical Assistance Programs (Division) 410
Agency and Division Administrative Rules Chapter Number

Patient-Centered Primary Care Home program revisions and clarifications
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 410-141-0860, 410-147-0362 and 410-146-0020

Statutory Authority: ORS 413.042, 414.065 and 413.032

Stats. Implemented: ORS 414.065, 413.032, and 413.042

Need for the Rule(s):

The Oregon Health Plan Program administrative rules govern Division payments for the PCPCH Program. The Division will permanently amend OAR 410-141-0860 to modify the Oregon Health Plan Primary Care Manager provider qualification and enrollment criteria to include Patient Centered Primary Care Homes. The Division also will permanently amend 410-146-0020 in the American Indian/Alaska Native Program and 410-147-0362 in the Federally Qualified Health Clinics/Rural Health Clinics Program, filed in conjunction with and referencing the more detailed OAR 410-141-0860.

Documents Relied Upon, and where they are available: N/A

Fiscal and Economic Impact: No adverse impact on small business. Medical clinics who qualify to meet the standards as a Patient Centered Primary Care Home under these rules may qualify for increased reimbursement as a small business.

Statement of Cost of Compliance:

1. Impact on state agencies, units of local government and the public (ORS 183.335(2)(b)(E)):
None

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:
Approximately 900 medical clinics and practices may be eligible for increased reimbursement if they qualify as a Patient Centered Primary Care Home under these rules.

b. Projected reporting, recordkeeping and other administrative activities required for compliance, including costs of professional services:

There are recordkeeping and reporting requirements for medical clinics which qualify as Patient Centered Primary Care Homes, however these clinics are also eligible to receive increased reimbursement under these Rules. The PCPCHs program is voluntary. While there may be additional administrative activities for those that wish to participate in the program, the Authority cannot estimate the cost.

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

How were small businesses involved in the development of this rule?
Through the Rule Advisory Committee meeting process.

Administrative Rule Advisory Committee consulted?: Yes

If not, why?:

Signature  Printed name JEAN S. DONOVAN Date 2-15-12

410-141-0860 Oregon Health Plan Primary Care Manager and Patient Centered Primary Care Home Provider Qualification and Enrollment

(1) Primary Care Managers (PCM) must be trained and certified or licensed, as applicable under Oregon statutes and administrative rules, in one of the following disciplines:

- (a) Doctors of medicine;
- (b) Doctors of osteopathy;
- (c) Naturopathic physicians;
- (d) Nurse Practitioners;
- (e) Physician assistants.

(2) The following entities may enroll as PCMs:

- (a) Hospital primary care clinics;
- (b) Rural Health Clinics (RHC); ~~(c) Community and Migrant Health Clinics;~~
- ~~(d)~~ Federally Qualified Health Clinics (FQHC);
- ~~(e)~~ Indian Health Service Clinics;
- ~~(f)~~ Tribal Health Clinics.

(3) Naturopaths must have a written agreement with a physician that is sufficient to support the provision of primary care, including prescription drugs, as well as the necessary referrals for hospital care.

(4) All applicants for enrollment as PCMs must:

- (a) Be enrolled as Oregon Division of Medical Assistance Programs (Division) providers;
- (b) Make arrangements to ensure provision of the full range of PCM Managed Services, including prescription drugs and hospital admissions;
- (c) Complete and sign the PCM Application (DMAP 30130-~~(7/11)~~).

(5) If the Division determines that the PCM or an applicant for enrollment as a PCM does not comply with the OHP administrative rules pertaining to the PCM program or the Division's General Rules; or if the Division determines that the health or welfare of Division members may be adversely affected or in jeopardy by the PCM the Division may:

- (a) Deny the application for enrollment as a PCM; or
- (b) Close enrollment with an existing PCM; ~~or and~~
- (c) Transfer the care of those PCM members enrolled with that PCM until such time ~~as~~ the Division determines that the PCM is in compliance.

(6) The Division may terminate the PCM agreement without prejudice to any obligations or liabilities of either party already accrued prior to termination, except when the obligations or liabilities result from the PCM's failure to terminate care for those PCM members. The PCM shall be solely responsible for its obligations or liabilities after the termination date when the obligations or liabilities result from the PCM's failure to terminate care for those PCM members.

