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NOTICE OF PROPOSED RULEMAKING
INCLUDING STATEMENT OF NEED & FISCAL IMPACT

FILED
04/25/2022 3:08 PM
ARCHIVES DIVISION
SECRETARY OF STATE

CHAPTER 410
OREGON HEALTH AUTHORITY
HEALTH SYSTEMS DIVISION: MEDICAL ASSISTANCE PROGRAMS

FILING CAPTION: Citizenship Waived Medical (CWM) Benefits Update, Program Name Change, and Billing Clarification

LAST DAY AND TIME TO OFFER COMMENT TO AGENCY: 05/21/2022 5:00 PM

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

A public rulemaking hearing may be requested in writing by 10 or more people, or by a group with 10 or more members, within 21 days following the publication of the Notice of Proposed Rulemaking in the Oregon Bulletin or 28 days from the date the Notice was sent to people on the agency mailing list, whichever is later. If sufficient hearing requests are received, the notice of the date and time of the rulemaking hearing must be published in the Oregon Bulletin at least 14 days before the hearing.

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NEED FOR THE RULE(S)

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. These rules need to be amended promptly so the Authority rule pertaining to the program name change from Citizen/Alien Waived Emergency Medical (CAWEM) to Citizenship Waived Medical (CWM); to remove prejudice language from the CWM program. CWM emergency benefits expanded to include Outpatient Dialysis, cancer and behavioral health crisis services effective January 1, 2022. New rule Division 134 defines CWM program emergency and supplemental state funded wrap-around benefits. MCE rules, 410-141-3805 are amended to allow HOP recipients to enroll in MCE. Eligibility policy rules, 410-200-0015, 0240, are amended to codify eligibility for the Healthier Oregon Program, Hospital and transportation rules are amended to clarify correct payment. Division 121 needed to include emergency medication for CWM.

DOCUMENTS RELIED UPON, AND WHERE THEY ARE AVAILABLE

- SB 558 (2017), HB 3391 (2017), HB 3352 (2021), HB 5202 (2022), HB 2391 (2017).
- Oregon Administrative Rules, Chapter 410 divisions 120, 121, 123, 141, 147, 200, 125 and 121 found at https://secure.sos.state.or.us/oard/displayChapterRules.action?selectedChapter=87
- The Health Evidence Review Commission (HERC) Prioritized list found at: https://www.oregon.gov/oha/HPA/DSI-HERC/Pages/Prioritized-List.aspx

STATEMENT IDENTIFYING HOW ADOPTION OF RULE(S) WILL AFFECT RACIAL EQUITY IN THIS STATE

The CWM name change removes prejudice language from rule. The emergency definition was revised to include the CWM population. The HOP program will provide Oregon Health Plan equivalent wrap-around coverage to more of the CWM population, to reduce health care inequalities in marginalized groups. Adding emergency medications was necessary in meeting CWM population needs.

FISCAL AND ECONOMIC IMPACT:

The fiscal and economic impact of the proposed changes increases the amount of Federal Funds (FF) received due to the addition of emergency services that are eligible for qualifying for federal match. The General Fund (GF) made available due to the increase in FF will be reinvested into these programs to increase the number of clients covered by the programs.

COST OF COMPLIANCE:

(1) Identify any state agencies, units of local government, and members of the public likely to be economically affected by the rule(s). (2) Effect on Small Businesses: (a) Estimate the number and type of small businesses subject to the rule(s); (b) Describe the expected reporting, recordkeeping and administrative activities and cost required to comply with the rule(s); (c) Estimate the cost of professional services, equipment supplies, labor and increased administration required to comply with the rule(s).

(1) The impact on state agencies, units of local government and the public (ORS 183.335(2)(b)(E): The change only impacts the amount of federal funds received due to the additional services qualifying for federal match. The GF made available due to the increase in FF will be reinvested into these programs to increase the number of clients covered by the programs.

(2)

(a) Small businesses and industries will not be subject to this rule.

(b) Small businesses will not be responsible for project reporting, recordkeeping and other administrative activities required for compliance, including cost of professional services.

(c) Small businesses will not be responsible for equipment, supplies, labor and increased administration required for compliance.

DESCRIBE HOW SMALL BUSINESSES WERE INVOLVED IN THE DEVELOPMENT OF THESE RULE(S):

The HOP Advisory Committee has participated in helping to guide decisions, provide outreach to members, community partners and providers, including how to limit adult eligibility under the $100 million budget designated for the first year. Under recommendations from this advisory work group, the program was renamed “Healthier Oregon” and will be open to adults 19-25 or 55 and older for the initial year. Pharmacy and Therapeutics Committee approved CWM emergency medications.

WAS AN ADMINISTRATIVE RULE ADVISORY COMMITTEE CONSULTED? YES

RULES PROPOSED:

410-120-0000, 410-120-1210, 410-120-1280, 410-121-0147, 410-125-0230, 410-134-0000, 410-134-0001, 410-134-0002, 410-134-0003, 410-134-0004, 410-134-0005, 410-141-3805, 410-200-0015, 410-200-0240

AMEND: 410-120-0000

RULE SUMMARY: The Authority is updating sections 0000,1210, and 1280 of division 120, to move the CWM program rules to its own division. The Authority is creating a new rule division in Chapter 410, division 134 to define CWM emergency and State funded wrap-around supplemental benefits for recipients. Division 141, revised to add Healthier Oregon Program (HOP) to MCE. Division 200, sections 0015 and 0240, revised to clarify definitions and eligibility criteria related to HOP. Division 125, section 0230, revised to address appropriate funding. Division 121 revised to include emergency medication for CWM.

CHANGES TO RULE:

410-120-0000
Acronyms and Definitions ¶

Identification of acronyms and definitions within this rule specifically pertain to their use within the Oregon Health Authority (Authority), Health Systems Division (Division) administrative rules, applicable to the medical assistance program. This rule does not include an exhaustive list of Division acronyms and definitions. For more information, see Oregon Health Plan (OHP) program OAR 410-141-30500 Acronyms and Definitions; 410-200-0015 General Definitions; and any appropriate governing acronyms and definitions in the Department of Human Services (Department) chapter 411, 413, or 461 administrative rules; or contact the Division.¶
(1) "Abuse" means provider practices that are inconsistent with sound fiscal, business, or medical practices and result in an unnecessary cost to the Authority or in reimbursement for services that are not medically necessary or medically appropriate. It also includes recipient practices that result in unnecessary cost to the Authority.¶
(2) "Action" means a termination, suspension of, or reduction in covered benefits, services, eligibility or an increase in beneficiary liability. This includes a determination by a skilled nursing facility or nursing facility to transfer or discharge a resident, or an adverse determination with regard to the preadmission screening and resident review requirements. For the definition as it is related to a CCO member, refer to OAR 410-141-30500.¶
(3) "Acupuncturist" means an individual licensed to practice acupuncture by the relevant state licensing board.¶
(4) "Acupuncture Services" means services provided by a licensed acupuncturist within the scope of practice as defined under state law.¶
(5) "Acute" means a condition, diagnosis, or illness with a sudden onset and that is of short duration.¶
(6) "Acquisition Cost" means, unless specified otherwise in individual program administrative rules, the net invoice price of the item, supply, or equipment plus any shipping or postage for the item.¶
(7) "Addictions and Mental Health Division" means the Division within the Authority's Health Systems Division that administers mental health and addiction programs and services.¶
(8) "Adequate Record Keeping" means documentation that supports the level of service billed. See OAR 410-120-1360, Requirements for Financial, Clinical, and Other Records, and the individual provider rules.¶
(9) "Administrative Medical Examinations and Reports" means examinations, evaluations, and reports, including copies of medical records requested on the OHP 729 form through the local Department branch office or requested or approved by the Authority to establish client eligibility for a medical assistance program or for casework planning.¶
(10) "Advance Directive" means an individual's instructions to an appointed person specifying actions to take in the event that the individual is no longer able to make decisions due to illness or incapacity.¶
(11) "Adverse determination" means a determination made that the individual does not require the level of services provided by a nursing facility or that the individual does or does not require specialized services.¶
(12) "Adverse Eevent" means an undesirable and unintentional, though not necessarily unexpected, result of medical treatment.¶
(13) "Aging and People with Disabilities (APD)" means the division in the Department of Human Services (Department) that administers programs for seniors and people with disabilities. This division was formerly named "Seniors and People with Disabilities (SPD)."¶
(14) "All-Inclusive Rate" or "Bundled Rate" means the nursing facility rate established for a facility. This rate includes all services, supplies, drugs, and equipment as described in OAR 411-070-0085 and in the Division's Pharmaceutical Services program administrative rules and the Home Enteral/Parenteral Nutrition and IV Services program administrative rules, except as specified in OAR 410-120-1340 Payment.¶
(15) "Allied Agency" means local and regional governmental agency and regional authority that contracts with the Authority or Department to provide the delivery of services to covered individuals (e.g., local mental health authority, community mental health program, Oregon Youth Authority, Department of Corrections, local health departments, schools, education service districts, developmental disability service programs, area agencies on aging (AAAs), federally recognized American Indian tribes).¶
(16) "Alternative Care Settings" means sites or groups of practitioners that provide care to members under contract with an MCE, including urgent care centers, hospice, birthing centers, out-placed medical teams in community or mobile health care facilities, long-term care facilities, and outpatient surgical centers.¶
(17) "Ambulance" means a specially equipped and licensed vehicle for transporting sick or injured individuals that meets the licensing standards of the Authority or the licensing standards of the state in which the ambulance provider is located.¶
(18) "Ambulatory Payment Classification" means a reimbursement method that categorizes outpatient visits into groups according to the clinical characteristics, the typical resource use, and the costs associated with the diagnoses and the procedures performed. The groups are called Ambulatory Payment Classifications (APCs).¶
(19) "Ambulatory Surgical Center (ASC)" means a facility licensed as an ASC by the Authority.¶
(20) "American Indian/Alaska Native (AI/AN)" means a member of a federally recognized Indian tribe, band, or group, and an Eskimo or Aleut or other Alaska native enrolled by the Secretary of the Interior pursuant to the

