Certificate and Order for Filing
TEMPORARY ADMINISTRATIVE RULES
A Statement of Need and Justification accompanies this form.

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

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

Darlene Nelson	503-945-6927	503-947-5221	dar.l.nelson@state.or.us
Rules Coordinator	Telephone	Fax	email

Communications Unit, 3rd Fl., DHS Bldg., 500 Summer St. NE-E35, Salem, Or. 97301-0177
Address

to become effective **10/1/11 through 3/23/2012**
Date upon filing or later — A maximum of 180 days including the effective date.

RULEMAKING ACTION

Rule Filing Caption: Patient Centered Primary Care Home (PCPCH)

AMEND: OARs **410-141-0860, OHP**
410-146-0020, AI/AN
410-147-0320, FQHC/RHC

Statutory Authority: ORS 413.042
Other Authority: None.
Statutes Implemented: ORS 413.042 and 414.065

Subject Matter:

The Oregon Health Plan (OHP or Managed Care) Program administrative rules govern the Division of Medical Assistance Programs' payments for the PCPCH Program. The Division temporarily amended 410-141-0860 to modify the Oregon Health Plan Primary Care Manager provider qualification and enrollment criteria to include Patient Centered Primary Care Home providers. The Division also temporarily amended 410-146-0020 in the American Indian/Alaska Native Program and 410-147-0362 in the Federally Qualified Health Clinics/Rural Health Clinics Program, filed in conjunction with and referencing the more detailed OAR 410-141-0860 in the OHP Program.

Authorized Signers: Judy Mohr Peterson 9-29-2011
Judy Mohr Peterson, Jean Phillips or Sandy Wood — Date

Secretary of State

Statement of Need and Fiscal Impact

A Certificate and Order for Filing Temporary Administrative Rules accompanies this form.

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

In the Matter of: The Temporary amendment of an administrative rule that governs payment for the Oregon Health Plan (OHP) Managed Care program (division 141), the American Indian/Alaska Native Program (division 146) and the Federally Qualified Health Centers (FQHC) and Rural Health Clinics (RHC) (division 147). The Division temporarily amended 410-141-0860, 410-146-0020 and 410-147-0320.

Rule Filing Caption: Patient Centered Primary Care Home (PCPCH)

Statutory Authority: ORS 413.042

Other Authority: None

Statutes Implemented: ORS 414.065, 413.042

Need for Rule(s): The Oregon Health Plan (OHP or Managed Care) Program administrative rules govern the Division of Medical Assistance Programs' payments for the PCPCH Program. The Division temporarily amended 410-141-0860 to modify the Oregon Health Plan Primary Care Manager provider qualification and enrollment criteria to include Patient Centered Primary Care Home providers. The Division also temporarily amended 410-146-0020 in the American Indian/Alaska Native Program and 410-147-0362 in the Federally Qualified Health Clinics/Rural Health Clinics Program, filed in conjunction with and referencing the more detailed OAR 410-141-0860 in the OHP Program.

Justification of Temporary Rule(s): The Division finds that following the permanent rule making process rather than taking this immediate rulemaking action will result in serious prejudice to public interest, to the interest of the Division providers. If the Division does not promptly incorporate the changes made to the Oregon Health Plan Primary Care Manager Provider Qualification and Enrollment, providers will be at risk of following incorrect criteria when enrolling as a recognized provider and seeking payment for services and submitting claims to the Division.

This temporary rulemaking action will avoid or mitigate the risks mentioned above by incorporating, in rule, the updated criteria for Primary Care Manager Provider Qualification and Enrollment to be effective October 1, 2011, subject to Centers for Medicare and Medicaid Services (CMS).

Documents Relied Upon, and where these can be viewed or obtained: SMD Letter 10024, Oregon State Plan Amendment #11-11 and Oregon Health Policy and Research (OHPR) Patient-Centered Primary Care Home Program Implementation Reference Guide dated August 2011

Other Agencies affected: None

Authorized Signers: Judy Mohr Peterson 9-29-2011
Judy Mohr Peterson, Jean Phillips or Sandy Wood — Date

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

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

(a) Doctors of medicine;

(b) Doctors of osteopathy;

(c) Naturopathic physicians;

(d) Nurse Practitioners;

(e) Physician assistants.