(7) Patient Centered Primary Care Homes (PCPCH):

~~(a) Definition:~~

~~(aA)~~ PCPCH is defined as a health care team, provider or clinic that is organized in accordance with these rules and as stated in the Oregon Health Authority (Authority) ~~and the~~ Office of Health Policy and Research (Office) Oregon Patient-Centered Primary Care Home Model Implementation Reference Guide (www.primarycarehome.oregon.gov):-

~~(A) The (PCPCH) must be able to identify patients with high risk environmental or medical factors, including patients with special health care needs, who will benefit from additional care planning. The PCPCH must coordinate the care of all memberspatients to ensure high-risk patients or patients with special health care needs have a person-centered plan that has been developed and reviewed with the patient or caregivers. Further care management activities must include, but are not limited to defining and following self-management goals, developing goals for preventive and chronic illness care, developing action plans for exacerbations of chronic illnesses, and developing end-of-life care plans when appropriate;~~

(B) The PCPCH team is interdisciplinary and inter-professional and must include non-physician health care professionals, such as a nurse care coordinator, nutritionist, social worker, behavioral health professional, or other traditional or non-traditional health care workers authorized through state plan or waiver authorities. These professionals may operate in a variety of ways, such as free standing, virtual, or based at any of the clinics and facilities outlined below in section (7) (a) (EG);

(C) The following definitions of six core services apply to ACA-Qualified patients mMembers and payments made for those services:-

(iB) Care coordination is defined within a PCPCH as an integral part of the PCPCH. MembersPatients will choose and be assigned to a provider, clinic or team to increase continuity with the chosen provider or team, and to ensure individual responsibility for care coordination functions. A person-centered plan willshall be developed based on the needs and desires of the patient with at least the following elements: options for accessing care, information on care planning and care coordination, names of other primary care team members when applicable and information on ways the team member participates in this care coordination. Care coordination functions can include but are not limited to: tracking of ordered tests and result notification, tracking referrals ordered by its clinicians, including referral status and whether consultation results have been communicated to patients and clinicians, and direct collaboration or co-management of patients with specialty mental health, substance abuse, and providers of services and supports to people with developmental disabilities and people receiving long term care services and supports. The Co-location of -between-behavioral health and primary care services is strongly encouraged:-

(iiG) Health pPromotion is defined as a PCPCH provider that supports continuity of care and health promotion through the development of a treatment relationship with the individual, other primary care team members and community providers. The PCPCH provider shall will promote the use of evidence based, culturally sensitive wellness and prevention by linking the enrollee with resources for smoking cessation, diabetes, asthma, self-help resources and other services based on individual needs and preferences. Health promotion activities shall will be utilized to promote patient and family education and self-management of the chronic conditions:-

(iiiD) Comprehensive Transitional Care is defined as a PCPCH that emphasizes transitional care by demonstrating either a written agreement and or procedures in place with its usual hospital providers, local practitioners, health facilities and community based services to ensure notification and coordinated, safe transitions, as well as improving the percentage of patients seen or contacted within 1 week of facility discharges:-

(ivE) Individual and Family Support Services is defined as a PCPCH that has processes in place for patient and family education; health promotion and prevention; self management supports; information and assistance to obtain available non-health care community resources, services and supports. The person-centered plan will reflect the client and family and caregiver preferences for education, recovery and self management. Peer supports, support groups and self care programs will be utilized to increase the client and caregivers knowledge about the client's individual disease:-

(vF) Referral to cCommunity and sSocial sSupport sServices is defined as the PCPCH demonstrated processes and capacity for referral to community and social support services, such as patient and family education, health promotion and prevention, and self management support efforts, including available community resources. Care coordination functions shall will include the use of the person-centered plan to manage such referrals and monitor follow up as necessary:-

(viG) Health Information Technology (HIT) is defined as the PCPCH that encourages the utilization of current, contracted or Implemented HIT systems to allow the PCPCH to share clinical information electronically in real time with the client, other providers and care entities, in concert with other

developing HIT infrastructure. PCPCHs are also encouraged to use HIT to link to, promote, manage and follow health promotion activities such as the use of registries, nurse and provider advice lines; connectivity to programs that enhance awareness of needed preventive treatments to communicate with health facilities; and to facilitate interdisciplinary collaboration among all members of the team including the client/patient, family and local supports to initiate, manage and follow up on community based and other social services referrals as developed.