Alaska Native Claims Settlement Act, 43 U.S.C. 1601, or a person who is considered by the Secretary of the Interior to be an Indian for any purpose.¶
(21) "American Indian/Alaska Native (AI/AN) Clinic" means a clinic recognized under Indian Health Services (IHS) law or by the Memorandum of Agreement between IHS and the Centers for Medicare and Medicaid Services (CMS).¶
(22) "Ancillary Services" means services supportive of or necessary for providing a primary service, such as anesthesiology, which is an ancillary service necessary for a surgical procedure.¶
(23) "Anesthesia Services" means administration of anesthetic agents to cause loss of sensation to the body or body part.¶
(24) "Appeal" means a request for review of an adverse determination, action or as it relates to an MCE an adverse benefit determination.¶
(25) "Area Agency on Aging (AAA)" means the designated entity with which the Department contracts to meet the requirements of the Older Americans Act and ORS Chapter 410 in planning and providing services to the elderly or elderly and disabled population.¶
(26) "Atypical Provider" means an entity able to enroll as a billing provider (BP) or rendering provider for medical assistance programs related non-health care services but that does not meet the definition of health care provider for National Provider Identification (NPI) purposes.¶
(27) "Audiologist" means an individual licensed to practice audiology by the State Board of Examiners for Speech Pathology and Audiology.¶
(28) "Audiology" means the application of principles, methods, and procedures of measurement, testing, appraisal, prediction, consultation, counseling, and instruction related to hearing and hearing impairment for the purpose of modifying communicative disorders involving speech, language, auditory function, including auditory training, speech reading and hearing aid evaluation, or other behavior related to hearing impairment.¶
(29) "Automated Voice Response (AVR)" means a computer system that provides information on clients' current eligibility status from the Division by computerized phone response.¶
(30) "Behavioral Health" means mental health, mental illness, addiction disorders, and substance use disorders.¶
(31) "Behavioral Health Assessment" means a qualified mental health professional's determination of a member's need for mental health services.¶
(32) "Behavioral Health Case Management" means services provide to members who need assistance to ensure access to mental health benefits and services from local, regional, or state allied agencies or other service providers.¶
(33) "Behavioral Health Evaluation" means a psychiatric or psychological assessment used to determine the need for mental health or substance use disorder services.¶
(34) "Benefit Package" means the package of covered health care services for which the client is eligible.¶
(35) "Billing Agent or Billing Service" means third party or organization that contracts with a provider to perform designated services in order to facilitate an Electronic Data Interchange (EDI) transaction on behalf of the provider.¶
(36) "Billing Provider (BP)" means an individual, agent, business, corporation, clinic, group, institution, or other entity who submits claims to or receives payment from the Division on behalf of a rendering provider and has been delegated the authority to obligate or act on behalf of the rendering provider.¶
(37) "Buying Up" means the practice of obtaining client payment in addition to the Division or managed care plan payment to obtain a non-covered service or item. (See OAR 410-120-1350 Buying Up.)¶
(38) "By Report (BR)"⁝ means services designated, as BR requires operative or clinical and other pertinent information to be submitted with the billing as a basis for payment determination. This information must include an adequate description of the nature and extent of need for the procedure. Information such as complexity of symptoms, final diagnosis, pertinent physical findings, diagnostic and therapeutic procedures, concurrent problems, and follow-up care will facilitate evaluation.¶
(39) "Case Management Services" means services provided to ensure that CCO members obtain health services necessary to maintain physical, mental, and emotional development and oral health. Case management services include a comprehensive, ongoing assessment of medical, mental health, substance use disorder or dental needs plus the development and implementation of a plan to obtain or make referrals for needed medical, mental, chemical dependency, or dental services, referring members to community services and supports that may include referrals to Allied Agencies.¶
(40) "Certified Traditional Health Worker" means an individual who has successfully completed a training program or doula training as required by OAR 410-180-0305, known to the Centers of Medicare and Medicaid as non-traditional health worker.¶
(41) "Child Welfare (CW)" means a division within the Department responsible for administering child welfare programs, including child abuse investigations and intervention, foster care, adoptions, and child safety.¶
(42) "Children's Health Insurance Program (CHIP)" means a federal and state funded portion of the Oregon

Health Plan (OHP) established by Title XXI of the Social Security Act and administered by the Authority.¶
(43) "Chiropractor" means an individual licensed to practice chiropractic by the relevant state licensing board.¶
(44) "Chiropractic Services" means services provided by a licensed chiropractor within the scope of practice as defined under state law and federal regulation.¶
(45) "Citizen~~/Alien-Waived Emergency~~ship Waived Medical (C~~AWE~~WM)" means ~~aliens~~ granted lawful temporary resident status or lawful permanent resident status under the Immigration and Nationality Act are eligible only for emergency services and limited service for pregnant ~~women~~people. Emergency services for C~~AWE~~WM are defined in OAR 410-1~~20-1210(4)(d).~~ 34-0003.¶
(46) "Claimant" means an individual who has requested a hearing.¶
(47) "Client" means an individual found eligible to receive OHP health services.¶
(48) "Clinical Nurse Specialist" means a registered nurse who has been approved and certified by the Board of Nursing to provide health care in an expanded specialty role.¶
(49) "Clinical Social Worker" means an individual licensed to practice clinical social work pursuant to state law.¶
(50) "Clinical Record" means the medical, dental, or mental health records of a client or member.¶
(51) "Co-morbid Condition" means a medical condition or diagnosis coexisting with one or more other current and existing conditions or diagnoses in the same patient.¶
(52) "Comfort Care" means medical services or items that give comfort or pain relief to an individual who has a terminal Illness, including the combination of medical and related services designed to make it possible for an individual with terminal Illness to die with dignity and respect and with as much comfort as is possible given the nature of the illness.¶
(53) "Community Health Worker" means an individual who:¶
(a) Has expertise or experience in public health;¶
(b) Works in an urban or rural community either for pay or as a volunteer in association with a local health care system;¶
(c) To the extent practicable, shares ethnicity, language, socioeconomic status, and life experiences with the residents of the community where the worker serves;¶
(d) Assists members of the community to improve their health and increases the capacity of the community to meet the health care needs of its residents and achieve wellness;¶
(e) Advocates for the individual patient and community health needs, building individual and community capacity to advocate for their health;¶
(f) Provides health education and information that is culturally appropriate to the individuals being served;¶
(g) Assists community residents in receiving the care they need;¶
(h) May give peer counseling and guidance on health behaviors; and¶
(i) May provide direct services such as first aid or blood pressure screening.¶
(54) "Community Mental Health Program (CMHP)" means the organization of all services for individuals with mental or emotional disorders operated by, or contractually affiliated with, a local Mental Health Authority operated in a specific geographic area of the state under an intergovernmental agreement or direct contract with the Authority.¶
(55) "Condition/Treatment Pair" means diagnoses described in the International Classification of Diseases Clinical Modifications, 10th edition (ICD-10-CM); the Diagnostic and Statistical Manual of Mental Disorders, 5th edition (DSM-V); and treatments described in the Current Procedural Terminology (CPT); or American Dental Association Codes (CDT) or the Authority Behavioral Health Fee Schedule, that, when paired by the Health Evidence Review Commission, constitute the line items in the Prioritized List of Health Services. Condition/treatment pairs may contain many diagnoses and treatments.¶
(56) "Contested Case Hearing" means a proceeding before the Authority under the Administrative Procedures Act when any of the following contests an adverse determination, action, or as it relates to an MCE enrollee, an adverse benefit determination:¶
(a) A client or member or their representative;¶
(b) A member of an MCE after resolution of the MCE's appeal process;¶
(c) An MCE member's provider; or¶
(d) An MCE.¶
(57) "Contiguous Area" means the area up to 75 miles outside the border of the State of Oregon.¶
(58) "Contiguous Area Provider" means a provider practicing in a contiguous area.¶
(59) "Continuing Treatment Benefit" means a benefit for clients who meet criteria for having services covered that were either in a course of treatment or scheduled for treatment the day immediately before the date the client's benefit package changed to one that does not cover the treatment.¶
(60) "Coordinated Care Organization (CCO)" has the meaning given that term in OAR 410-141-3~~0~~500.¶
(61) "Co-Payments" means the portion of a claim or medical, dental, or pharmaceutical expense that a client must pay out of their own pocket to a provider or a facility for each service. It is usually a fixed amount that is paid at the

time service is rendered. (See OAR 410-120-1230 Client Copayment.)¶
(62) "Cost Effective" means the lowest cost health service or item that, in the judgment of Authority staff or its contracted agencies, meets the medical needs of the client.¶
(63) "Covered Services" means medically necessary and appropriate health services and items described in ORS Chapter 414 and applicable administrative rules and the Prioritized List of Health Services above the funding line set by the legislature. Covered services include services that are:¶
(a) Ancillary services ~~(OAR 410-141-0480)~~;¶
(b) Diagnostic services necessary to determine the existence, nature, or extent of the client or member's disease, disorder, disability or condition;¶
(c) Necessary for compliance with the requirements for parity in mental health and substance use disorder benefits in 42 CFR part 438, subpart k;¶
(d) Necessary for compliance with the requirements for Early and Periodic Screening, Diagnosis and Treatment as specified in the Oregon Health Plan 1115 Demonstration Project (waiver).¶
(64) "Current Dental Terminology (CDT)" means a listing of descriptive terms identifying dental procedure codes used by the American Dental Association.¶
(65) "Current Procedural Terminology (CPT)" means a medical code set developed by the American Medical Association used to report medical, surgical, and diagnostic procedures and services performed by physicians and other health care providers.¶
(66) "Date of Receipt of a Claim" means the date on which the Authority receives a claim as indicated by the Internal Control Number (ICN) assigned to a claim. Date of receipt is shown as the Julian date in the 5th through 7th position of the ICN.¶
(67) "Date of Service" means the date on which the client receives medical services or items, unless otherwise specified in the appropriate provider rules. For items that are mailed or shipped by the provider, the date of service is the date on which the order was received, the date on which the item was fabricated, or the date on which the item was mailed or shipped.¶
(68) "Declaration for Mental Health Treatment" means a written statement of an individual's decisions concerning his or her mental health treatment. The individual makes the declaration when they are able to understand and make decisions related to treatment that is honored when the individual is unable to make such decisions.¶
(69) "Dental Emergency Services" means dental services provided for severe tooth pain, unusual swelling of the face or gums, or an avulsed tooth.¶
(70) "Dental Services" means services provided within the scope of practice as defined under state law by or under the supervision of a dentist or dental hygienist.¶
(71) "Dentist" means an individual licensed to practice dentistry pursuant to state law of the state in which the ~~or she~~ practice~~s~~ dentistry or an individual licensed to practice dentistry pursuant to federal law for the purpose of practicing dentistry as an employee of the federal government.¶
(72) "Denturist" means an individual licensed to practice denture technology pursuant to state law.¶
(73) "Denturist Services" means services provided within the scope of practice as defined under state law by or under the personal supervision of a denturist.¶
(74) "Dental Hygienist" means an individual licensed to practice hygiene under the direction of a licensed professional within the scope of practice pursuant to state law.¶
(75) "Dental Hygienist with an Expanded Practice Permit" means an individual licensed to practice dental hygiene services as authorized by the Board of Dentistry with an Expanded Practice Dental Hygienist Permit (EPDHP) pursuant to state law.¶
(76) "Dentally Appropriate" means health services, items, or dental supplies:¶
(a) Recommended by a licensed health provider practicing within the scope of their license;¶
(b) Safe, effective and appropriate for the patient based on standards of good dental practice and generally recognized by the relevant scientific or professional community based on the best available evidence;¶
(c) Not solely for the convenience or preference of an OHP client, member or a provider of the service, item or dental supply; and¶
(d) The most cost effective of the alternative levels or types of health services, items, or supplies that are covered services that can be safely and effectively provided to a client or member in the Division or MCE's judgement;¶
(e) All covered services must be medically appropriate for the member or client but not all medically appropriate services are covered services.¶
(77) "Department of Human Services (Department or DHS)" means the agency established in ORS Chapter 409, including such divisions, programs and offices as may be established therein.¶
(78) "Department Representative" means an individual who represents the Department and presents the Department's position in a hearing.¶
(79) "Diagnosis Code" means as identified in the International Classification of Diseases, 10th revision, Clinical Modification (ICD-10-CM). The primary diagnosis code is shown in all billing claims, unless specifically excluded in