(2) The following entities may enroll as PCM~~rimary Care Manager~~s:

(a) Hospital primary care clinics;

(b) Rural Health Clinics (RHC);

(c) Community and Migrant Health Clinics;

(d) Federally Qualified Health Clinics (FQHC);

(e) Indian Health Service Clinics;

(f) Tribal Health Clinics.

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

(4) All applicants for enrollment as PCM~~srimary Care Managers~~ must:

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

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

(c) Complete and sign the PCM~~rimary Care Manager~~ Application (D~~O~~MAP 3030~~119~~ (7~~12~~/11~~93~~)).

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

(a) Deny the application for enrollment as a PCM~~rimary Care Manager~~;

(b) Close enrollment with an existing PCM~~rimary Care Manager~~; ~~and/~~or

(c) Transfer the care of those PCM members enrolled with that PCM~~rimary Care Manager~~ until such time ~~it can be~~ as the Division determines~~d~~ that the PCM~~rimary Care Manager~~ is in compliance.

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

~~[ED. NOTE: Forms referenced are available from the agency.]~~ (7) Patient Centered Primary Care Homes (PCPCH):

(a) Definition:

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

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

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

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

(b) Provider Enrollment:

(A) PCPCHs that are recognized through the Authority and determined by the Office in accordance with OAR 409-055-0030 to meet PCPCH standards may apply to be enrolled with the Division as a PCPCH provider. Upon completion of enrollment and assignment of members, the Division shall enroll the PCPCH providers in the Medicare Medicaid Information

System (MMIS) to pair them with members receiving primary care from the provider and the Division shall pay providers a PMPM payment, or the FCHP as applicable to provide PCPCH services.

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

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

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

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

(F) Termination of Authority-recognized PCPCH enrollment shall be the date established by the Authority.

(c) Member Assignment and Provider Payment:

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

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

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

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

(E) ACA members are:

(i) Members with one or more of the following conditions;

(ii) Members with a mental health condition, substance abuse disorder, asthma, diabetes, heart disease and BMI over 25, HIV/AIDS, hepatitis, chronic kidney disease or cancer;

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

(G) For ACA qualified members, the PMPM amount of the payment shall be based on the PCPCH tier as determined by the Authority and the Office and shall be:

(i) $10 for tier 1

(ii $15 for tier 2 and

(iii) $24 for tier 3.

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

(i) $2 for tier 1

(ii) $4 for tier 2 and

(iii) $6 for tier 3.

(I) The Division shall make PMPM payment based on PCPCH tier specified through the PCPCH recognition process and on the members ACA

qualification who are receiving primary care from a provider recognized by the Authority as a PCPCH in accordance with OAR 409-055-0030. Fully Capitated Health Plans (FCHP) and Physician Care Organizations (PCO) shall make payments to PCPCH with ACA-qualified members enrolled in PCPCH receiving primary care from a provider recognized by the Authority as a PCPCH in accordance with OAR 409-055-0030.

(J) Managed Care plans must use an alternative payment methodology that supports the Authority's goal of improving the efficiency and quality of health services for primary care homes by decreasing the use of fee-for-service reimbursement models.

(K) It is the Authority's intention that the PCPCH Program not duplicate other similar programs such as PCM and Disease Management, and the Authority shall not make PCPCH payments for members who participate in these programs.

(d) Documentation Requirements:

(A) Providers must document in member's medical record the member's engagement, education and agreement to participate in PCPCH within twelve months of initial participation.

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

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

(D) Providers must notify the Division program coordinator when a member moves out of the service area, terminates care, or no longer receives primary care from the provider's PCPCH as stated in OAR 410-141-0080 and 410-141-0120. Member assignment shall be terminated at the end of the month for which PCPCH services terminated, unless a move to another PCPCH provider begins primary care no later than the 15th of month.

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

(F) FCHP and PCOs shall provide quarterly reports to the Authority, no later than the 15th of January, April, and July that includes the following for the preceding quarter:

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

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

(iii) Number of members receiving primary care in those sites; and

(iv) Number of members with one or more chronic conditions receiving primary care at those sites

---

Stat. Auth.: ORS ~~409.050~~413.042
Stats. Implemented: ORS 414.065 and 413.042

10-1-11 (T)

410-146-0020 Memorandum of Agreement Reimbursement Methodology

(1) In 1996, a Memorandum of Agreement (MOA) between the ~~Health Care Financing Administration (HCFA, now called the~~ Centers for Medicare and Medicaid Services~~, or~~ (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 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.