~~(HB) The (PCPCH) must be able to identify patients with high risk environmental or medical factors, including patients with special health care needs, who will benefit from additional care planning. The PCPCH must coordinate the care of all members to ensure high-risk patients or patients with special health care needs have a person-centered plan that has been developed and reviewed with the patient or caregivers. Further care management activities must include, but are not limited to defining and following self-management goals, developing goals for preventive and chronic illness care, developing action plans for exacerbations of chronic illnesses, and developing end-of-life care plans when appropriate.~~

(GD) Providers who may apply to become a PCPCH, include but are not limited to: physicians (Family Practice, General Practice, including pediatricians, gynecologists, obstetricians, Internal Medicine, Certified Nurse Practitioner and Physician Assistants); clinical practices or clinical group practices; FQHCs; RHC; Tribal clinics; community health centers; community mental health programs; and drug and alcohol treatment programs with integrated Primary Care Providers.

~~(J) FQHC and RHC clinics that choose to participate in the PCPCH program must meet the requirements and adhere to rules outlined in OAR 409-055-0000 through OAR 409-055-0080 in addition to OAR 410-141-0860, Oregon Health Plan Primary Care Manager and Patient Centered Primary Care Home Provider Qualification and Enrollment.~~

~~(JD) The PCPCH team is interdisciplinary and inter-professional and must include non-physician health care professionals, such as a nurse care coordinator, nutritionist, social worker, behavioral health professional, or other traditional or non-traditional health care workers authorized through state plan or waiver authorities. These professionals may operate in a variety of ways, such as free standing, virtual, or based at any of the clinics and facilities outlined above.~~

(b) Provider Enrollment:

(A) PCPCHs that are recognized through the Authority and determined by the Office in accordance with OAR 409-055-0030 to meet PCPCH standards ~~may~~ must apply to be enrolled with the Division as a PCPCH provider in order to receive reimbursement (OAR 410-120-1260), except as otherwise provided in OAR 410-120-1295. Upon completion of enrollment and assignment of members, the Division shall enroll the PCPCH providers in the Medicaid Management Information System (MMIS) to pair them with members receiving primary care from the provider and the Division shall pay providers a PMPM payment, or the FGHP as applicable to provide PCPCH services.

~~(BB) Providers seeking reimbursement from the Division, except as otherwise provided in OAR 410-120-1295 or 943-120-1295, must be enrolled as a provider in accordance with OAR 410-120-1260. Signing the provider agreement enclosed in the application package constitutes agreement by performing and billing providers to comply with all applicable Division provider rules, federal and state laws and regulations. This also includes provider enrollment forms 3972, 3973, 3974 and any other applicable forms determined by provider type.~~

GB) Practices and providers that may apply to become a PCPCH, include: -physicians (family practice, general practice, pediatricians, gynecologists, obstetricians, Internal Medicine), Certified Nurse Practitioner and Physician Assistants, clinical practices or clinical group practices; FQHCs; RHCs; Tribal clinics; Community health centers; Community Mental Health Programs and Drug and Alcohol Treatment Programs with integrated Primary Care Providers;

~~(C) In addition to completing the PCPCH provider enrollment packet, the provider must submit to the Division a list of Medicaid fee-for-service (FFS) members in a format provided by the Division. Those PCPCH providers serving FCHP clients must submit the information as required to the managed care plan.~~

~~(CDG) New Authority-recognized PCPCH enrollment shall be effective on or after October 1, 2011 or the date established by the Authority upon receipt of required information.~~

~~(EDD) Authority-recognized PCPCH tier enrollment changes shall be effective the first of the next month or a date approved by the Authority Division following enrollment.~~

~~(FEE) Termination of Authority-recognized PCPCH enrollment shall be the date established by the Authority. All providers shall comply with Provider Sanctions as outlined in OAR 410-120-1400.~~

~~(c) Member-Patient Assignment
and Provider Payment~~

~~(A) The Division shall authorize appropriate payments only after the Centers for Medicare and Medicaid Services approves implementation of the PCPCH Program. This provision only affects the initial start-up of the Medicaid portion of the PCPCH program.~~

~~(B) In addition to completing the Division's provider enrollment packet process, the PCPCH clinic must submit to the Division a list of Medicaid fee-for-service (FFS) memberpatients in a format approved by the Division.~~

~~(C) PCPCHs serving clients enrolled in a managed care organization (MCO) (an FCHP and or PCO) clients must consult the plan-MCO on the plans methodology for determining how to submit a patient list to that the plan-MCO. will submit to the DivisionThe Division will work with the MCOmanaged care in submitting a list of their identified memberpatients.~~

~~(D)
(B) PCPCH PMPM payment patients shall be as specified in section (7)(c)(J) of this an addendum to the provider enrollment form between the Division and the PCPCH provider. The payment shall be based on the tier of PCPCH and each member's patient's status as either ACA-qualified or non-ACA qualified.~~