individual provider rules. Where they exist, diagnosis codes shall be shown to the degree of specificity outlined in OAR 410-120-1280, Billing.¶
(80) "Diagnosis Related Group (DRG)" means a system of classification of diagnoses and procedures based on the ICD-10-CM.¶
(81) "Diagnostic Services" mean those services required to diagnose a condition, including but not limited to: radiology, ultrasound, other diagnostic imaging, electrocardiograms, laboratory and pathology examinations, and physician or other professional diagnostic or evaluative services.¶
(82) "Division (Division)" means the Health Systems Division within the Authority. The Division is responsible for coordinating the medical assistance programs within the State of Oregon including the Oregon Health Plan (OHP) Medicaid demonstration, the State Children's Health Insurance Program (SCHIP-Title XXI), and several other programs.¶
(83) "Durable Medical Equipment, Prosthetics, Orthotics and Medical Supplies (DMEPOS)" means equipment that can stand repeated use and is primarily and customarily used to serve a medical purpose. Examples include wheelchairs, respirators, crutches, and custom built orthopedic braces. Medical supplies are non-reusable items used in the treatment of illness or injury. Examples of medical supplies include diapers, syringes, gauze bandages, and tubing.¶
(84) "Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services (aka, Medicheck)" mean the Title XIX program of EPSDT services for eligible clients under age 21. It is a comprehensive child health program to assure the availability and accessibility of required medically necessary and medically appropriate health care services and items and to help Authority clients and their parents or guardians effectively use them.¶
(85) "Electronic Data Interchange (EDI)" means the exchange of business documents from application to application in a federally mandated format or, if no federal standard has been promulgated, using bulk transmission processes and other formats as the Authority designates for EDI transactions. For purposes of rules OAR 943-120-0100 through OAR 943-120-0200, EDI does not include electronic transmission by web portal.¶
(86) "EDI Submitter" means an individual or an entity authorized to establish an electronic media connection with the Authority to conduct an EDI transaction. An EDI submitter may be a trading partner or an agent of a trading partner.¶
(87) "Electronic Verification System (EVS)" means eligibility information that has met the legal and technical specifications of the Authority in order to offer eligibility information to enrolled providers of the Division.¶
(88) "Emergency Department" means the part of a licensed hospital facility open 24 hours a day to provide care for anyone in need of emergency treatment.¶
(89) "Emergency Medical Condition" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or with respect to a pregnant ~~woma~~person, the health of the ~~woma~~person or their unborn child) in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part. An emergency medical condition is determined based on the presenting symptoms (not the final diagnosis) as perceived by a prudent layperson (rather than a health care professional) and includes cases in which the absence of immediate medical attention would not in fact have had the adverse results described in the previous sentence. ~~(This definition does not apply to clients with CAWEM benefit package. CAWEM emergency services are governed by OAR 410-120-1210(4)(d)(C).~~ ¶
(90) "Emergency Medical Transportation" means transportation necessary for a client with an emergency medical condition as defined in this rule and requires a skilled medical professional such as an Emergency Medical Technician (EMT) and immediate transport to a site, usually a hospital, where appropriate emergency medical service is available.¶
(91) "Emergency Services" means health services from a qualified provider necessary to evaluate or stabilize an emergency medical condition, including inpatient and outpatient treatment that may be necessary to assure within reasonable medical probability that the patient's condition is not likely to materially deteriorate from or during a client's discharge from a facility or transfer to another facility.¶
(92) "Evidence-Based Medicine" means the conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individual patients. The practice of evidence-based medicine means integrating individual clinical expertise with the best available external clinical evidence from systematic research. By individual clinical expertise we mean the proficiency and judgment that individual clinicians acquire through clinical experience and clinical practice. Increased expertise is reflected in many ways, but especially in more effective and efficient diagnosis and in the more thoughtful identification and compassionate evaluation [sic] of individual patients' predicaments, rights, and preferences in making clinical decisions about their care. By best available external clinical evidence we mean clinically relevant research, often from the basic sciences of medicine, but especially from patient-centered clinical research into the accuracy and precision of diagnostic tests (including the clinical examination), the power of prognostic markers, and the efficacy and safety of therapeutic,

rehabilitative, and preventive regimens. External clinical evidence both invalidates previously accepted diagnostic tests and treatments and replaces them with new ones that are more powerful, more accurate, more efficacious, and safer. (Source: BMJ 1996; 312:71-72 (13 January)). In addition, Evidence-Based Medicine takes into account the quality of evidence and the confidence that may be placed in findings.¶
(93) "False Claim" means a claim that a provider knowingly submits or causes to be submitted that contains inaccurate, misleading, or omitted information and such inaccurate, misleading, or omitted information would result, or has resulted, in an overpayment.¶
(94) "Family Planning Services" means services for clients of child bearing age (including minors who can be considered to be sexually active) who desire such services and that are intended to prevent pregnancy or otherwise limit family size.¶
(95) "Federally Qualified Health Center (FQHC)" means a federal designation for a medical entity that receives grants under Section 329, 330, or 340 of the Public Health Service Act or a facility designated as an FQHC by Centers for Medicare and Medicaid (CMS) upon recommendation of the U.S. Public Health Service.¶
(96) "Fee-for-Service Provider" means a health care provider who is not reimbursed under the terms of an Authority contract with a Coordinated Care Organization or Prepaid Health Plan (PHP). A medical provider participating in a PHP or a CCO may be considered a fee-for-service provider when treating clients who are not enrolled in a PHP or a CCO.¶
(97) "Fraud" means an intentional deception or misrepresentation made by an individual with the knowledge that the deception could result in some unauthorized benefit to him or some other person. It includes any act that constitutes fraud under applicable federal or state law.¶
(98) "Fully Dual Eligible" means for the purposes of Medicare Part D coverage (42 CFR 423.772), Medicare clients who are also eligible for Medicaid, meeting the income and other eligibility criteria adopted by the Authority for full medical assistance coverage.¶
(99) "General Assistance (GA)" means medical assistance administered and funded 100 percent with State of Oregon funds through OHP.¶
(100) "Grievance" means an expression of dissatisfaction about any matter other than an adverse benefit determination. Grievances may include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the enrollee's rights regardless of whether remedial action is requested.¶
(101) "Health Care Interpreter" Certified or Qualified have the meaning given those terms in ORS 413.550.¶
(102) "Health Care Professionals" means individuals with current and appropriate licensure, certification, or accreditation in a medical, mental health, or dental profession who provide health services, assessments, and screenings for clients within their scope of practice, licensure, or certification.¶
(103) "Healthcare Common Procedure Coding System (HCPCS)" means a method for reporting health care professional services, procedures, and supplies. HCPCS consists of the Level I - American Medical Association's Physician's Current Procedural Terminology (CPT), Level II - National codes, and Level III - Local codes. The Division uses HCPCS codes; however, the Division uses Current Dental Terminology (CDT) codes for the reporting of dental care services and procedures.¶
(104) "Health Evidence Review Commission" means a commission that, among other duties, develops and maintains a list of health services ranked by priority from the most to the least important representing the comparative benefits of each service to the population served.¶
(105) "Health Insurance Portability and Accountability Act (HIPAA) of 1996 (HIPAA)" means the federal law (Public Law 104-191, August 21, 1996) with the legislative objective to assure health insurance portability, reduce health care fraud and abuse, enforce standards for health information, and guarantee security and privacy of health information.¶
(106) "Health Maintenance Organization (HMO)" means a public or private health care organization that is a federally qualified HMO under Section 1310 of the U.S. Public Health Services Act. HMOs provide health care services on a capitated, contractual basis.¶
(107) "Health Plan New/non-categorical client (HPN)" means an individual who is 19 years of age or older, is not pregnant, is not receiving Medicaid through another program, and who must meet all eligibility requirements to become an OHP client.¶
(108) "Hearing Aid Dealer" means an individual licensed by the Board of Hearing Aid Dealers to sell, lease, or rent hearing aids in conjunction with the evaluation or measurement of human hearing and the recommendation, selection, or adaptation of hearing aids.¶
(109) "Home Enteral Nutrition" means services provided in the client's place of residence to an individual who requires nutrition supplied by tube into the gastrointestinal tract as described in the Home Enteral/Parenteral Nutrition and IV Services program provider rules.¶
(110) "Home Health Agency" means a public or private agency or organization that has been certified by Medicare as a Medicare home health agency and that is licensed by the Authority as a home health agency in Oregon and

meets the capitalization requirements as outlined in the Balanced Budget Act (BBA) of 1997.¶
(111) "Home Health Services" means part-time or intermittent skilled nursing services, other therapeutic services (physical therapy, occupational therapy, speech therapy), and home health aide services made available on a visiting basis in a place of residence used as the client's home.¶
(112) "Home Intravenous Services" means services provided in the client's place of residence to an individual who requires that medication (antibiotics, analgesics, chemotherapy, hydrational fluids, or other intravenous medications) be administered intravenously as described in the Home Enteral/Parenteral Nutrition and IV Services program administrative rules.¶
(113) "Home Parenteral Nutrition" means services provided in the client's residence to an individual who is unable to absorb nutrients via the gastrointestinal tract, or for other medical reasons, requires nutrition be supplied parenterally as described in the Home Enteral/Parenteral Nutrition and IV Services program administrative rules.¶
(114) "Hospice" means a public agency or private organization or subdivision of either that is primarily engaged in providing care to terminally ill individuals and is certified by the federal Centers for Medicare and Medicaid Services as a program of hospice services meeting current standards for Medicare and Medicaid reimbursement and Medicare Conditions of Participation and is currently licensed by the Oregon Health Authority, Public Health Division.¶
(115) "Hospital" means a facility licensed by the Public Health Division as a general hospital that meets requirements for participation in OHP under Title XVIII of the Social Security Act. The Division does not consider facilities certified by CMS as religious non-medical facilities as hospitals for reimbursement purposes. Out-of-state hospitals shall be considered hospitals for reimbursement purposes if they are licensed as a short term acute care or general hospital by the appropriate licensing authority within that state and if they are enrolled as a provider of hospital services with the Medicaid agency within that state.¶
(116) "Hospital-Based Professional Services" means professional services provided by licensed practitioners or staff based on a contractual or employee/employer relationship and reported as a cost on the Hospital Statement of Reasonable Cost report for Medicare and the Calculation of Reasonable Cost (division 42) report for the Division.¶
(117) "Hospital Dentistry" means dental services normally done in a dental office setting, but due to specific client need (as detailed in OAR chapter 410 division 123) are provided in an ambulatory surgical center or inpatient or outpatient hospital setting under general anesthesia (or IV conscious sedation, if appropriate).¶
(118) "Hospital Laboratory" means a laboratory providing professional technical laboratory services as outlined under laboratory services in a hospital setting as either an inpatient or outpatient hospital service whose costs are reported on the hospital's cost report to Medicare and to the Division.¶
(119) "Indian Health Care Provider" (IHCP) means an Indian health program operated by the Indian Health Service (IHS) or by an Indian Tribe, Tribal Organization or an urban Indian organization (otherwise known as an I/T/U) as defined in section 4 of the Indian Health Care Improvement Act (25 U.S.C. 1603.¶
(120) "Indian Health Program" means any Indian Health Service (IHS) facility, any federally recognized tribe or tribal organization, or any FQHC with a 638 designation.¶
(121) "Indian Health Service (IHS)" means an operating division (OPDIV) within the U.S. Department of Health and Human Services (HHS) responsible for providing medical and public health services to members of federally recognized tribes and Alaska Natives.¶
(122) "Indian Managed Care Entities" (IMCE) means a CCO, MCO, PIHP, PAHP, PCCM, or PCCM entity that is controlled (section 1903(m)(1)(C) of the Act) by the Indian Health Service, a Tribe, Tribal Organization, or Urban Indian Organization, or a consortium, which may be composed of one or more Tribes, Tribal Organizations, or Urban Indian Organizations, and which also may include the Service.¶
(123) "Indigent" means for the purposes of access to the Intoxicated Driver Program Fund (ORS 813.602), individuals with-out health insurance coverage, public or private, who meet standards for indigence adopted by the federal government as defined in ORS 813.602(5).¶
(124) "Individual Adjustment Request Form (OHP 1036)" means a form used to resolve an incorrect payment on a previously paid claim, including underpayments or overpayments.¶
(125) "Inpatient Hospital Services" means services that are furnished in a hospital for the care and treatment of an inpatient. (See Division Hospital Services program administrative rules in chapter 410, division 125 for inpatient covered services.)¶
(126) "Institutional Level of Income Standards (ILIS)" means three times the amount SSI pays monthly to a person who has no other income and who is living alone in the community. This is the standard used for Medicaid eligible individuals to calculate eligibility for long-term nursing care in a nursing facility, Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID), and individuals on ICF/IID waivers or eligibility for services under Aging and People with Disabilities (APD) Home and Community Based Services program.¶
(127) "Institutionalized" means a patient admitted to a nursing facility or hospital for the purpose of receiving

