

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

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

**RULE CAPTION**

Managed Care Entity (MCE) Billing and Payment

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

June 15, 2016	10:30	500 Summer St NE, Salem, OR 97301, Room 137B	Sandy Cafourek
Hearing Date	Time	Location	Hearings Officer

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

**RULEMAKING ACTION**

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

**ADOPT:**

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

**REPEAL:** OAR 410-141-0420

**RENUMBER:**

**AMEND & RENUMBER:**

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

Other Auth.:

Stats. Implemented: ORS 414.065 & 414.610 - 414.685

**RULE SUMMARY**

The Division's rule requires Managed Care Entities (MCEs) to demonstrate that they are able to provide coordinated care services efficiently, effectively, and economically. This is the first OHP managed care rule to consolidate the MCE requirements for billing and payment into one administrative rule. This is also the first OHP managed care rule to utilize the term Managed Care Entities (MCE) when making collective reference to those managed care plans providing the delivery system under the Oregon Health Plan. The Division proposes "Managed care entity (MCE)" means an entity that enters into a contract to provide services in a managed care delivery system including, but not limited to, managed care organizations, prepaid health plans, and primary care case managers. Revisions to language have been made in the following areas:

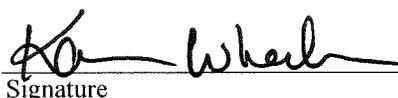
- Clarifying the four-month billing requirement;
- Specifying separate plan type requirements as applicable;
- Aligning the pharmacy preauthorization timeline with 410-141-3070 Preferred Drug List Requirements;
- Updating claim submission timeframes with CFR and the 2016 contracts;
- Clarifying school-based health service considerations; and
- Updating A and B Hospital payment methodology language in order to align with current practices.

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

June 17, 2016 by 5 p.m.

Send comments to: [dmap.rules@state.or.us](mailto:dmap.rules@state.or.us)

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

  
Signature

Karen Wheeler  
Printed name

5/16/16  
Date

**STATEMENT OF NEED AND FISCAL IMPACT**

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

Oregon Health Authority, Health Systems Division, Medical Assistant Programs (Division)

410

Agency and Division

Administrative Rules Chapter Number

Managed Care Entity (MCE) Billing and Payment

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

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

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

Other Authority:

Stats. Implemented: ORS 414.065 & 414.610 - 414.685

Need for the Rule(s): The Division's rule requires Managed Care Entities (MCEs) to demonstrate that they are able to provide coordinated care services efficiently, effectively, and economically. This is the first OHP managed care rule to consolidate the MCE requirements for billing and payment into one administrative rule. This is also the first OHP managed care rule to utilize the term Managed Care Entities (MCE) when making collective reference to those managed care plans providing the delivery system under the Oregon Health Plan. The Division proposes "Managed care entity (MCE)" means an entity that enters into a contract to provide services in a managed care delivery system including, but not limited to, managed care organizations, prepaid health plans, and primary care case managers. Revisions to language have been made in the following areas:

- Clarifying the four-month billing requirement;
- Specifying separate plan type requirements as applicable;
- Aligning the pharmacy preauthorization timeline with 410-141-3070 Preferred Drug List Requirements;
- Updating claim submission timeframes with CFR and the 2016 contracts;
- Clarifying school-based health service considerations; and
- Updating A and B Hospital payment methodology language in order to align with current practices.

Documents Relied Upon, and where they are available: OAR 410-141-3070 Preferred Drug List Requirements

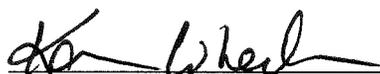
Fiscal and Economic Impact: No fiscal impact on the Authority, other state agencies, local government, clients, the public, or small businesses is anticipated.

Statement of Cost of Compliance:

1. Impact on state agencies, units of local government and the public (ORS 183.335(2)(b)(E)): None anticipated.
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: None anticipated.
  - b. Projected reporting, recordkeeping and other administrative activities required for compliance, including costs of professional services: None anticipated.
  - c. Equipment, supplies, labor and increased administration required for compliance: Amending these rules will not add additional reporting, record keeping or other administrative activities.

How were small businesses involved in the development of this rule? Small businesses were invited to participate in the RAC

Administrative Rule Advisory Committee consulted?: Yes, RAC 3/31/16. If not, why?:

  
Signature

Karen Wheeler  
Printed name

5/16/16  
Date

410-141-3420

**Managed Care Entity (MCE) Billing and Payment**

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

(a) Submit bills within no greater than four months of the date of service for all cases, except as provided for in (1) (b) of this rule. MCEs may negotiate terms within this timeframe agreeable to both parties;

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

(A) Pregnancy;

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

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

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

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

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

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

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

(4) Providers shall verify, before providing services, that the ~~member-client~~ is:

(a) ~~eligible~~ Eligible for ~~coordinated care~~ Division services ~~programs and~~;

(b) Whether the client is assigned to an MCE on the date of service.