Stat. Auth.: ORS 413.042 and 414.065;

Stats. Implemented: ORS 414.065

10-1-11

410-147-0362 Change in Scope of Services

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(A) Maintaining electronic medical records (EMR);

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

(C) Updating practice management systems;

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

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

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

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

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

(a) A change in office hours;

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

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

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

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

(7) Threshold change in cost per visit: To qualify for a rate adjustment, changes must result in a minimum 5% change in cost per visit. This minimum threshold may be met by changes that occur over

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

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

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

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

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

(d) Certification by the Addiction and Mental Health Division (AMH) of a health center's outpatient mental health program is required if mental health services are provided by nonlicensed providers. Refer to OAR 410-147-0320(3)(i) and (5)(h) for certification requirements; and

(e) A letter of licensure or approval by AMH is required for health centers providing addiction, alcohol and chemical dependency services. Refer to OAR 410-147-0320 (3) (j) and (5)(i); and

(f) The clinic is responsible for providing complete and accurate copies of the above documentation. Health centers may submit a maximum of one change in scope application per year.

(9) Upon receipt of a health center's written change in scope of services request, the FQHC/RHC Program manager will:

(a) Review all documents for completeness, accuracy and compliance with program rules. An incomplete application will result in a delay in the Division's review until the complete application is received; and

(b) Respond to the health center with a decision within 90 days of receipt of a complete application.

(10) Providers may appeal this decision in accordance with the provider appeal rules set forth in OAR 410-120-1560.

(11) Approved change in scope of service requests will result in PPS rate adjustments:

(a) A separate mental health or dental PPS encounter rate will be calculated if a FQHC or RHC adds dental or mental health (including addiction, and alcohol and chemical dependency) services, and costs associated with these service categories were not included in the original cost statements used to determine the baseline PPS encounter rate;

(b) If costs associated with dental or mental health services were included in the original cost statements, whether negligible or significant, health centers have the option of having an adjusted single encounter rate, or requesting a separate dental or mental health rate.

(12) The new rate will be effective beginning the first day of the quarter immediately following the date the Division approves the change in scope of services adjustment (e.g. January, April, July, or October 1):

(a) The Division will not implement adjusted PPS rates (for qualifying change in scope of service requests) retroactive to the date a change in scope of services was implemented by the health center;

(b) It is a health center's responsibility to request a timely change in scope of service rate adjustment.

(13) For changes occurring on or after October 1, 2008, the effective date of this policy, FQHCs and RHCs are required to:

(a) For anticipated changes, health centers should submit prospective costs for the Division to calculate a new per visit rate. These costs will be based on reasonable cost projections and reviewed by the Division. Health centers may later request a subsequent rate adjustment based on actual costs;

(b) For gradual or unanticipated changes, health centers must provide at least six months of actual costs beginning the date on which the change in the cost per visit threshold is met, or beginning in the calendar year of the FQHC/RHC's fiscal year in which the changes were implemented and the cost threshold was met. For example, a health center implements a change in scope of services in 2008, but the additional costs incurred do not meet the 5% threshold criteria. In 2009 the health center implements additional scope of service changes. Additional costs incurred in 2009 together with the costs incurred for 2008 meet the 5% threshold. The health center would report costs for 2009;

(c) Health centers may submit both actual costs (for prior changes) as well as projected costs (for anticipated changes). Prior to submitting both actual and projected costs, health centers should work with the Division's FQHC/RHC Program manager to confirm the appropriate time periods of costs to submit.

(14) For changes that occurred prior to the effective date of this policy, October 1, 2008, FQHCs and RHCs are required to:

(a) Submit cost reports for either:

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

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

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

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

(15) FQHC and RHCs clinics that choose to participate in the 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)Since the PCPCH Program is outside of a change in scope, providers who choose to participate and meet all related requirements shall receive payment outside their PPS rate per the PMPM payment established by OAR 410-141-0860;

(b)If a provider already established and receives a PPS rate that included language such as medical homes or health homes then they must submit a change in scope in order to receive the PMPM payment for the PCPCH program.

Stat. Auth.: ORS 413.042 and 414.065 and 413.032

Other Authority: None

Stats. Implemented: ORS 414.065 and 413.032

10-1-11 (T)