nursing or hospital care for a period of 30 days or more.¶
(128) "International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM) (including volumes 1, 2, and 3, as revised annually)" means a book of diagnosis codes used for billing purposes when treating and requesting reimbursement for treatment of diseases.¶
(129) "Joint fair hearing request" means a request for a fair hearing that is included in an appeal request submitted to an Exchange or other insurance affordability program or appeals entity, in accordance with the signed agreement between the agency and an Exchange or Exchange appeals entity or other program or appeals entity described in 42 CFR 435.1200~~(b)(3)~~.¶
(130) "Laboratory" means a facility licensed under ORS 438 and certified by CMS, Department of Health and Human Services (DHHS), as qualified to participate under Medicare and to provide laboratory services (as defined in this rule) within or apart from a hospital. An entity is considered to be a laboratory if the entity derives materials from the human body for the purpose of providing information for the diagnosis, prevention, or treatment of any disease or impairment of or the assessment of the health of human beings. If an entity performs even one laboratory test, including waived tests for these purposes, it is considered to be a laboratory under the Clinical Laboratory Improvement Act (CLIA).¶
(131) "Laboratory Services" means those professional and technical diagnostic analyses of blood, urine, and tissue ordered by a physician or other licensed practitioner of the healing arts within ~~his or t~~heir scope of practice as defined under state law and provided to a patient by or under the direction of a physician or appropriate licensed practitioner in an office or similar facility, hospital, or independent laboratory.¶
(132) "Licensed Direct Entry Midwife" means a practitioner who has acquired the requisite qualifications to be registered or legally licensed to practice midwifery by the Public Health Division.¶
(133) "Liability Insurance" means insurance that provides payment based on legal liability for injuries or illness. It includes, but is not limited to, automobile liability insurance, uninsured and underinsured motorist insurance, homeowner's liability insurance, malpractice insurance, product liability insurance, Worker's Compensation, and general casualty insurance. It also includes payments under state wrongful death statutes that provide payment for medical damages.¶
(134) "Long-Term Acute Care (LTAC) Hospital" means a facility that provides specialty care designed for patients with serious medical problems that require intense, special treatment for an extended period of time.¶
(135) "Long-term Care or Long-term Services and Supports" means Medicaid funded Long-term care or long-term services and supports services that include:¶
(a) "Long-term Care" as defined in OAR 461-001-0000 means the system through which the Department of Human Services provides a broad range of social and health services to eligible adults who are aged, blind, or have disabilities for extended periods of time. This includes nursing homes and behavioral health care outlined in OAR chapter 410, division 172 Medicaid Behavioral Health, including state psychiatric hospitals;¶
(b) "Long-term Services and Supports" means the Medicaid services and supports provided under a CMS approved waiver to assist individual's needs and to avoid institutionalization as defined in OAR chapter 411, division 4 and defined as Medicaid Home and Community-Based Settings and Services (HCBS) and as outlined in OAR chapter 410, division 172 (Medicaid Payment for Behavioral Health Services).¶
(136) "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, primary care case managers and Coordinated Care Organizations.¶
(137) "Managed Care Organization (MCO)" means a contracted health delivery system providing capitated or prepaid health services, also known as a Prepaid Health Plan (PHP). An MCO is responsible for providing, arranging, and making reimbursement arrangements for covered services as governed by state and federal law. An MCO may be a Chemical Dependency Organization (CDO), Dental Care Organization (DCO), Mental Health Organization (MHO), or Physician Care Organization (PCO).¶
(138) "Maternity Case Management" means a program available to pregnant clients. The purpose of maternity case management is to extend prenatal services to include non-medical services that address social, economic, and nutritional factors. For more information refer to the Division's Medical-Surgical Services program administrative rules.¶
(139) "Medicaid" means a joint federal and state funded program for medical assistance established by Title XIX of the Social Security Act as amended and administered in Oregon by the Authority.¶
(140) "Medical Assistance Eligibility Confirmation" means verification through the Electronic Verification System (EVS), AVR, Secure Web site or Electronic Data Interchange (EDI), or an authorized Department or Authority representative.¶
(141) "Medical Assistance Program" means a program for payment of health services provided to eligible Oregonians, including Medicaid and CHIP services under the OHP Medicaid Demonstration Project and Medicaid and CHIP services under the State Plan.¶
(142) "Medical Care Identification" means the card commonly called the "medical card" or medical ID issued to

clients (called the Oregon Health ID starting Aug. 1, 2012).-¶
(143) "Medical Services" means care and treatment provided by a licensed medical provider directed at preventing, diagnosing, treating, or correcting a medical problem.-¶
(144) "Medical Transportation" means transportation to or from covered medical services.-¶
(145) "Medically Appropriate" means health services, items, or medical supplies that are:-¶
(a) Recommended by a licensed health provider practicing within the scope of their license;-¶
(b) Safe, effective, and appropriate for the patient based on standards of good health practice and generally recognized by the relevant scientific or professional community based on the best available evidence;-¶
(c) Not solely for the convenience or preference of an OHP client, member, or a provider of the service item or medical supply; and-¶
(d) The most cost effective of the alternative levels or types of health services, items, or medical supplies that are covered services that can be safely and effectively provided to a Division client or member in the Division or MCE's judgment;¶
(e) All covered services must be medically appropriate for the member or client but not all medically appropriate services are covered services.¶
(146) "Medically Necessary" means health services and items that are required by a client or member to address one or more of the following:-¶
(a) The prevention, diagnosis, or treatment of a client or member's disease, condition, or disorder that results in health impairments or a disability;-¶
(b) The ability for a client or member to achieve age-appropriate growth and development;-¶
(c) The ability for a client or member to attain, maintain, or regain independence in self-care, ability to perform activities of daily living or improve health status; or¶
(d) The opportunity for a client or member receiving Long Term Services & Supports (LTSS) as defined in these rules to have access to the benefits of non-institutionalized community living, to achieve person centered care goals, and to live and work in the setting of their choice;¶
(e) A medically necessary service must also be medically appropriate. All covered services must be medically necessary but not all medically necessary services are covered services.¶
(147) "Medicare" means a federally administered program offering health insurance benefits for persons aged 65 or older and certain other aged or disabled persons. This program includes:-¶
(a) Hospital Insurance (Part A) for inpatient services in a hospital or skilled nursing facility, home health care, and hospice care; and-¶
(b) Medical Insurance (Part B) for physicians' services, outpatient hospital services, home health care, end-stage renal dialysis, and other medical services and supplies;-¶
(c) Prescription drug coverage (Part D) means covered Part D drugs that include prescription drugs, biological products, insulin as described in specified paragraphs of section 1927(k) of the Social Security Act, and vaccines licensed under section 351 of the Public Health Service Act. It also includes medical supplies associated with the injection of insulin. Part D covered drugs prohibit Medicaid Title XIX Federal Financial Participation (FFP). For limitations, see the Division's Pharmaceutical Services program administrative rules in chapter 410, division 121.-¶
(148) "Medicare Advantage" means an organization approved by CMS to offer Medicare health benefits plans to Medicare beneficiaries.-¶
(149) "Medicheck for Children and Teens" means services also known as Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services. The Title XIX program of EPSDT services is for eligible clients under age 21. It is a comprehensive child health program to assure the availability and accessibility of required medically necessary or medically appropriate health care services and to help Authority clients and their parents or guardians effectively use them.-¶
(150) "Member" means an OHP client enrolled with a pre-paid health plan or coordinated care organization.-¶
(151) "National Correct Coding Initiative (NCCI)" means the Centers for Medicare and Medicaid Services (CMS) developed the National Correct Coding Initiative (NCCI) to promote national correct coding methodologies and to control improper coding leading to inappropriate payment.-¶
(152) "National Drug Code or (NDC)" means a universal number that identifies a drug. The NDC number consists of 11 digits in a 5-4-2 format. The Food and Drug Administration assigns the first five digits to identify the manufacturer of the drug. The manufacturer assigns the remaining digits to identify the specific product and package size. Some packages will display less than 11 digits, but the number assumes leading zeroes.-¶
(153) "National Provider Identification (NPI)" means federally administered provider number mandated for use on HIPAA covered transactions; individuals, provider organizations, and subparts of provider organizations that meet the definition of health care provider (45 CFR 160.103) and who conduct HIPAA covered transactions electronically are eligible to apply for an NPI. Medicare and Medicaid covered entities are required to apply for an NPI.-¶