~~(E) The Division acknowledges the slow pace of federal approval. As a result, the Division will implement PMPM payments for non-ACA memberpatients who are not enrolled in an FCHP or PCO as soon as federal approval has been received. The Division will integrate this service into rate setting and managed care responsibilities at the first available opportunity. This provision only affects the start up phase of the program and is acknowledgment of a more gradual implementation than was originally intended.~~

~~(GFE) Members-Patients assigned must have full medical eligibility with either Oregon Health Plan (OHP) Plus (BMH, BMP, BMM or BMD) or OHP Standard (KIT) Bbenefits planspackages, this excludes CAWEM Plus (CWX) and QMB (MED) only.~~

~~(DGF) An ACA-qualified member-patient is a member-patient who meetsing the criteria described in these rules as authorized by Section 1945-2703 in of the Patient Protection and Affordable Care Act; of the Social Security Act.~~

~~(EHG) ACA-qualified members-patients are:~~

~~(i) Members-Patients with-with:~~

~~(l) Aa serious and persistent mental health condition; or one or more of the following conditions~~

~~(II) a~~ At least two chronic conditions proposed by the state and approved by the federal CMS Centers for Medicare and Medicaid Services; or

~~(III) e~~ One chronic condition and at risk of another;

~~(ii) Members with a mental health condition, substance abuse disorder, asthma, diabetes, heart disease and BMI over 25, HIV/AIDS, hepatitis, chronic kidney disease or cancer; A detailed list of qualifying conditions will be posted on the agency website after the state receives federal approval. The types of conditions include a mental health condition, substance use disorders, asthma, diabetes, heart disease, BMI over 25 or for memberpatients under the age of 20, the equivalent measure would be BMI equal or greater than 85 percentile, HIV/AIDS, hepatitis, chronic kidney disease and cancer;~~

~~(iii) Providers and plans are to use information published by the US Preventive Task Force when making decisions about the particular risk factors for an additional chronic condition that may lead a memberpatient with one chronic condition to meet the criteria of one chronic condition and at risk of another. The conditions and risk factors shall be documented in the memberpatient's medical record.~~

~~(F)~~ All other members are considered non-ACA-qualified members.

~~(d) Provider payment: Payment for PCPCH described in these rules is contingent on federal approval and will not be made until the Division has received the necessary authority. The Division will post approval announcement on it's website and other methods of informing providers, plans and the public;~~

~~(G)~~ J For fee-for-service ACA-qualified memberpatients, the PMPM amount of the payment shall be based on the PCPCH tier as determined by the Authority and the Office and shall be:

~~(i) \$10 for tier 1;~~

~~(ii) \$15 for tier 2 and;~~

~~(iii) \$24 for tier 3;~~

~~(H)~~ B For FFS non-ACA-qualified memberpatients, the PMPM amount of the payment shall be based on the PCPCH tier as determined by the Authority and the Office and shall be:

~~(i) \$2 for tier 1;~~

~~(ii) \$4 for tier 2 and;~~

~~(iii) \$6 for tier 3.~~

~~(I)~~ C The Division shall make PMPM payments based on the PCPCH clinic's recognized tier specified through the PCPCH recognition process and on the member-patient's who are ACA status-qualified qualification who are receiving primary care from a provider recognized by the Authority as a PCPCH in accordance with OAR 409-055-0030. MCOs Fully Capitated Health Plans (FCHP) and Physician Care Organizations (PCO) shall make payments to PCPCH with ACA-qualified members enrolled in PCPCH receiving primary care from a PCPCH clinics providers recognized by the Authority as a PCPCH in accordance with OAR 409-055-0030;

~~(J)~~ M Managed Care plans FCHP and PCO MCOs must use an alternative payment methodology that supports the DMAP the Division Authority's goal of improving the efficiency and quality of health services for primary care homes by decreasing the use of fee-for-service reimbursement models. PMPM payment is an alternative methodology;

~~(K)~~ N It is the Division's the DMAP Authority's intention that the PCPCH Program will not duplicate other similar services or programs such as PCM and medical case Disease Management management, and the Authority shall not make PCPCH payments for member-patients

who participate in these programs. Providers or clinics will not receive PCPCH payment for patients that DMAP the Division is making payment for PCM or other ongoing care coordinated services and programs. DMAP The Division may review on a program-to-program basis if care coordination programs are complimentary with PCPCH.