(5) Providers shall use the Authority's tools and the CCOMCE's tools, as applicable, to determine if the service to be provided is covered under the member's OHP benefit package. Providers shall also identify the party responsible for covering the intended service and seek pre-prior authorizations from the appropriate payer before providing services. Before providing a non-covered service, the provider shall complete an DMAP OHP 3165, or facsimile, signed by the client, as described in OAR 141-120-1280.

(56) CCOMCEs shall pay for all covered capitated and coordinated care services. These services shall be billed directly to the CCOMCE, unless the CCOMCE or the Authority specifies otherwise. CCOMCEs may require providers to obtain preauthorization-prior authorization to deliver certain capitated or coordinated care services.

(67) Payment by the CCOMCE to participating providers for capitated or coordinated care services is a matter between the CCOMCE and the participating provider except as follows:

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

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

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

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

(D) The specific number of days following receipt of the additional information that an redetermination-approval or denial shall be made/issued;

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

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

(b) CCOMCEs shall make a determination on at least 95 percent of valid preauthorization-prior authorization requests within two working days of receipt of a preauthorization-prior authorization or reauthorization request related to urgent services, alcohol and drug services, or care required while in a skilled nursing facility.;

~~(c) Preauthorization for prescription drugs shall be completed and the pharmacy notified within 24 hours. If a preauthorization for a prescription cannot be completed within the 24 hours, the CCO shall provide for the dispensing of at least a 72-hour supply if there is an immediate medical need for the drug. CCOs shall notify providers of the determination within two working days of receipt of the request; Prior authorization for prescription drugs marked for urgent review shall be reviewed within 24 hours. If an urgent prior authorization for a prescription drug cannot be completed within 24 hours, the MCE shall provide for the dispensing of at least a 72-hour supply if there is an immediate medical need for the drug. All pharmacy requests, including those not marked urgent, shall be reviewed and a decision rendered within 72 hours of original receipt of the prior authorization request;~~

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

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

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

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

~~(ef) CCOsMCEs shall pay or deny at least 90 percent of valid claims within 45-30 calendar days of receipt and at least 99 percent of valid claims within 60-90 calendar days of receipt. CCOs MCEs shall make an initial determination on 99 percent of all claims submitted within 60 calendar days of receipt;~~

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

(hg) CCOsMCEs may not require providers to delay billing to the CCOMCE;

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

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

(jk) CCOsMCEs may not delay or deny payments because a co-payment was not collected at the time of service;

(L) MCEs may not delay or deny payments for occupational therapy, physical therapy, speech therapy, nurse services, etc., when a child is receiving such services as school-based health services (SBHS) through either an Individual Educational Plan (IEP) or an Individualized Family Service Plan (IFSP). These services are supplemental to other health plan covered therapy services and are not considered duplicative services. Individuals with Disabilities Education Act (IDEA) mandated school sponsored SBHS will not apply toward the member's therapy allowances. SBHS Medicaid covered IDEA services are provided to eligible children in their education program settings by public education enrolled providers billing MMIS for these services to Medicaid through the Authority for reimbursement under Federal Financial Participation (FFP) as part of cost sharing on a fee-for-service basis.

(78) CCOsMCEs shall pay for Medicare coinsurances and deductibles up to the Medicare or CCOsMCE's allowable for covered services the member receives within the CCOMCE participating provider network for authorized referral care and urgent care services or emergency services the member receives from non-participating providers. CCOsMCEs may not pay for Medicare coinsurances and deductibles for non-urgent or non-emergent care members receive from non-participating providers.

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

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

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

(10) MCEs shall pay for ancillary, as defined in 410-120-0000, covered services provided by a non-participating provider that are not prior authorized if all of the following conditions exist:

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

(b) The ancillary covered service was delivered in good faith without the prior authorization; and

(c) It was an ancillary covered service that would have been prior authorized with a participating provider if the MCE's referral procedures had been followed;

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

(e) Except as specified in OAR 410-141-3140 Emergency and Urgent Care Services, MCEs shall not be required to pay for covered treatment services provided by a non-participating provider, unless:

(A) The MCE does not have a participating provider that will meet the member's medical need; and

(B) The MCE has authorized care to a non-participating provider.

(f) Notwithstanding OAR 410-120-1280, non-participating providers may not attempt to bill the member for services rendered;

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

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

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

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

annually to the Authority in a manner to be prescribed to CCOMCE's compliance with these requirements.