(154) "Naturopathic physician" means an individual licensed to practice naturopathic medicine by the Oregon Board of Naturopathic Medicine.¶
(155) "Naturopathic Services" means services provided within the scope of practice as defined under state law and by rules of the Oregon Board of Naturopathic Medicine.¶
(156) "Non-covered Services" means services or items for which the Authority is not responsible for payment or reimbursement. Non-covered services are identified in:¶
(a) OAR 410-120-1200 Excluded Services and Limitations; and¶
(b) OAR 410-120-1210 Medical Assistance Benefit Packages and Delivery System;¶
(c) OAR 410-141-0480 OHP Benefit Package of Covered Services;¶
(d) OAR 410-141-0520 Prioritized List of Health Services; and¶
(e) Any other applicable Division administrative rules.¶
(157) "Non-Emergent Medical Transportation Services (NEMT)"means transportation to or from a source of covered service, that does not involve a sudden, unexpected occurrence which creates a medical crisis requiring emergency medical services as defined in OAR 410-120-0000 and requiring immediate transportation to a site, usually a hospital, where appropriate emergency medical care is available.¶
(158) "Non-Paid Provider" means a provider who is issued a provider number for purposes of data collection or non-claims-use of the Provider Web Portal (e.g., eligibility verification).¶
(159) "Nurse Anesthetist, C.R.N.A." means a registered nurse licensed in the State of Oregon as a CRNA who is currently certified by the National Board of Certification and Recertification for Nurse Anesthetists.¶
(160) "Nurse Practitioner" means an individual licensed as a registered nurse and certified by the Board of Nursing to practice as a nurse practitioner pursuant to state law.¶
(161) "Nurse Practitioner Services" means services provided within the scope of practice of a nurse practitioner as defined under state law and by rules of the Board of Nursing.¶
(162) "Nursing Facility" means a facility licensed and certified by the Department and defined in OAR 411-070-0005.¶
(163) "Nursing Services" means health care services provided to a patient by a registered professional nurse or a licensed practical nurse under the direction of a licensed professional within the scope of practice as defined by state law.¶
(164) "Nutritional Counseling" means counseling that takes place as part of the treatment of an individual with a specific condition, deficiency, or disease such as diabetes, hypercholesterolemia, or phenylketonuria.¶
(165) "Occupational Therapist" means an individual licensed by the State Board of Examiners for Occupational Therapy.¶
(166) "Occupational Therapy" means the functional evaluation and treatment of individuals whose ability to adapt or cope with the task of living is threatened or impaired by developmental deficiencies, physical injury or illness, the aging process, or psychological disability. The treatment utilizes task-oriented activities to prevent or correct physical and emotional difficulties or minimize the disabling effect of these deficiencies on the life of the individual.¶
(167) "Ombudsman Services" means advocacy services provided by the Authority to clients whenever the client is reasonably concerned about access to, quality of, or limitations on the health services provided.¶
(168) "Oregon Health ID" means a card the size of a business card that lists the client name, client ID (prime number), and the date it was issued.¶
(169) "Oregon Health Plan (OHP)" means the Medicaid and Children's Health Insurance (CHIP) Demonstration Project that expands Medicaid and CHIP eligibility beyond populations traditionally eligible for Medicaid to other low-income populations and Medicaid and CHIP services under the State Plan¶
(170) "Optometric Services" means services provided within the scope of practice of optometrists as defined under state law.¶
(171) "Optometrist" means an individual licensed to practice optometry pursuant to state law.¶
(172) "Oregon Health Authority (Authority)" means the agency established in ORS Chapter 413 that administers the funds for Titles XIX and XXI of the Social Security Act. It is the single state agency for the administration of the medical assistance program under ORS chapter 414. For purposes of these rules, the agencies under the authority of the Oregon Health Authority are the Public Health Division, Health Systems Division, External Relations, Health Policy and Analytics, Fiscal and Operations, Health System Division, Office of Equity and Inclusion, and the Oregon State Hospital.¶
(173) "Oregon Youth Authority (OYA)" means the state department charged with the management and administration of youth correction facilities, state parole and probation services, and other functions related to state programs for youth corrections.¶
(174) "Out-of-State Providers" means any provider located outside the borders of the State of Oregon:¶
(a) Contiguous area providers are those located no more than 75 miles from the border of the State of Oregon;¶
(b) Non-contiguous area providers are those located more than 75 miles from the borders of the State of Oregon.

¶
(175) "Outpatient Hospital Services" means services that are furnished in a hospital for the care and treatment of an outpatient. For information on outpatient-covered services, see the Division's Hospital Services administrative rules chapter 410, division 125.¶
(176) "Overdue Claim" means a valid claim that is not paid within 45 days of the date it was received.¶
(177) "Overpayment" means a payment made by the Authority to a provider in excess of the correct Authority payment amount for a service. Overpayments are subject to repayment to the Authority.¶
(178) "Overuse" means use of medical goods or services at levels determined by Authority medical staff or medical consultants to be medically unnecessary or potentially harmful.¶
(179) "Paid Provider" means a provider who is issued a provider number for purposes of submitting medical assistance program claims for payment by the Authority.¶
(180) "Payment Authorization" means authorization granted by the responsible agency, office, or organization for payment prior or subsequent to the delivery of services, as described in these general rules and the appropriate program rules. See the individual program rules for services requiring authorization.¶
(181) "Peer Review Organization (PRO)" means an entity of health care practitioners of services contracted by the state to review services ordered or furnished by other practitioners in the same professional field.¶
(182) "Peer Support Specialist" including Family Support Specialist and Youth Support Specialist has the meaning given that term in OAR 410-180-0305.¶
(183) "Peer Wellness Specialist" including Family Support Specialist and Youth Support Specialist means an individual who is responsible for assessing mental health service and support needs of the individual's peers through community outreach, assisting individuals with access to available services and resources, addressing barriers to services and providing education and information about available resources and mental health issues in order to reduce stigmas and discrimination toward consumers of mental health services and to provide direct services to assist individuals in creating and maintaining recovery, health, and wellness.¶
(184) "Person Centered Care" means care that reflects the individual patient's strengths and preferences, reflects the clinical needs of the patient as identified through an individualized assessment, is based upon the patient's goals, and will assist the patient in achieving the goals.¶
(185) "Personal Health Navigator" means an individual who provides information, assistance, tools, and support to enable a patient to make the best health care decisions in the patient's particular circumstances and in light of the patient's needs, lifestyle, combination of conditions, and desired outcome.¶
(186) "Pharmaceutical Services" means services provided by a pharmacist, including medications dispensed in a pharmacy upon an order of a licensed practitioner prescribing within the scope of practice.¶
(187) "Pharmacist" means an individual licensed to practice pharmacy pursuant to state law.¶
(188) "Physical Capacity Evaluation" means an objective, directly observed measurement of a person's ability to perform a variety of physical tasks combined with subjective analysis of abilities of the individual.¶
(189) "Physical Therapist" means an individual licensed by the relevant state licensing authority to practice physical therapy.¶
(190) "Physical Therapy" means treatment comprising exercise, massage, heat or cold, air, light, water, electricity, or sound for the purpose of correcting or alleviating any physical or mental disability, or the performance of tests as an aid to the assessment, diagnosis, or treatment of a human being. Physical therapy may not include radiology or electrosurgery.¶
(191) "Physician" means an individual licensed to practice medicine pursuant to state law of the state in which ~~he or s~~they practice~~s~~ medicine or an individual licensed to practice medicine pursuant to federal law for the purpose of practicing medicine under a contract with the federal government. A physician may be an individual licensed under ORS 677 or ORS 685.¶
(192) "Physician Assistant" means an individual licensed as a physician assistant in accordance with ORS 677. Physician assistants provide medical services under the direction and supervision of an Oregon licensed physician according to a practice description approved by the Board of Medical Examiners.¶
(193) "Physician Services" means services provided within the scope of practice as defined under state law by or under the personal supervision of a physician.¶
(194) "Podiatric Services" means services provided within the scope of practice of podiatrists as defined under state law.¶
(195) "Podiatrist" means an individual licensed to practice podiatric medicine pursuant to state law.¶
(196) "Post-Payment Review" means review of billings or other medical information for accuracy, medical appropriateness, level of service, or for other reasons subsequent to payment of the claim.¶
(197) "Practitioner" means an individual licensed pursuant to state law to engage in the provision of health care services within the scope of the practitioner's license or certification.¶
(198) "Prepaid Health Plan (PHP)" means a managed health, dental, chemical dependency, or mental health organization that contracts with the Authority on a case managed, prepaid, capitated basis under OHP. PHPs may

be a Chemical Dependency Organization (CDO), Dental Care Organization (DCO), Mental Health Organization (MHO), or Physician Care Organization (PCO).¶
(199) "Primary Care Dentist (PCD)" means a dental practitioner responsible for supervising and coordinating initial and primary dental care within their scope of practice for their members.¶
(200) "Primary Care Provider (PCP)" means any enrolled medical assistance provider who has responsibility for supervising, coordinating, and providing initial and primary care within their scope of practice for identified clients. PCPs initiate referrals for care outside their scope of practice, consultations, and specialist care and assure the continuity of medically appropriate client care. A Federally qualified PCP means a physician with a specialty or subspecialty in family medicine, general internal medicine, or pediatric medicine as defined in OAR 410-130-0005.¶
(201) "Prior Authorization (PA)" means payment authorization for specified medical services or items given by Authority staff or its contracted agencies prior to provision of the service. A physician referral is not a PA.¶
(202) "Prioritized List of Health Services" means the listing of conditions and treatment pairs developed by the Health Evidence Review Commission for the purpose of administering OHP.¶
(203) "Private Duty Nursing Services" means nursing services provided within the scope of license by a registered nurse or a licensed practical nurse under the general direction of the patient's physician to an individual who is not in a health care facility.¶
(204) "Provider" means an individual, facility, institution, corporate entity, or other organization that supplies health services or items, also termed a rendering provider, or bills, obligates, and receives reimbursement on behalf of a rendering provider of services, also termed a billing provider (BP). The term provider refers to both rendering providers and BP unless otherwise specified.¶
(205) "Provider Organization" means a group practice, facility, or organization that is:¶
(a) An employer of a provider, if the provider is required as a condition of employment to turn over fees to the employer; or¶
(b) The facility in which the service is provided, if the provider has a contract under which the facility submits claims; or¶
(c) A foundation, plan, or similar organization operating an organized health care delivery system, if the provider has a contract under which the organization submits the claim; and¶
(d) Such group practice, facility, or organization is enrolled with the Authority, and payments are made to the group practice, facility, or organization;¶
(e) An agent if such entity solely submits billings on behalf of providers and payments are made to each provider. (See Subparts of Provider Organization.)¶
(206) "Psychiatric Emergency Services (PES)" means medical and behavioral health services provided to individuals experiencing an acute disturbance of thought, mood, behavior, or social relationship that requires an immediate intervention as defined by the patient, family, or the community to prevent harm to the patient or others.¶
(207) "Public Health Clinic" means a clinic operated by a county government.¶
(208) "Public Rates" means the charge for services and items that providers, including hospitals and nursing facilities, made to the general public for the same service on the same date as that provided to Authority clients.¶
(209) "Qualified Medicare Beneficiary (QMB)" means a Medicare beneficiary as defined by the Social Security Act and its amendments.¶
(210) "Qualified Medicare and Medicaid Beneficiary (QMM)" means a Medicare beneficiary who is also eligible for Division coverage.¶
(211) "Quality Improvement" means the efforts to improve the level of performance of a key process or processes in health services or health care.¶
(212) "Quality Improvement Organization (QIO)" means an entity that has a contract with CMS under Part B of Title XI to perform utilization and quality control review of the health care furnished, or to be furnished, to Medicare and Medicaid clients; formerly known as a Peer Review Organization.¶
(213) "Radiological Services" means those professional and technical radiological and other imaging services for the purpose of diagnosis and treatment ordered by a physician or other licensed practitioner of the healing arts within the scope of practice as defined under state law and provided to a patient by or under the direction of a physician or appropriate licensed practitioner in an office or similar facility, hospital, or independent radiological facility.¶
(214) "Recipient" means an individual who is currently eligible for medical assistance (also known as a client).¶
(215) "Recreational Therapy" means recreational or other activities that are diversional in nature (includes, but is not limited to, social or recreational activities or outlets).¶
(216) "Recoupment" means an accounts receivable system that collects money owed by the provider to the Authority by withholding all or a portion of a provider's future payments.¶
(217) "Referral" means the transfer of total or specified care of a client from one provider to another. As used by