(de) Documentation Rrequirements:

(A) For ACA and Nnon-ACA-Qqualified Memberpatients, PCPCHs shall assure that Pproviders must document in member's medical record the member's patient's engagement, education and agreement to participate in the PCPCH program is documented within sixtwelve months of initial participation;- Note the standardization of all time frames to six months will create one standard timeframe for all Members to allow for ease ability and compliance. This will shorten the timeframes for Non-ACA Members.

(B) For ACA-qualified members, providers must document in member's patients medical record the members engagement, education and agreement to participate in PCPCH within six months of initial participation.

(BC) PCPCHs shall assure that for each ACA-qualified memberpatient, Pproviders, are working ing with the member patient to, shall develop a person-person-centered plan for each ACA-qualified member within six months of initial participation and revise as needed;:-

(CD) PCPCHs shall assure that theyProviders must notify the Division's PCPCH program-Program eCoordinator when a member patient moves out of the service area, terminates care, or no longer receives primary care from the provider's PCPCH clinic as stated in OAR 410-141-0080 and 410-141-0120. Member Patient assignment shall be terminated at the end of the month for which PCPCH services terminated, unless a move to another PCPCH provider begins primary care before the end of the month. In this situation, which the disenrollment and payment will be proratedno later than the 15th of month;:-

(DE) On a monthly basis, FGHPs and PGOs-MCOs shall provide the Division a monthly list of PCPCH providers and members-patients assigned to each provider. -Information from the MCOsFGHP and PGOs shall specify identify ACA-qualifying memberspatients;:-

(E) PCPCH providersclinics and MCOs, and FGHPs and PGOs have to- must report to the Division a complete list of their ACA--qualified memberpatients, no less than quarterly. Reporting to the Division these individuals on this list is evidence that the provider has complied with the service and documentation requirements. The Division will not make payments for memberpatients that are not reported on these quarterly reports or for memberpatients where documentation requirements isare not met;:-

(F) PCPCH providers-clinics must also log on to the PCPCH provider portal, which will be available at www.primarycarehome.oregon.gov, no less than quarterly. -In conjunction with submission of the quarterly patient listlist above, logging on to the PCPCH provider portalthis activity serves as evidence that the provider-clinic has complied with the service and documentation requirements. Providers-Clinics will have the opportunity to track quality measures through the portal and use this as a panel management tool if desired;:-

(G) If a PCPCH clinics that havehas their own information technology system can use their own system as an alternative to the PCPCH provider portal. To do this, PCPCH clinics must:

(i) Be able to document quarterly usage of the system and have the ability to retain documentation that they have utilized that system for panel management purposes; and with the same frequency as listed above (F);

(ii) they can submit a request in writing to the Division to utilize their system as an alternative. The Division will respond to each request in writing.-

(HF) For ACA-qualified memberpatients, PCPCH providers-clinics shall provide and document in the member's medical record one of the six core services or an activity that is defined in the service definition at least quarterly. Documentation of the services provided must be kept in the patient's medical record;-

(GI) PCPCH need to share shall provide their Division PCPCH pProviderclinic number when referring a patient to another provider; to ensure it is added to the claim as a referring provider. The PCPCH will also need to document the referral in the patient's medical record;-

(JHF) MCOsFCHP and PCOs shall provide quarterly reports to the DMAPthe Division Authority, no later than the 15th of January, April, and July and October shall provide the Division with the whichthat includes the following information for the preceding quarter:

- (i) Number of clinics or sites that meet PCPCH standards;
- (ii) Number of Primary Care Providers in those service delivery sites;
- (iii) Number of members-patients receiving primary care in those sites; and
- (iv) Number of members-patients with one or more chronic conditions receiving primary care at those sites.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.065 and 413.042

410-146-0020 Memorandum of Agreement Reimbursement Methodology

(1) In 1996, a Memorandum of Agreement (MOA) between the Centers for Medicare and Medicaid Services (CMS) and the Indian Health Service (IHS) established the roles and responsibilities of CMS and IHS regarding the Division of Medical Assistance Programs' (Division) American Indian/Alaska Native (AI/AN) Program individuals. The MOA addresses payment for Medicaid services provided to AI/AN individuals on and after July 11, 1996, through health care facilities owned and operated by AI/AN tribes and tribal organizations, which are funded through Title I or V of the Indian Self-Determination and Education Assistance Act (Public Law 93-638).

