

Program: FQHC/RHC/IHS and Tribal 638

Administrative rule revisions proposed to be effective: March 23, 2012

Submit comments: No later than February 2, 2012

- Review the attached rule to be newly adopted;
- Review the Statement of Need and Fiscal Impact Statement and submit any available information for possible fiscal/economic impact these revisions may have on small businesses, local government and the general public.

Submit comments for the Managed Care Program rules to:

Helena Kesch  
RHC/RHC/IHS and Tribal 638 Rules Program Policy Analyst  
Patient Centered Primary Care Home  
OHA - Division of Medical Assistance Programs  
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Secretary of State  
**STATEMENT OF NEED AND FISCAL IMPACT**

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

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

March 2012 Patient-Centered Primary Care Home (PCPCH);

**Rule Caption**

**In the Matter of:** The proposed amendment of administrative rules in the Oregon Health Plan (FQHC/RHC/IHS and Tribal 638) Program. The Division will amend 410-146-0020 and 410-147-0362.

**Statutory Authority:** ORS 414.065 and 413.042

**Other Authority:** None

**Stats. Implemented:** ORS 414.065

**Need for the Rule(s):** The Oregon Health Plan (FQHC/RHC/IHS and Tribal 638) Program administrative rules govern the Division of Medical Assistance Programs' (Division) payment for services to certain clients. The Division needs to amend rules listed below as follows:

- 410-146-0020 to permanently amend PCPCH reimbursement methodology; Effective Oct. 2011, the Division temporarily amended to modify the reimbursement methodology to include Patient Centered Primary Care Home providers.
- 410-147-0362 to permanently amend PCPCH change in scope; Effective Oct. 2011, the Division temporarily amended to modify the change in scope to include Patient Centered Primary Care Home providers.

**Documents Relied Upon, and where they are available:** None

**Fiscal and Economic Impact:** None

**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 any fiscal or economic impact to state agencies of local government, the general public or small businesses.

**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 types of small businesses include doctor's offices, specialty groups, small clinics and community based providers, however our system does not flag which providers are part of a larger clinic or corporation, therefore we are unable to estimate the number of small businesses that are subject to the rules but 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?** The Division consulted the public sector with a Public Meeting Notice posted on the agency website and an invitation was emailed to more than 250 people that have expressed interest in the rule making process, 2 weeks in advance of a Rule Advisory Committee (RAC) meeting held on 12/1/11. Those invited are made up of large and small provider groups, businesses and associations. No small businesses were indicated per the RAC sign in sheet.

**Administrative Rule Advisory Committee consulted?** Yes, a RAC meeting was held on 12/1/11, which included members of the public sector.

**If not, why?**

**Proposed effective date: on or before March 23, 2012**

**Signature** Judy Mohr Peterson, Jean S. Donovan or Sandy Wood

**Date**

## **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) 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 nonlicensed 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. Providers who choose to participate and meet all related requirements shall receive a separate payment per the PMPM payment established by OAR 410-141-0860;

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(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.

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(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)

Program: Managed Care

Administrative rule revisions proposed to be effective: March 23, 2012

Submit comments: No later than February 2, 2012

- Review the attached rule to be newly adopted;
- Review the Statement of Need and Fiscal Impact Statement and submit any available information for possible fiscal/economic impact these revisions may have on small businesses, local government and the general public.

Submit comments for the Managed Care Program rules to:

**Katrina Gonzales**

Managed Care Rules Program Policy Analyst  
OHA - Division of Medical Assistance Programs  
(503)945-6919

[Katrina.m.gonzales@state.or.us](mailto:Katrina.m.gonzales@state.or.us)

Secretary of State  
**STATEMENT OF NEED AND FISCAL IMPACT**

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

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

March 2012 Patient-Centered Primary Care Home (PCPCH);

**Rule Caption**

**In the Matter of:** The proposed amendment of administrative rules in the Oregon Health Plan (Managed Care) Program. The Division will amend 410-141-0860.

**Statutory Authority:** ORS 414.065 and 413.042

**Other Authority:** None

**Stats. Implemented:** ORS 414.065

**Need for the Rule(s):** The Oregon Health Plan (Managed Care) Program administrative rules govern the Division of Medical Assistance Programs' (Division) payment for services to certain clients. The Division needs to amend rules listed below as follows:

- 410-141-0860 to permanently amend PCPCH Provider Qualification; Effective Oct. 2011, the Division temporarily amended 410-141-0860 to modify the Oregon Health Plan Primary Care Manager provider qualification and enrollment criteria to include Patient Centered Primary Care Home providers.

**Documents Relied Upon, and where they are available:** None

**Fiscal and Economic Impact:** None

**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 any fiscal or economic impact to state agencies of local government, the general public or small businesses.

**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 types of small businesses include doctor's offices, specialty groups, small clinics and community based providers, however our system does not flag which providers are part of a larger clinic or corporation, therefore we are unable to estimate the number of small businesses that are subject to the rules but 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?** The Division consulted the public sector with a Public Meeting Notice posted on the agency website and an invitation was emailed to more than 250 people that have expressed interest in the rule making process, 2 weeks in advance of a Rule Advisory Committee (RAC) meeting held on 12/1/11. Those invited are made up of large and small provider groups, businesses and associations. No small businesses were indicated per the RAC sign in sheet.

**Administrative Rule Advisory Committee consulted?** Yes, a RAC meeting was held on 12/1/11, which included members of the public sector.