the Authority, the term referral also includes a request for a consultation or evaluation or a request or approval of specific services. In the case of clients whose medical care is contracted through a Prepaid Health Plan (PHP), or managed by a Primary Care Physician, a referral is required before non-emergency care is covered by the PHP or the Authority.¶
(218) "Remittance Advice (RA)" means the automated notice a provider receives explaining payments or other claim actions. It is the only notice sent to providers regarding claim actions.¶
(219) "Rendering provider" means an individual, facility, institution, corporate entity, or other organization that supplies health services or items, also termed a provider, or bills, obligates, and receives reimbursement on behalf of a provider of services, also termed a ~~b~~Billing ~~p~~Provider (BP). The term rendering provider refers to both providers and BP unless otherwise specified.¶
(220) "Request for Hearing" means a clear expression in writing by an individual or representative that the individual wishes to appeal a Department or Authority decision or action and wishes to have the decision considered by a higher authority.¶
(221) "Representative" means an individual who can make OHP-related decisions for a client who is not able to make such decisions themselves.¶
(222) "Retroactive Medical Eligibility" means eligibility for medical assistance granted to a client retroactive to a date prior to the client's application for medical assistance.¶
(223) "Ride" means non-emergent medical transportation services for a client either to or from a location where covered services are provided. "Ride" does not include client-reimbursed medical transportation or emergency medical transportation in an ambulance.¶
(224) "Rural" means a geographic area that is ten or more map miles from a population center of 30,000 people or less.¶
(225) "Sanction" means an action against providers taken by the Authority in cases of fraud, misuse, or abuse of Division requirements.¶
(226) "School Based Health Service" means a health service required by an Individualized Education Plan (IEP) during a child's education program that addresses physical or mental disabilities as recommended by a physician or other licensed practitioner.¶
(227) "Self-Sufficiency" means the division in the Department of Human Services that administers programs for adults and families.¶
(228) "Service Agreement" means an agreement between the Authority and a specified provider to provide identified services for a specified rate. Service agreements may be limited to services required for the special needs of an identified client. Service agreements do not preclude the requirement for a provider to enroll as a provider.¶
(229) "Sliding Fee Schedule" means a fee schedule with varying rates established by a provider of health care to make services available to indigent and low-income individuals. The sliding-fee schedule is based on ability to pay.¶
(230) "Social Worker" means an individual licensed by the Board of Clinical Social Workers to practice clinical social work.¶
(231) "Speech-Language Pathologist" means an individual licensed by the Oregon Board of Examiners for Speech Pathology.¶
(232) "Speech-Language Pathology Services" means the application of principles, methods, and procedure for the measuring, evaluating, predicting, counseling, or instruction related to the development and disorders of speech, voice, or language for the purpose of preventing, habilitating, rehabilitating, or modifying such disorders in individuals or groups of individuals.¶
(233) "State Facility" means a hospital or training center operated by the State of Oregon that provides long-term medical or psychiatric care.¶
(234) "Subparts (of a Provider Organization)" means for NPI application, subparts of a health care provider organization would meet the definition of health care provider (45 CFR 160.103) if it were a separate legal entity and if it conducted HIPAA-covered transactions electronically or has an entity do so on its behalf and could be components of an organization or separate physical locations of an organization.¶
(235) "Subrogation" means right of the state to stand in place of the client in the collection of third party resources (TPR).¶
(236) "Substance Use Disorder (SUD) Services" means assessment, treatment, and rehabilitation on a regularly scheduled basis or in response to crisis for alcohol or other drug abuse for dependent members and their family members or significant others, consistent with Level I, Level II, or Level III of the most currently published edition of the American Society of Addiction Medicine Patient Placement Criteria (ASAM PPC). SUD is an interchangeable term with Chemical Dependency (CD), Alcohol and other Drug (AOD), and Alcohol and Drug (A & D).¶
(237) "Supplemental Security Income (SSI)" means a program available to certain aged and disabled persons that is

administered by the Social Security Administration through the Social Security office.¶
(238) "Surgical Assistant" means an individual performing required assistance in surgery as permitted by rules of the State Board of Medical Examiners.¶
(239) "Suspension" means a sanction prohibiting a provider's participation in the medical assistance programs by deactivation of the provider's Authority-assigned billing number for a specified period of time. No payments, Title XIX, or State Funds will be made for services provided during the suspension. The number shall be reactivated automatically after the suspension period has elapsed.¶
(240) "Targeted Case Management (TCM)" means activities that assist the client in a target group in gaining access to needed medical, social, educational, and other services. This includes locating, coordinating, and monitoring necessary and appropriate services. TCM services are often provided by allied agency providers.¶
(241) "Termination" means a sanction prohibiting a provider's participation in the Division's programs by canceling the provider's Authority-assigned billing number and agreement. No payments, Title XIX, or state funds will be made for services provided after the date of termination. Termination is permanent unless:¶
(a) The exceptions cited in 42 CFR 1001.221 are met; or¶
(b) Otherwise stated by the Authority at the time of termination.¶
(242) "Third Party Liability (TPL), Third Party Resource (TPR), or Third party payer" means a medical or financial resource that, under law, is available and applicable to pay for medical services and items for an Authority client.¶
(243) "Transportation" means medical transportation.¶
(244) "Service Authorization Request" means a member's initial or continuing request for the provision of a service including member requests made by their provider or the member's authorized representative.¶
(245) "Type A Hospital" means a hospital identified by the Office of Rural Health as a Type A hospital.¶
(246) "Type B AAA" means an AAA administered by a unit or combination of units of general purpose local government for overseeing Medicaid, financial and adult protective services, and regulatory programs for the elderly or the elderly and disabled.¶
(247) "Type B AAA Unit" means a Type B AAA funded by Oregon Project Independence (OPI), Title III-Older Americans Act, and Title XIX of the Social Security Act.¶
(248) "Type B Hospital" means a hospital identified by the Office of Rural Health as a Type B hospital.¶
(249) "Urban" means a geographic area that is less than ten map miles from a population center of 30,000 people or more.¶
(250) "Urgent Care Services" means health services that are medically appropriate and immediately required to prevent serious deterioration of a client's health that are a result of unforeseen illness or injury.¶
(251) "Usual Charge (UC)" means the lesser of the following unless prohibited from billing by federal statute or regulation:¶
(a) The provider's charge per unit of service for the majority of non-medical assistance users of the same service based on the preceding month's charges;¶
(b) The provider's lowest charge per unit of service on the same date that is advertised, quoted, or posted. The lesser of these applies regardless of the payment source or means of payment;¶
(c) Where the provider has established a written sliding fee scale based upon income for individuals and families with income equal to or less than 200 percent of the federal poverty level, the fees paid by these individuals and families are not considered in determining the usual charge. Any amounts charged to third party resources (TPR) are to be considered.¶
(252) "Utilization Review (UR)" means the process of reviewing, evaluating, and assuring appropriate use of medical resources and services. The review encompasses quality, quantity, and appropriateness of medical care to achieve the most effective and economic use of health care services.¶
(253) "Valid Claim" means an invoice received by the Division or the appropriate Authority or Department office for payment of covered health care services rendered to an eligible client that:¶
(a) Can be processed without obtaining additional information from the provider of the goods or services or from a TPR; and¶
(b) Has been received within the time limitations prescribed in these General Rules (OAR 410 division 120).¶
(254) "Valid Preauthorization" means a document the Authority, a PHP, or CCO receives requesting a health service for a member who would be eligible for the service at the time of the service, and the document contains:¶
(a) A beginning and ending date not exceeding twelve months, except for cases of PHP or CCO enrollment where four months may apply; and¶
(b) All data fields required for processing the request or payment of the service including the appropriate billing codes.¶
(255) "Vision Services" means provision of corrective eyewear, including ophthalmological or optometric examinations for determination of visual acuity and vision therapy and devices.¶
(256) "Volunteer" (for the purposes of NEMT) means an individual selected, trained and under the supervision of the Department who is providing services on behalf of the Department in a non-paid capacity except for incidental

expense reimbursement under the Department Volunteer Program authorized by ORS 409.360.
Statutory/Other Authority: ORS 413.042, 414.065
Statutes/Other Implemented: ~~ORS~~ 414.065

AMEND: 410-120-1210

RULE SUMMARY: The Authority is updating sections 0000,1210, and 1280 of division 120, to move the CWM program rules to its own division. The Authority is creating a new rule division in Chapter 410, division 134 to define CWM emergency and State funded wrap-around supplemental benefits for recipients. Division 141, revised to add Healthier Oregon Program (HOP) to MCE. Division 200, sections 0015 and 0240, revised to clarify definitions and eligibility criteria related to HOP. Division 125, section 0230, revised to address appropriate funding. Division 121 revised to include emergency medication for CWM.

CHANGES TO RULE:

410-120-1210
Medical Assistance Benefit Packages and Delivery System ¶

(1) The services clients are eligible to receive are based on their benefit package. Not all packages receive the same benefits.¶
(2) The Health Systems Division (Division), Medical Assistance Programs benefit package description, codes, eligibility criteria, coverage, limitations, and exclusions are identified in these rules.¶
(3) The limitations and exclusions listed here are in addition to those described in OAR 410-120-1200 and in any chapter 410 OARs.¶
(4) Benefit package descriptions:¶
(a) Oregon Health Plan (OHP) Plus:¶
(A) Benefit package identifier: BMH;¶
(B) Eligibility criteria: As defined in federal regulations and in the 1115 OHP waiver demonstration, a client is categorically eligible for medical assistance if the ~~or she is~~y are eligible under a federally defined mandatory, selected, optional Medicaid program or the Children's Health Insurance Program (CHIP) and also meets Oregon Health Authority (Authority) adopted income and other eligibility criteria;¶
(C) Coverage includes:¶
(i) Services above the funding line on the Health Evidence Review Commission (HERC) Prioritized List of Health Services (Prioritized List), (OAR 410-141-3820 through 410-141-3830);¶
(ii) Ancillary services, (OAR 410-141-3820);¶
(iii) Substance use disorder treatment and recovery services provided through local substance use disorder treatment and recovery providers;¶
(iv) Mental health services based on the Prioritized List to be provided by Board licensed, certified, or credentialed providers or through Community Mental Health Programs certified and credentialed providers;¶
(v) Hospice;¶
(vi) Post-hospital extended care benefit up to a 20-day stay in a nursing facility for non-Medicare Division clients who meet Medicare criteria for a post-hospital skilled nursing placement. This benefit requires prior authorization by pre-admission screening (OAR 411-070-0043) or by the Coordinated Care Organization (CCO) for clients enrolled in a CCO.¶
(D) Limitations: The following services have limited coverage for non-pregnant adults age 21 and older, who are outside of the protected postpartum eligibility period (see OAR 410-200-0135). (Refer to the cited OAR chapters and divisions for details):¶
(i) Selected dental (OAR chapter 410, division 123 and 200);¶
(ii) Vision services such as frames, lenses, contacts corrective devices and eye exams for the purpose of prescribing glasses or contacts (OAR chapter 410, division 140 and 200).¶
(b) OHP with Limited Drugs:¶
(A) Benefit package identifier: BMM, BMD;¶
(B) Eligibility criteria: Eligible clients are eligible for Medicare and Medicaid benefits;¶
(C) Coverage includes: Services covered by Medicare and OHP Plus as described in this rule;¶
(D) Limitations:¶
(i) The same as OHP Plus as described in this rule;¶
(ii) Drugs excluded from Medicare Part D coverage that are also covered under the medical assistance programs, subject to applicable limitations for covered prescription drugs (Refer to OAR chapter 410, division 121 for specific limitations). These drugs include but are not limited to:¶
(I) Over-the-counter (OTC) drugs;¶
(II) Barbiturates (except for dual eligible individuals when used in the treatment of epilepsy, cancer or a chronic mental health disorder as Part D will cover those indications).¶