(2) The IHS and CMS, pursuant to an agreement with the Office of Management and Budget (OMB), developed an all-inclusive rate to be used for billing directly to and reimbursement by Medicaid. This rate is sometimes referred to as the "OMB," "IHS," "All-Inclusive" (AIR), "encounter," or "MOA" rate and is referenced throughout these rules as the "IHS rate." The IHS rate is updated and published in the Federal Register each fall:

(a) The rate is retroactive to the first of the year;

(b) The Division automatically processes a retroactive billing adjustment each year to ensure payment of the updated rate.

(3) IHS direct health care service facilities, established, operated, and funded by IHS; enroll as an AI/AN provider and receive the IHS rate.

(4) Under the MOA, tribal 638 health care facilities can choose to be designated a certain type of provider or facility for enrollment with Division. The designation determines how the Division pays for the Medicaid services provided by that provider or facility. Under the MOA, a tribal 638 health care facility may do one of the following:

(a) Operate as a Tribal 638 health care facility. The health center would enroll as AI/AN provider and choose reimbursement for services at either:

(A) The IHS rate; or

(B) A cost-based rate according to the Prospective Payment System (PPS). Refer to OARs 410-147-0360, Encounter Rate Determinations, 410-147-0440, Medicare Economic Index (MEI), 410-147-0480, Cost Statement (DMAP 3027) Instructions, and 410-147-0500, Total Encounters for Cost Reports; or

(b) If it so qualifies, operate as any other provider type recognized under the State Plan, and receive that respective reimbursement methodology.

(5) AI/AN and the Division's Federally Qualified Health Center (FQHC) and Rural Health Clinics (RHC) Program providers may be eligible to receive the supplemental/wraparound payment for services furnished to clients enrolled with a Prepaid Health Plan (PHP). Refer to AI/AN OAR 410-146-0420 and FQHC/ RHC administrative rules OAR chapter 410, division 147.

(6) AI/AN providers may be eligible for an administrative match contract with the Division. AI/AN providers are not eligible to participate in the Medicaid Administrative Claiming (MAC) Program if they:

(a) Receive reimbursement for services according to the cost-based PPS rate methodology; or

(b) Receive financial compensation for out-stationed outreach worker activities.

(7) An AIAN clinic that chooses to participate in the Patient Centered Primary Care Home Program (**PCPCH**) must meet the requirements and adhere to rules outlined in OAR 409-055-0000 through 409-055-0080 Office for Oregon Health Policy and Research and OAR 410-141-0860 Oregon Health Plan Primary Care Manager and Patient Centered Primary Care Home Provider Qualification and Enrollment.

(a) The PCPCH program is outside the Prospective Payment system and the IHS/MOA rate. Providers who choose to participate and meet all PCPCH related requirements shall receive a separate reimbursement per the per member per month (PMPM) payment established by OAR 410-141-0860;

Stat. Auth.: ORS 413.042 and 414.065;

Stats. Implemented: ORS 414.065

10-1-11

410-147-0362 Change in Scope of Services

(1) As required by 42 USC § 1396a(bb)(3)(B), the Division of Medical Assistance Programs (Division) must adjust Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) Prospective Payment System (PPS) encounter rates based on any increase or decrease in the scope of FQHC or RHC services, as defined by 42 USC §§ 1396d(a)(2)(B-C).

(2) The Centers for Medicare and Medicaid Services (CMS) defines a “change in scope of services” as one that affects the type, intensity, duration, and/or amount of services provided by a health center. CMS’ broad definition of change in scope of services allows the Division the flexibility to develop a more precise definition of what qualifies as a change in scope as it relates to the elements “type,” “intensity,” “duration,” and “amount” and procedures for implementing these adjustments. This rule defines the Division’s policy for implementing FQHC and RHC PPS rate adjustments based on a change in scope of services.

(3) A change in the scope of FQHC or RHC services may occur if the FQHC or RHC has added, dropped or expanded any service that meets the definition of an FQHC or RHC service as defined by 42 USC §§ 1396d(a)(2)(B-C).

(4) A change in the cost of a service is not considered in and of itself a change in the scope of services. An FQHC or RHC must demonstrate how a change in the scope of services impacts the overall picture of health center services rather than focus on the specific change alone. For example, while health centers may increase services to higher-need populations, this increase may be offset by growth in the number of lower intensity visits. Health centers therefore need to demonstrate an overall change to health centers’ services.

