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MEMORANDUM

TO: OREGON TRIBAL HEALTH DIRECTORS & BOARD DELEGATES

FROM: JIM ROBERTS, POLICY ANALYST

SUBJECT: OR REVISED REIMBURSEMENT RULES

DATE: 4/3/2012

The attached rule adopts permanent changes to OAR 410-141-0860 to modify the Oregon Health Plan Primary Care Manager provider qualification and enrollment criteria to include the Indian Health Service (IHS), Tribal and urban Indian health programs as Patient Centered Primary Care Homes (PCPCH). This is a favorable change as it will now allow IHS, Tribal and urban Indian health programs to participate in this PCPCH program. The regulation stipulates that if a IHS, Tribe or urban health program choose to participate in the PCPCH program, they must meet the requirements in this rule.

The changes also 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 changes to these regulations specify that payments made under the PCPCH are outside of the Perspective Payment System and the OMB encounter rate. The rule explains that providers who choose to participate and meet all PCPCH related requirements shall receive a separate reimbursement per member per month (PMPM) payment established by OAR 410-141-0860.

Please note, this does not affect your reimbursement rate for providing services, it is intended as a wrap-around incentive payment for participating in the PCPCH program.

If you should have questions concerning this rule, please feel free to contact me at (503) 228-4185 or by email at jroberts@npaihb.org.

Secretary of State
Certificate and Order for Filing

PERMANENT ADMINISTRATIVE RULES

I certify that the attached copies* are true, full and correct copies of the PERMANENT Rule(s) adopted on [upon filing] by the
Date prior to or same as filing date

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

to become effective [3/22/12]. Rulemaking Notice was published in the [3/1/12] Oregon Bulletin.**
Date upon filing or later — Month and Year

RULE CAPTION

Patient-Centered Primary Care Home program revisions and clarifications

RULEMAKING ACTION

AMEND: OAR 410-141-0860, 410-146-0020 and 410-147-0362

REPEAL: OAR 410-141-0860(T), 410-146-0020(T) and 410-147-0362(T)

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.

Authorized Signer — Printed name — Date

*With this original, file one photocopy of certificate, one paper copy of rules listed in Rulemaking Actions, and electronic copy of rules. **The Oregon Bulletin is published the 1st of each month and updates rules found in the OAR Compilation. For publication in Bulletin, rule and notice filings 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, when filings are accepted until 5:00 pm on the preceding workday.

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

(1) Definitions:

(a) ACA-qualified conditions will be posted on the agency website. The types of conditions include a mental health condition, substance use disorders, asthma, diabetes, heart disease, BMI over 25 or for patients 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;(e) An ACA-qualified patient is a patient who meets the criteria described in these rules as authorized by Section 2703 of the Patient Protection and Affordable Care Act.

(b) ACA-qualified patients are individuals with:

(i) A serious mental health condition; or

(ii) At least two chronic conditions proposed by the state and approved by CMS; or

(iii) One chronic condition and at risk of another qualifying condition as described above;

(A) Providers and plans are to use information published by the US Preventive Services Task Force, Bright Futures, and HRSA Women's Preventive Services when making decisions about the particular risk factors for an additional chronic condition that may lead a patient with one chronic condition to meet the criteria of one chronic condition and at risk of another.

(B) The conditions and risk factors shall be documented in the patient's medical record.

(c) Core services are defined as:

(i) *Comprehensive Care Management* is identifying patients with high risk environmental or medical factors, including patients with special health care needs, who will benefit from additional care planning. Care management activities may include but are not limited to population panel management, 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.

(ii) *Care coordination* is an integral part of the PCPCH. Care coordination functions will include the use of the person centered plan to manage such referrals and monitor follow up as necessary. The Division shall assign clients to a provider, clinic, or team to increase continuity of care and ensure responsibility for individual client care coordination functions, including but not limited to:

(A) Tracking ordered tests and notifying all appropriate care-givers and clients of results;

(B) Tracking referrals ordered by its clinicians, including referral status and whether consultation results have been communicated to clients and clinicians; and

(C) Directly collaborating or co-managing clients with specialty mental health and substance abuse, and providers of services and supports to people with developmental disabilities and people receiving long- term care services and supports. (The Division strongly encourages co-location of behavioral health and primary care services.);

(iii) *Health promotion* is demonstrated when a PCPCH provider supports continuity of care and good health through the development of a treatment relationship with the client, other primary care team members and community providers. The PCPCH provider shall promote the use of evidence-based, culturally sensitive wellness and prevention by linking the client with resources for smoking cessation, diabetes, asthma, self-help resources and other services based on individual needs and preferences. The PCPCH shall use health promotion activities to promote patient and family education and self-management of their ACA-qualifying conditions;

(iv) *Comprehensive transitional care* is demonstrated when a PCPCH emphasizes transitional care with either a written agreement 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 improve the percentage of patients seen or contacted within one (1) week of facility discharges;

(v) *Individual and family support services* are demonstrated when a PCPCH has processes in place for:

(A) Patient and family education;

(B) Health promotion and prevention;

(C) Self-management supports; and

(D) Information and assistance to obtain available non-health care community resources, services and supports.