(E) Exclusions: Drugs or classes of drugs covered by Medicare Part D Prescription Drug;¶
(F) Payment for services is limited to the Medicaid-allowed payment less the Medicare payment up to the amount of co-insurance and deductible;¶
(G) Cost sharing related to Medicare Part D is not covered since drugs covered by Part D are excluded from the benefit package.¶
(c) Qualified Medicare Beneficiary (QMB)-Only:¶
(A) Benefit Package identifier code MED;¶
(B) Eligibility criteria: Eligible clients are Medicare Part A and B beneficiaries who have limited income but do not meet the income standard for full medical assistance coverage;¶
(C) Coverage: Is limited to the co-insurance or deductible for the Medicare service. Payment is based on the Medicaid-allowed payment less the Medicare payment up to the amount of co-insurance and deductible but no more than the Medicare allowable;¶
(D) Providers may not bill QMB-only clients for the deductible and coinsurance amounts due for services that are covered by Medicare;¶
(E) Medicare is the source of benefit coverage for service; therefore, an OHP 3165 is not required for this eligibility group. A Medicare Advance Beneficiary Notice of Noncoverage (ABN) may be required by Medicare, refer to Medicare for ABN requirements.¶
(d) Citizen~~/Alien-Waived Emergency Medical (CAWEM):¶~~
~~(A) Benefit Package identifier CWM;¶~~
~~(B) Eligibility criteria: Eligible clients are non-qualified aliens that are 19 years and older, not eligible for other Medicaid programs solely because they do not meet the citizen and immigration status requirement pursuant to Oregon Administrative Rules (OAR) 410-200-0215;¶~~
~~(C) Coverage is limited to:¶~~
~~(i) Emergency medical services as defined by 42 CFR 440.255: Sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in: placing the patient's health in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part (the "prudent layperson standard" does not apply to the CAWEM emergency definition);¶~~
~~(I) The Authority determines if the primary condition requiring treatment meets the definition of an emergency medical condition in 42 CFR 440.255, and the condition is confirmed through review of clinical records;¶~~
~~(II) The Authority pays for all related medically necessary health care services and professional services provided. These services include, but are not limited to such things as Anesthesia, surgical, and recovery services; Emergency medical transportation; Laboratory, x-ray, and other diagnostics and the professional interpretations; Medical equipment and supplies; Medications.¶~~
~~(ii) Labor and Delivery.¶~~
~~(iii) Emergency Dialysis to treat acute renal failure or end stage renal disease is considered an emergency and is covered under CAWEM emergency assistance, when received through a hospital emergency department or Hospital facility, which includes fistula placement and other required access. OHA does not pay for diagnostics or predialysis intervention, such as surgery for fistula placement anticipating the need for dialysis, or any services related to preparing for dialysis under CAWEM emergency assistance.¶~~
~~(D) Exclusions: The following services are not covered even if they are sought as emergency services:¶~~
~~(i) Prenatal or postpartum care;¶~~
~~(ii) Sterilization;¶~~
~~(iii) Family Planning;¶~~
~~(iv) Preventive care;¶~~
~~(v) Organ transplants and transplant-related services, including pre-evaluations and post-operative care;¶~~
~~(vi) Chemotherapy;¶~~
~~(vii) Hospice;¶~~
~~(viii) Home health;¶~~
~~(ix) Private duty nursing;¶~~
~~(x) Eyeglasses and exams;¶~~
~~(xi) Dental services provided outside of an emergency department hospital setting;¶~~
~~(xii) Outpatient drugs or over-the-counter products, except when prescribed on the same day and associated with the qualifying emergency service;¶~~
~~(xiii) Non-emergency medical transportation;¶~~
~~(xiv) Therapy services;¶~~
~~(xv) Durable medical equipment and medical supplies;¶~~
~~(xvi) Rehabilitation services.¶~~
~~(e) CAWEM Reproductive Health Equity Fund (RHEF) benefit:¶~~

~~(A) Benefit Package identifier CWM; ¶~~
~~(B) Eligibility criteria: Eligible clients are those individuals eligible under the CAWEM benefit in subsection (d) of these rules; ¶~~
~~(C) Coverage: This is a state-funded women's reproductive health benefit administered by the Public Health Division. For full coverage and criteria, refer to OAR chapter 333, division 004. The Health Systems Division administers a subset of the benefits described in OAR chapter 333, division 004 as follows: ¶~~
~~(i) Abortion services occurring in a hospital;¶~~
~~(ii) Sterilization.¶~~
~~(f) CAWEM Plus:¶~~
~~(A) Benefit Package identifier code CWX;¶~~
~~(B) Eligibility criteria: As defined in federal regulations and in the Children's Health Insurance Program (CHIP) state plan, eligible clients are non-qualified aliens that are pregnant women, 19 years and older, at or below 185 percent of the Federal Poverty Level (FPL), and not eligible for other Medicaid programs solely because they do not meet the citizen and immigration status requirement, pursuant to Oregon Administrative Rules (OAR) 410-200-0215; ¶~~
~~(C) Coverage includes: services covered by OHP Plus as described above;¶~~
~~(D) Exclusions: The following services are not covered for this program:¶~~
~~(i) Postpartum care (except when provided and billed as part of a global obstetric package code that includes the delivery procedure);¶~~
~~(ii) Sterilization;¶~~
~~(iii) Abortion;¶~~
~~(iv) Death with dignity services;¶~~
~~(v) Hospice.¶~~
~~(E) The day after pregnancy ends, eligibility for medical services shall be based on eligibility categories established in OAR chapters 461 and 410.¶~~
~~(g) CAWEM Plus RHEF benefit:¶~~
~~(A) Benefit Package identifier code CWX; ¶~~
~~(B) Eligibility criteria: Eligible clients are CAWEM pregnant women not eligible for Medicaid based on immigration status, at or below 185 percent of the Federal Poverty Level (FPL). These Qualified aliens eligible for the CAWEM Plus prenatal program are also eligible for a state-funded benefit pursuant to ORS 414.432; ¶~~
~~(C) Coverage includes:¶~~
~~(i) Postpartum care delivered outside of the global obstetric package not included under the CAWEM Plus benefit, 60 days following the pregnancy end date. Postpartum eligibility period is as described in OAR 410-200-0240; ¶~~
~~(ii) Services covered by OHP Plus for 60 days following the pregnancy end date as described in (4)(a)(C) of these rules;¶~~
~~(iii) Services as described in subsection (e)(C) of these rules.¶~~
~~(h) Cover All Kids benefit:¶~~
~~(A) Benefit Package identifier code BMH, PERC CK, CL, CM, CN, CO, CP, CR;¶~~
~~(B) Eligibility criteria: Eligible clients are non-qualified aliens that are under age 19, not eligible for other Medicaid programs solely because they do not meet the citizen and immigration status requirement pursuant to Oregon Administrative Rules (OAR) 410-200-0215. Coverage is a state funded medical benefit pursuit to ORS 414.231;¶~~
~~(C) Coverage is an OHP Plus equivalent benefit that includes:¶~~
~~(i) Services above the funding line on the Health Evidence Review Commission (HERC) Prioritized List of Health Services (Prioritized List), (OAR 410-141-3820 through 410-141-3830);¶~~
~~(ii) Ancillary services, (OAR 410-141-3820);¶~~
~~(iii) Substance use disorder treatment and recovery services provided through local substance use disorder treatment and recovery providers;¶~~
~~(iv) Mental health services based on the Prioritized List to be provided by Board licensed, certified, or credentialed providers or through Community Mental Health Programs certified and credentialed providers;¶~~
~~(v) Hospice;¶~~
~~(vi) Post-hospital extended care benefit, up to a 20-day stay in a nursing facility for non-Medicare Division clients who meet Medicare criteria for a post-hospital skilled nursing placement. This benefit requires prior authorization by pre-admission screening (OAR 411-070-0043), or by the Coordinated Care Organization for clients enrolled in a CCO~~ship Waived Medical (CWM): Benefit package and supplemental benefits, refer to OAR 410-134-0003.¶
(5) Division clients are enrolled for covered health services to be delivered through one of the following means:¶
(a) Coordinated Care Organization (CCO):¶
(A) These clients are enrolled in a CCO that provides integrated and coordinated health care;¶
(B) CCO services are obtained from the CCO or by referral from the CCO that is responsible for the provision and reimbursement for physical health, substance use disorder treatment and recovery, mental health services or

dental care.¶
(b) Fee-for-service (FFS):¶
(A) These clients are not enrolled in a CCO;¶
(B) Subject to limitations and restrictions in the Division's individual program rules, the client can receive health care from any Division-enrolled provider that accepts FFS clients. The provider shall bill the Division directly for any covered service and shall receive a fee for the service provided.
Statutory/Other Authority: ORS 413.042
Statutes/Other Implemented: ORS 413.042, ORS 414.025, 414.065, 414.329, 414.706, 414.710, 414.~~2~~432, 414.312, 414.43~~2~~0, 414.690

AMEND: 410-120-1280

RULE SUMMARY: The Authority is updating sections 0000,1210, and 1280 of division 120, to move the CWM program rules to its own division. The Authority is creating a new rule division in Chapter 410, division 134 to define CWM emergency and State funded wrap-around supplemental benefits for recipients. Division 141, revised to add Healthier Oregon Program (HOP) to MCE. Division 200, sections 0015 and 0240, revised to clarify definitions and eligibility criteria related to HOP. Division 125, section 0230, revised to address appropriate funding. Division 121 revised to include emergency medication for CWM.