~~(1011)~~ For Type A or Type B hospitals transitioning from Cost-Based Reimbursement (CBR) to an Alternative Payment Methodology (APM):

(a) Sections ~~(110)–(132)~~ only apply to services provided by Type A or Type B hospitals to clients or members that are enrolled in an CCOMCE;

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

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

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

~~(1112)~~ Redetermination of which Type A or Type B hospitals shall stay on CBR or transition off from CBR:

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

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

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

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

~~(1213)~~ Non-contracted Type A or Type B hospital rates for those transitioning or transitioned from off of CBR:

(a) Reimbursement rates under this section shall be based on Charges shall be discounted hospital charges for both inpatient and outpatient services. ~~The initial reimbursement rate effective January 1, 2015 shall be based on the individual hospital's~~

most-recently-filed Medicare cost report adjusted to reflect the hospital's Medicaid/OHP mix of services;

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

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

(d) ASU shall contact hospitals regarding price increases during March of each year. On an annual basis, each Type A or Type B hospital that has transitioned from CBR shall complete a template provided by the Authority that calculates the hospital's change in prices for their CCOMCE population;

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

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

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

(1314) Members may receive certain services on a Fee-for-Service (FFS) basis:

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

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

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

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

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

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

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

(1415) Coverage of services through the OHP benefit package of covered services is limited by OAR 410-141-0500 (Excluded Services and Limitations for OHP Clients).

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

Stats. Implemented: ORS 414.065 & 414.610 - 414.685

410-141-0420

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

~~(1) Providers shall submit all billings for members following these timeframes:~~

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

~~(A) Pregnancy;~~

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

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

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

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

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

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

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

~~(4) Providers shall verify before providing services that the member is eligible for the Division's programs on the date of service using the Authority and PHP's tools, as applicable, and that the service to be provided is covered under the member's OHP Benefit Package. Providers shall also identify the party responsible for covering the intended service and seek preauthorizations from the appropriate payer before providing services. Before providing a non-covered service, the provider shall complete and have the member sign an Authority 3165, or facsimile, as described in OAR 410-120-1280.~~

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

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

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

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

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

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

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

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

~~(F) Sending notice of the decision with appeal rights to the member when the determination is a denial of the requested service as specified in OAR 410-141-0263.~~

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

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

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

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

~~(d) For all other preauthorization requests, PHPs shall notify providers of an approval, denial, or need for further information within 14 calendar days of receipt of the request as outlined in OAR 410-141-0263. PHPs shall make reasonable efforts to obtain the necessary information during the 14-day period. However, the PHP may use an additional 14 days to obtain follow-up information if the PHP justifies to the Authority upon request the need for additional information and how the delay is in the member's best interest. If the PHP extends the timeframe, it shall give the member written notice of the reason for the extension as outlined in OAR 410-141-0263. The PHP shall make a determination as the member's health condition requires but no later than the expiration of the extension;~~

~~(e) PHPs shall pay or deny at least 90 percent of valid claims within 45 calendar days of receipt and at least 99 percent of valid claims within 60 calendar days of receipt. PHPs~~

shall make an initial determination on 99 percent of all claims submitted within 60 calendar days of receipt;

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

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

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

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

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

~~(7) FCHPs, PCOs, and MHOs shall pay for Medicare coinsurances and deductibles up to the Medicare or PHP's allowable for covered services the member receives within the PHP for authorized referral care and for urgent care services or emergency services the member receives from non-participating providers. FCHPs, PCOs, and MHOs are not responsible for Medicare coinsurances and deductibles for non-urgent or non-emergent care members receive from non-participating providers.~~

~~(8) FCHPs and PCOs shall pay transportation, meals, and lodging costs for the member and any required attendant for out-of-state services that the FCHP and PCO have arranged and authorized when those services are available within the state, unless otherwise approved by the Authority.~~

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

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

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

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

~~(d) The PHP shall pay non-participating providers (providers enrolled with the Authority that do not have a contract with the PHP) for covered services that are subject to reimbursement from the PHP, the amount specified in OAR 410-120-1295. This rule~~

~~does not apply to providers that are Type A or Type B hospitals, as they are paid in accordance with ORS 414.727.~~

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

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

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

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

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

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

~~(c) The reimbursement methodology for each hospital shall be recalculated every two years thereafter;~~

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

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

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

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

~~(c) Subsequent year reimbursement rates shall be adjusted and calculated by the Actuarial Services Unit (ASU) based on the individual hospital's annual price increase and the Authority's global budget rate increase as defined by the CMS 1115 waiver~~

using the following formula:  $\text{Current Reimbursement Rate} \times (1 + \text{Global Budget Increase}) / (1 + \text{Hospital Price Increase})$ ;

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

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

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

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

~~(13) Members enrolled with PHPs may receive certain services on a FFS basis:~~

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

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

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

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

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

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

~~(g) FCHPs and PCOs that contract with FQHCs and RHCs shall negotiate a rate of reimbursement that is not less than the level and amount of payment that the FCHP or~~

~~PCO would make for the same service furnished by a provider who is not an FQHC nor RHC, consistent with the requirements of Balanced Budget Act (BBA) 4712(b)(2).~~

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

~~(15) All members enrolled with a PCO receive inpatient hospital services on a FFS basis:~~

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

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

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

~~(16) Clients not enrolled with a PHP receive services on a FFS basis:~~

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

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

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

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

~~Stats. Implemented: ORS 414.065 & 414.610-414.685~~