(vi) *Referral to community and social support services* is demonstrated through the PCPCH's 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.

(d) Patient Centered Primary Care Home (PCPCH) pursuant to OAR 409-055-0010 (7) is defined as a health care team or clinic as defined in ORS 414.655, meets the standards pursuant to OAR 409-055-0040, and has been recognized through the process pursuant to OAR 409-055-0040.

(e) A 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, community health workers, personal health navigators and peer wellness specialists authorized through State plan or waiver authorities. (*Community health workers, personal health navigators and peer wellness specialists are

individuals who meet criteria established by the Oregon Health Authority, have passed criminal history background check, and in the judgment of the Authority, hiring agency, and licensed health professional approving the patient centered plan, have the knowledge, skills, and abilities to safely and adequately provide the services authorized). These PCPCH professionals may operate in a variety of ways, such as free standing, virtual, or based at any of the clinics and facilities.(f) Person-centered plan is defined as the plan that shall be developed by the PCPCH and reflect the client and family/caregiver preferences for education, recovery and self-management as well as management of care coordination functions. Peer supports, support groups and self care programs shall be utilized to increase the client and caregivers knowledge about the client's health and health-care needs. The person-centered plan shall be based on the needs and desires of the client including at least the following elements:

(i) Options for accessing care;

(ii) Information on care planning and care coordination;

(iii) Names of other primary care team members when applicable; and
(iv) Information on ways the team member participates in this care coordination;

(f) 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:

(i) Doctors of medicine;

(ii) Doctors of osteopathy;

(iii) Naturopathic physicians;

(iv) Nurse Practitioners;

(v) Physician assistants.

(vi) Naturopaths who have a written agreement with a physician sufficient to support the provision of primary care, including prescription drugs, and the necessary referrals for hospital care.

(2) Enrollment requirements:

(a) To enroll as a PCM, all applicants must:

(i) Be enrolled as Oregon Division of Medical Assistance Programs (Division) providers;

(ii) Make arrangements to ensure provision of the full range of PCM Managed Services, including prescription drugs and hospital admissions;

(iii) Complete and sign the PCM Application (DMAP 3030 (7/11).

(iv) 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 clients 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 clients enrolled with that PCM until such time as the Division determines that the PCM is in compliance.

(v) The Division may terminate their 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.

(b) To enroll as a PCPCH with the Division, all applicants must:

(i) Apply to and be "recognized" as a PCPCH by the Oregon Health Authority (Authority) as organized in accordance with relevant Oregon Office of Health Policy and Research (OHPR) administrative rules (OAR 409-055-0000 to 409-055-0090), the Division administrative rules (chapter 410, division 141), and OHPRs Oregon Patient Centered Primary Care Home Model, dated October 2011 and found at www.primarycarehome.oregon.gov. The Authority grants PCPCH recognition only when a practice, site, clinic or individual provider is successful in the application process with the Authority;

(A) The type of practice, site, clinic or individual provider 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.

(B) PCPCH services will occur under the direction of licensed health professionals, physicians, physician assistants, nurse practitioners, nurses, social workers, or professional counselors.

(ii) PCPCH providers must complete the enrollment process in order to receive reimbursement (OAR 410-120-1260), except as otherwise stated in OAR 410-120-1295. The Provider Enrollment Attachment (attachment to the *Provider Enrollment Agreement*) sets forth the relationship between the Division and the PCPCH site (recognized clinic or provider) to receive payment for providing PCPCH services under OHP OAR 410-141-0860.

(iii) New PCPCH enrollment shall be effective on or after October 1, 2011 or the date established by the Division upon receipt of required information. *(Note: PCPCH tier*

enrollment changes shall be effective the first of the next month or a date approved by the Division).

(iv) The PCPCH enrollment process requires the PCPCH submit a list of fee-for-service (FFS) clients to the Division in a format approved by the Division. The PCPCH must identify current OHP clients being treated within their practice. The PCPCH shall identify that patients are ACA qualified or not as defined in these rules.

(v) PCPCHs serving clients enrolled in a managed care organization (MCO, FCHP or PCO) must consult the MCO on the procedures for developing a OHP client list. The MCO shall submit the list of their identified clients to the Division. Identified client lists are submitted to the Division so that the Division can assign the appropriate clients to the PCPCH and begin making payments for services rendered, all in accordance with relevant OARs.