(5) The following examples are offered as guidance to FQHCs and RHCs to facilitate understanding the types of changes that may be recognized as part of the definition of a change in scope of services. These examples should not be interpreted as a definitive nor comprehensive delineation of the definition of scope of service. Examples include:

(a) A change in scope of services from what was initially reported and incorporated in the baseline PPS rate. Examples of eligible changes in scope of services include, but are not limited to:

(A) Changes within medical, dental or mental health (including addiction, alcohol and chemical dependency services) service areas (e.g. vision, physical/occupation therapy, internal medicine, oral surgery, podiatry, obstetrics, acupuncture, or chiropractic);

(B) Services that do not require a face-to-face visit with an FQHC or RHC provider will be recognized (e.g. laboratory, radiology, case-management, supportive rehabilitative services, and enabling services.)

(b) A change in the scope of services resulting from a change in the types of health center providers. A change in providers alone without a corresponding change in scope of services does not constitute an eligible change. Examples of eligible changes include but are not limited to:

(A) A transition from mid-level providers (e.g. nurse practitioners) to physicians with a corresponding change in scope of services provided by the health center;

(B) The addition or removal of specialty providers (e.g., pediatric, geriatric or obstetric specialists) with a corresponding change in scope of services provided by the health center (e.g. delivery services);

(i) If a health center reduces providers with a corresponding removal of services, there may be a decrease in the scope of services;

(ii) If a health center hires providers to provide services that were referred outside of the health center, there may be an increase in the scope of services;

(c) A change in service intensity or service delivery model attributable to a change in the types of patients served including, but not limited to, homeless, elderly, migrant, or other special populations. A change in the types of patients served alone is not a valid change in scope of services. A change in

the type of patients served must correspond with a change in scope of services provided by the health center;

(d) Changes in operating costs attributable to capital expenditures associated with a modification of the scope of any of the health center services, including new or expanded service facilities. A change in capital expenditures must correspond with a change in scope of services. (e.g. the addition of a radiology department);

(e) A change in applicable technologies or medical practices:

(A) Maintaining electronic medical records (EMR);

(B) Updating or replacing obsolete diagnostic equipment (which may also necessitate personnel changes); or

(C) Updating practice management systems;

(f) A change in overall health center costs due to changes in state or federal regulatory or statutory requirements. Examples include but are not limited to:

(A) Changes in laws or regulations affecting health center malpractice insurance;

(B) Changes in laws or regulations affecting building safety requirements; or

(C) Changes in laws or regulations relating to patient privacy.

(6) The following changes do not qualify as a change in scope of service, unless there is a corresponding change in services as described in sections (3) - (5):

(a) A change in office hours;

(b) Adding staff for the same service-mix already provided;

(c) Adding a new site for the same service-mix provided;

(d) A change in office location or office space; or

(e) A change in the number of patients served.

(7) Threshold change in cost per visit: To qualify for a rate adjustment, changes must result in a minimum 5% change in cost per visit. This minimum threshold may be met by changes that occur over the course of several years (e.g. health centers would use the cost report for the year in which all changes were implemented and the 5% cost/visit was met, as described in sections (13) and (14) of this rule). A change in the cost per visit is not considered in and of itself a change in the scope of services. The 5% change in cost per visit must be a result of one or more of the changes in the scope of services provided by a health center, as defined in sections (3) - (5) of this rule. The intent of this threshold is to avoid administrative burden caused by minor change in scope adjustments.

(8) If a FQHC or RHC has experienced an increase or decrease in the health center's scope of services, as described in sections (3)-(5) of this rule and that meets the threshold requirement of section (7) of this rule, the FQHC or RHC must submit to the Division a written application as outlined below. The Division may also initiate a review of whether a change in scope of services has occurred at a health center:

(a) A written narrative describing the specific changes in health center services, and how these changes relate to a change in the health center's overall picture of services;

(b) An estimate of billable Medicaid encounters for the forthcoming 12-month period so the financial impact to the Division can be accounted for;

(c) A cost statement. All costs and expenses reported must be in agreement with the principles of reasonable cost reimbursement as found at 42 CFR 413, [Health Care Financing Administration \(HCFA\)Centers for Medicare and Medicaid Services](#) Publication 15-1 (Provider Reimbursement Manual), and any other regulations mandated by the Federal government. Any situations not covered will be based on Generally Accepted Accounting Principals (GAAP). See Change in Scope Cost Report Instructions;