**If not, why?**

**Proposed effective date: on or before March 23, 2012**

**Signature** Judy Mohr Peterson, Jean S. Donovan or Sandy Wood

**Date**

## 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);
- (d) Federally Qualified Health Clinics (FQHC);
- (e) Indian Health Service Clinics;
- (f) Tribal Health Clinics.

Deleted: (c) Community and Migrant 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 3030 (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; (b) Close enrollment with an existing PCM; or

(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.

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(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.

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

(a) Definition:

(A) 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), Office of Health Policy and Research (Office) Oregon Patient-Centered Primary Care Home Model Implementation Reference Guide:

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[The following definitions apply to ACA Qualified Members and payments made for those services.](#)

(B) Care coordination is defined within a PCPCH as an integral part of the PCPCH. Members 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 will 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 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 between behavioral health and primary care services is strongly encouraged.

(C) Health Promotion 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 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 will be utilized to promote patient and family education and self-management of the chronic conditions.

(D) 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.

(E) 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

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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.

(F) Referral to Community and Social Support Services 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 will include the use of the person-centered plan to manage such referrals and monitor follow up as necessary.

(G) 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, family and local supports to initiate, manage and follow up on community based and other social services referrals as developed.

(H) 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.

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(I) Providers who may apply to become a PCPCH, include physicians (Family Practice, General Practice, pediatricians, gynecologists,

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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.

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(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.

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(J) 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 apply to be enrolled with the Division as a PCPCH provider. 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 [Per Member Per Month](#) (PMPM) payment, or the FCHP as applicable to provide PCPCH services.

(B) 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.

(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.

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

(E) Authority-recognized PCPCH tier enrollment changes shall be effective the first of the next month following enrollment.

(F) 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 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) PCPCH PMPM payment shall be as specified in an [attachment](#) 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 status as either ACA-qualified or non-ACA qualified.

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(C) Members assigned must have full medical eligibility with either Oregon Health Plan (OHP) Plus or OHP Standard Benefits packages, this excludes CAWEM Plus and QMB only.

(D) ACA-qualified member is a member meeting criteria described in these rules as authorized by Section 1945 of the Social Security Act.

(E) ACA members are:

(i) Members with [at least two chronic conditions proposed by the state and approved by the federal Centers for Medicare and Medicaid Services](#),

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one chronic condition and at risk of another, or one serious and persistent mental health condition.

(ii) A detailed list of qualifying conditions will be posted on the agency website. The types of conditions include a mental health condition, substance use disorders, asthma, diabetes, heart disease and BMI over 25, HIV/AIDS, hepatitis, chronic kidney disease and cancer.

(iii) Providers and plans are to use information published by the US Preventative Task Force when making decisions about the particular risk factors for an additional chronic condition that may lead a member 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 members medical record.

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Deleted: 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;

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

(G) For ACA qualified members, 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) For non-ACA qualified members, 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) The Division shall make PMPM payment based on PCPCH tier specified through the PCPCH recognition process and on the members ACA qualification who are receiving primary care from a provider recognized by

the Authority as a PCPCH in accordance with OAR 409-055-0030. Fully Capitated Health Plans (FCHP) and Physician Care Organizations (PCO) shall make payments to providers recognized by the Authority as a PCPCH in accordance with OAR 409-055-0030.

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(J) Managed Care plans must use an alternative payment methodology that supports the DMAP'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.

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(K) It is the DMAP's intention that the PCPCH Program will not duplicate other similar services or programs such as PCM and medical case management, and the Authority shall not make PCPCH payments for members who participate in these programs. Provider will not receive PCPCH payment for patients that DMAP is making for PCM or other ongoing care coordinated services and programs. DMAP may review on a program to program basis if care coordination programs are complimentary with PCPCH.

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(d) Documentation Requirements:

(A) For ACA and Non-ACA-Qualified Members, providers must document in member's medical record the member's engagement, education and agreement to participate in PCPCH within six 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.

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(B) Provider, working with the member, shall develop a person centered plan for each ACA-qualified member within six months of initial participation and revise as needed.

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(C) Providers must notify the Division program coordinator when a member moves out of the service area, terminates care, or no longer receives primary care from the provider's PCPCH as stated in OAR 410-141-0080 and 410-141-0120. Member assignment shall be terminated at the end of the month for which PCPCH services terminated, unless a move to another

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PCPCH provider begins primary care before the end of the month, which the disenrollment and payment will be prorated,

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(D) FCHPs and PCOs shall provide the Division a monthly list of PCPCH providers and members assigned to each provider. Information from the FCHP shall specify ACA-qualifying members.

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(E) PCPCH providers and FCHPs have to report to the Division a complete list of their ACA qualified members, no less than quarterly. Reporting to the Division those individuals on this list is evidence that the provider has complied with the service and documentation requirements. The Division will not make payments for members that are not reported on these quarterly reports or for members where documentation requirement is not met.

(F) For ACA qualified members, PCPCH providers shall provide and document in the member's medical record one of six core services or an activity that is defined in the service definition at least quarterly.

(G) PCPCH need to share their Division Provider 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.

(H) FCHP and PCOs shall provide quarterly reports to DMAP, no later than the 15<sup>th</sup> of January, April, July and October which includes the following for the preceding quarter:

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(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 receiving primary care in those sites; and

(iv) Number of members 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

10-1-11 (T)