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

(3) Payment: The Division shall make per member per month (PMPM) payments based on the PCPCH clinic's recognized tier and on the patient's ACA status.

(a) PCPCH payments are made as follows:

(i)For fee-for-service (FFS) ACA-qualified patients, the amount of the PMPM shall be based on the PCPCH tier:

(A) $ 10 for tier 1;

(B) $15 for tier 2 and;

(C) $24 for tier 3.

(ii) For FFS non-ACA-qualified patients, the amount of the PMPM shall be based on the PCPCH tier:

(A) $2 for tier 1;

(B) $4 for tier 2 and;

(C) $6 for tier 3.

(b) For MCO enrolled ACA-qualified members MCO's are responsible for payment to PCPCH providers assigned to the PCPCH. MCOs shall make payments to PCPCH clinics in accordance with OAR 409-055-0030. If an MCO retains any portion of the PCPCH payment, that portion shall be used to carry out functions related to PCPCH and is subject to approval and oversight by the Division.

(c) MCOs that wish to use PCPCH payment methodology and/or amount different than Division must receive Division approval

(d)The Division shall not provide additional PMPM payment to the MCOs for non-ACA-qualified members. For MCO enrolled non-ACA-qualified members PCPCH payment responsibility will be integrated into MCOs capitation payments and covered services at the next opportunity to revise capitation rates expected on or near July 1, 2012.

(e) MCOs must use an alternative payment methodology that supports the Division's goal of improving the efficiency and quality of health services for primary care homes by decreasing the use of FFS reimbursement models. PMPM payment is an alternative methodology.

(f) It is the Division'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 patients who participate in these programs. The Division may review on a program to program basis if care coordination programs are complimentary with PCPCH.

(4) Client Assignment:

(a) OHP clients' participation with PCPCH is voluntary. OHP clients can opt-out at any time from a PCPCH.

(b) The Division will provide client notice of PCPCH assignment including information about benefits of PCPCH and how to notify the Division if they wish to opt out.

(c) The Division shall remove PCPCH assignment from clients who choose not to participate in a PCPCH Program.

(d) Upon completion of PCPCH enrollment process and approval from CMS, the Division will implement PMPM payments for non-ACA patients who are not enrolled in an FCHP or PCO. 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;

(e) Clients assigned must have full medical eligibility with either Oregon Health Plan (OHP) Plus (BMH, BMP, BMM or BMD) or OHP Standard (KIT) benefit plans, this excludes CAWEM Plus (CWX) and QMB (MED) only.

(5) Documentation Requirements:

(a)The PCPCH must coordinate the care of all assigned clients who do not choose to opt out of the PCPCH Program, to ensure they have a "person-centered plan" that has been developed with the client or the client's caregiver. The PCPCH must provide an assigned client with at least one of the six "core" services as defined in Oregon State Medicaid Plan, each quarter and document the service(s) in the medical record in order to be eligible for payment.

(b) PCPCHs shall assure that the patient's engagement, education and agreement to participate in the PCPCH program are documented within six months of initial participation;

(c) PCPCHs shall assure that for each patient, providers are working with the patient to develop a person-centered plan within six months of initial participation and revise as needed;

(d) For ACA-qualified patients, PCPCH clinics shall provide 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;

(e) PCPCHs shall assure that they notify the Division when a patient moves out of the service area, terminates care, or no longer receives primary care from the PCPCH clinic as stated in OAR 410-141-0080 and 410-141-0120. 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, the disenrollment and payment will be prorated;

(f) PCPCH clinics and MCOs must report to the Division a complete list of their Medicaid PCPCH patients, no less than quarterly. The Division will not make payments for patients that are not reported on these quarterly reports or for patients where documentation requirements are not met; PCPCH clinics and MCOs may provide the Division information on new member assignment or termination member assignment on a more frequent basis if they desire;

(g) PCPCH clinics must 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 list, logging on to the PCPCH provider portal serves as evidence that the clinic has complied with the service and documentation requirements. Clinics will have the opportunity to track quality measures through the portal and use this as a panel management tool;

(h) PCPCH clinics that have 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 for panel management purposes; and

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

(i) MCOs, no later than the 15th of January, April, July and October shall provide the Division with the following information for the preceding quarter:

(A) Number of clinics or sites that meet PCPCH standards;

(B) Number of Primary Care Providers in those service delivery sites;

(C) Number of patients receiving primary care in those sites; and

(D) Number of ACA-qualified patients receiving primary care at those sites

(j) PCPCH shall provide their Division PCPCH clinic 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.

Stat. Auth.: ORS 413.042 and 414.655

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

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, 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. 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;

(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.

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

Stat. Auth.: ORS 413.042 and 414.065 and 413.032

Stats. Implemented: ORS 414.065 and 413.032

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

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, 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. 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;

(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.

(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