- (d) Certification by the Addiction and Mental Health Division (AMH) of a health center's outpatient mental health program is required if mental health services are provided by non-licensed providers. Refer to OAR 410-147-0320(3)(i) and (5)(h) for certification requirements; and
- (e) A letter of licensure or approval by AMH is required for health centers providing addiction, alcohol and chemical dependency services. Refer to OAR 410-147-0320 (3) (j) and (5)(i); and
- (f) The clinic is responsible for providing complete and accurate copies of the above documentation. Health centers may submit a maximum of one change in scope application per year.
- (9) Upon receipt of a health center's written change in scope of services request, the FQHC/RHC Program manager will:
- (a) Review all documents for completeness, accuracy and compliance with program rules. An incomplete application will result in a delay in the Division's review until the complete application is received; and
- (b) Respond to the health center with a decision within 90 days of receipt of a complete application.
- (10) Providers may appeal this decision in accordance with the provider appeal rules set forth in OAR 410-120-1560.
- (11) Approved change in scope of service requests will result in PPS rate adjustments:
- (a) A separate mental health or dental PPS encounter rate will be calculated if a FQHC or RHC adds dental or mental health (including addiction, and alcohol and chemical dependency) services, and costs associated with these service categories were not included in the original cost statements used to determine the baseline PPS encounter rate;
- (b) If costs associated with dental or mental health services were included in the original cost statements, whether negligible or significant, health centers have the option of having an adjusted single encounter rate, or requesting a separate dental or mental health rate.
- (12) The new rate will be effective beginning the first day of the quarter immediately following the date the Division approves the change in scope of services adjustment (e.g. January, April, July, or October 1):
- (a) The Division will not implement adjusted PPS rates (for qualifying change in scope of service requests) retroactive to the date a change in scope of services was implemented by the health center;
- (b) It is a health center's responsibility to request a timely change in scope of service rate adjustment.
- (13) For changes occurring on or after October 1, 2008, the effective date of this policy, FQHCs and RHCs are required to:
- (a) For anticipated changes, health centers should submit prospective costs for the Division to calculate a new per visit rate. These costs will be based on reasonable cost projections and reviewed by the Division. Health centers may later request a subsequent rate adjustment based on actual costs;
- (b) For gradual or unanticipated changes, health centers must provide at least six months of actual costs beginning the date on which the change in the cost per visit threshold is met, or beginning in the calendar year of the FQHC/RHC's fiscal year in which the changes were implemented and the cost threshold was met. For example, a health center implements a change in scope of services in 2008, but the additional costs incurred do not meet the 5% threshold criteria. In 2009 the health center implements additional scope of service changes. Additional costs incurred in 2009 together with the costs incurred for 2008 meet the 5% threshold. The health center would report costs for 2009;
- (c) Health centers may submit both actual costs (for prior changes) as well as projected costs (for anticipated changes). Prior to submitting both actual and projected costs, health centers should work with the Division's FQHC/RHC Program manager to confirm the appropriate time periods of costs to submit.
- (14) For changes that occurred prior to the effective date of this policy, October 1, 2008, FQHCs and RHCs are required to:

(a) Submit cost reports for either:

(A) The first year of actual costs beginning the date on which a change in the cost per visit threshold is met; or

(B) The calendar year or the FQHC/RHC's fiscal year in which the changes were implemented and the cost threshold was met;

(b) For changes that occurred over multiple and overlapping time periods, FQHC/RHCs will submit actual costs for the time period beginning when all changes were in effect. For example, if changes occurred in 2003 and 2004, health centers would submit their 2004 cost report that would include costs for changes implemented in both 2003 and 2004;

(c) Rate adjustments calculated using costs from prior fiscal years will be adjusted by the Medicare Economic Index (MEI) to present.

(15) FQHC and RHCs clinics that choose to participate in the Patient Centered Primary Care Home (PCPCH) Program must meet the requirements and adhere to rules outlined in OAR 409-055-0000 through OAR 409-055-0080 and OAR 410-141-0860, Oregon Health Plan Primary Care Manager and Patient Centered Primary Care Home Provider Qualification and Enrollment:

(a) The PCPCH Program is outside the Prospective Payment system. Since the PCPCH Program is outside of a change in scope, providers who choose to participate and meet all related requirements shall receive a separate payment outside their PPS rate per the PMPM payment established by OAR 410-141-0860;

(b) If a provider has a PPS rate that includes costs for operating a medical home or health home but would like to participate as a PCPCH, then they must submit a change in scope for a change in service delivery method. If a provider already established and receives a PPS rate that included language such as medical homes or health homes then they must submit a change in scope in order to receive the PMPM payment for the PCPCH program.

(c) Becoming a PCPCH does not qualify as a change in scope.

Stat. Auth.: ORS 413.042 and 414.065 and 413.032

Other Authority: None

Stats. Implemented: ORS 414.065 and 413.032

10-1-11 (T)