CHANGES TO RULE:

410-120-1280
Billing ¶

(1) A provider enrolled with the Authority or providing services to a client in an MCE under the Oregon Health Plan (OHP) may not seek payment from the client for any services covered by Medicaid fee-for-service or through contracted health care plans, except as authorized by the Authority under this rule:. ¶
(2) Identification of eligibility and third-party liability:. The provider shall:¶
(a) Verify the client's eligibility for medical assistance and benefit package prior to rendering service pursuant to OAR 410-120-1140;¶
(b) Make "reasonable efforts" to identify third-party resources as described in section (10)(b) of this rule; and¶
(c) Ask the client at the point of service and verify prior to billing if the client has medical assistance, is applying for medical assistance, enrolled with an MCE or has other third-party liability.¶
(3) If a provider's patient is a medical assistance recipient, the provider must:¶
(a) Comply with the provisions in sections (10) through (12) of this rule regarding third-party resources;¶
(b) Submit a claim to the Authority or MCE, if no third-party resources are available or the provider has complied with section (2)(a) of this rule;-¶
(c) Delay any billing or collection action against the patient for 90 calendar days from submitting the claim to the Authority or MCE, except as authorized in section (4) of this rule;¶
(d) If no payment is received from the Authority or MCE within 90 calendar days from the date the claim was submitted:-¶
(A) Verify the patient's eligibility for the date of service;¶
(B) If the patient was not eligible for medical assistance on the date of service, proceed with the provider's normal billing and collection process; or¶
(C) If the patient was eligible for medical assistance on the date of service, and the provider does not have a completed agreement to pay form (3165, 3166, 4109), the provider is not allowed to bill the client, collect payment from the client, or assign an unpaid claim to a collection agency or similar entity pursuant to ORS 414.066, except as authorized by section (5) of this rule.¶
(4) For Medicaid covered services, the provider must not:¶
(a) Bill the Authority more than the provider's usual charge (see definitions) or the reimbursement specified in the applicable Authority program rules;¶
(b) Bill the client for missed appointments. A missed appointment is not considered to be a distinct Medicaid service by the federal government and as such is not billable to the client or the Authority;-¶
(c) Bill the client for services or treatments that have been denied due to provider error, except as authorized under section (5) of these rules. Examples of provider error could be things such as required documentation not submitted for a prior authorization, or a prior authorization not submitted.-¶
(5) Providers may only bill a client or a financially responsible relative or representative of that client in the following situations: ¶
(a) The client did not inform the provider of their Oregon Health plan I.D., MCE I.D. card, or third-party insurance card, or gave a name that did not match OHP I.D. at the time of or after a service was provided; and therefore, the provider could not bill the appropriate payer for reasons including but not limited to the lack of prior authorization, or because the time limit to submit the claim for payment has passed. The provider shall verify eligibility at the time of service pursuant to OAR 410-120-1140 and prior to billing or collection pursuant to OAR 410-120-1280, and document attempts to obtain coverage information prior to billing the client;-¶
(b) The client became eligible for benefits retroactively but did not meet all of the other criteria required to receive the service;-¶
(c) A third-party payer made payments directly to the client for services provided;-¶
(d) The client has the limited Citizen-Alienship Waived Emergency Medical benefit package (CAWEWM).

C~~AWE~~WM clients have the benefit package identifier of CWM. Clients receiving C~~AWE~~WM benefits may be billed for services that are scheduled or routine care and not part of the C~~AWE~~WM emergency only benefits. See OAR 410-1~~20-1210~~34-0003 for coverage. The provider shall document that the client was informed in advance that the service or item would not be covered by the Division. An OHP 3165 is ~~not~~ required, ~~but is recommended for these~~for pre-scheduled, routine, non-urgent/emergent services;~~¶~~
(e) The client has requested a continuation of benefits during the contested case hearing process, and the final decision was not in favor of the client. The client shall pay for any charges incurred for the denied service on or after the effective date on the Notice of Action or Notice of Appeal Resolution. The provider must complete the OHP 3165 pursuant to section (5)(h) of this rule before providing these services;¶
(f) The client has requested to privately pay for services denied as not meeting the prior authorization, HERC or other criteria. Refer to non-covered services in this rule section (5)(h);¶
(g) The client has requested to privately pay for a covered service. In this situation, the provider may bill the client if the provider informs the client in advance of all of the following:~~¶~~
(A) The requested service is a covered service, and the appropriate payer (the Authority, MCE, or third-party payer) would pay the provider in full for the covered service; and~~¶~~
(B) The estimated cost of the covered service, including all related charges, the amount that the appropriate payer (Authority or MCE) would pay for the service, and that the provider cannot bill the client for an amount greater than the amount the appropriate payer would pay;~~ and ¶~~
(C) That the client knowingly and voluntarily agrees to pay for the covered service;~~¶~~
(D) The provider documents in writing, signed by the client or the client's representative, indicating that~~t~~;¶
(i) The provider gave the client the information described in section (5)(g)(A-C)~~; that t~~ of this rule;¶
(ii) The client had an opportunity to ask questions, obtain additional information, and consult with the client's caseworker or client representative; and~~ that t~~¶
(iii) The client agreed to privately pay for the service by signing an agreement incorporating all of the information described above.¶
(E) The provider must give a copy of the signed agreement to the client. A provider may not submit a claim for payment for covered services to the Authority or to the client's MCE or third-party payer that is subject to the agreement.~~¶~~
(h) Non-covered services by the Authority, or MCE (non-covered services include services denied under prior authorization. Refer to OAR 410-120-0000 for a definition of non-covered services). Before providing the non-covered service, the client must sign the provider-completed Agreement to Pay (OHP 3165~~ or 3166~~, 3166, or 4109) or a facsimile containing all of the information and elements of the 3165 or 3166 as shown in Table 3165~~ and~~, 3166, or 4109 of this rule. The completed OHP 3165, 3166, 4109 or facsimile is valid only if the estimated fee does not change and the service is scheduled within 30 days of the client's signature. For some long-term services, such as labor and delivery, a single form can span the duration of the pregnancy. Providers must make a copy of the completed OHP 3165, 3166 or 4109 form or facsimile available to the Authority or MCE upon request.¶
(6) Code set requirements:~~¶~~
(a) Federal Code Set requirements (45 CFR 162) apply to all Medicaid Code Set requirements, including the use of diagnostic or procedure codes for prior authorization, claims submissions, and payments. Code Set has the meaning set forth in 45 CFR 162.103, and it includes the codes and the descriptors of the codes. Federal Code Set requirements are mandatory, and the Authority lacks any authority to delay or alter their application or effective dates as established by the U.S. Department of Health and Human Services;~~¶~~
(b) The Authority shall adhere to the Code Set requirements in 45 CFR 162.1000-162.1011;~~¶~~
(c) Periodically, the Authority shall update its provider rules and tables to conform to national codes. In the event of an alleged variation between an Authority-listed code and a national code, the Authority shall apply the national code in effect on the date of request or date of service;~~¶~~
(d) Only codes with limitations or requiring prior authorization are noted in ~~rules~~OAR. National Code Set issuance alone may not be construed as coverage or a covered service by the Authority;~~¶~~
(e) The Authority adopts by reference the National Code Set revisions, deletions, and additions issued and published by the American Medical Association (Current Procedural Terminology - CPT) and on the CMS website (Healthcare Common Procedural Coding System - HCPCS). This code adoption may not be construed as coverage or as a covered service by the Authority.~~¶~~
(7) Claims:~~¶~~
(a) Upon submission of a claim to the Authority for payment, the provider agrees that it has complied with all Division program rules. Submission of a claim, however, does not relieve the provider from the requirement of a signed provider agreement;~~¶~~
(b) A provider enrolled with the Division shall bill using the Authority assigned provider number, or the National Provider Identification (NPI) number if the NPI is available, pursuant to OAR 410-120-1260;~~¶~~
(c) The provider may not bill the Division more than the provider's usual charge (see Definitions) or the

reimbursement specified in the applicable Division program rules;-¶
(d) Claims shall be submitted on the appropriate form as described in the individual Division program rules or electronically in a manner authorized in OAR Chapter 943, Division 120;-¶
(e) Medicare will send crossover claims to the Authority or contracted health plan after adjudication by Medicare. When billing Medicare as the primary payer, claims for all Medicaid/Medicare members shall include all applicable payer information (with Medicare as primary and Medicaid as secondary) so that Medicare can automatically transmit the correct Medicare payment, coinsurance, and deductible information to the Authority or MCE;¶
(f) Claims must be for services provided within the provider's licensure or certification;-¶
(g) Unless otherwise specified, claims shall be submitted after:-¶
(A) Delivery of service; or-¶
(B) Dispensing, shipment or mailing of the item.-¶
(h) The provider shall submit true and accurate information when billing the Division. Use of a billing provider does not do away with the performing provider's responsibility for the truth and accuracy of submitted information;-¶
(i) A claim is considered a valid claim only if it contains all data required for processing. See the appropriate provider rules and supplemental information for specific instructions and requirements;-¶
(j) A provider or its contracted agency, including billing providers, may not submit or cause to be submitted:-¶
(A) Any false claim for payment;-¶
(B) Any claim altered in such a way as to result in a payment for a service that has already been paid;-¶
(C) Any claim upon which payment has been made or is expected to be made by another source until after the other source has been billed with the exception of (10)(c)(A-D) of this rule. If the other source denies the claim or pays less than the Medicaid allowable amount, a claim may be submitted to the Division. Any amount paid by the other source must be clearly entered on the claim form and must include the appropriate TPL Explanation Code;-¶
(D) Any claim for furnishing specific care, items, or services that has not been provided.-¶
(k) If an overpayment has been made by the Authority, the provider is required to do one of the following:-¶
(A) Adjust the original claim to show the overpayment as a credit in the appropriate field:¶
(i) Submit an Individual Adjustment Request (OHP 1036); or¶
(ii) Adjust the claim on the Provider Web Portal at https://www.or-medicaid.gov;¶
(B) Refund the amount of the overpayment on any claim;-¶
(C) Void the claim via the Provider Web Portal if the Division overpaid due to an erroneous billing;-¶
(D) If the overpayment occurred because of a payment from a third-party payer refer to section (10)(f) of this rule.¶
(L) A provider who, after having been previously warned in writing by the Division or the Department of Justice about improper billing practices, is found to have continued improper billing practices and has had an opportunity for a contested case hearing shall be liable to the Division for up to triple the amount of the Division established overpayment received as a result of the violation.-¶
(8) Diagnosis code requirement:-¶
(a) A primary diagnosis code is required on all claims, using the ICD-10-CM diagnosis code set, unless specifically excluded in individual Division program rules;-¶
(b) The primary diagnosis code must be the code that most accurately describes the client's condition;-¶
(c) All diagnosis codes are required to the highest degree of specificity;-¶
(d) Hospitals shall follow national coding guidelines and bill using the seventh digit where applicable in accordance with methodology used in the Medicare Diagnosis Related Groups.-¶
(9) Procedure code requirement:-¶
(a) For claims requiring a procedure code the provider shall bill as instructed in the appropriate Division program rules and shall use the appropriate HIPAA procedure code set such as CPT, HCPCS, ICD-10-PCS, ADA CDT, NDC, established according to 45 CFR 162.1000 to 162.1011, which best describes the specific service or item provided;-¶
(b) For claims that require the listing of a procedure code as a condition of payment, the code listed on the claim must be the code that most accurately describes the services provided. Hospitals shall follow national coding guidelines;-¶
(c) When there is no appropriate descriptive procedure code to bill the Division, the provider shall use the code for "unlisted services." Instructions on the specific use of unlisted services are contained in the individual provider rules. A complete and accurate description of the specific care, item, or service must be documented on the claim;-¶
(d) Where there is one CPT, CDT, or HCPCS code that according to CPT, CDT, and HCPCS coding guidelines or standards describes an array of services, the provider shall bill the Division using that code rather than itemizing the services under multiple codes. Providers may not "unbundle" services in order to increase the payment.-¶
(10) Third-Party Liability (TPL):-¶
(a) Federal law requires that state Medicaid agencies take all reasonable measures to ensure that in most

instances the Division shall be the payer of last resort;-¶
(b) Providers shall make reasonable efforts to obtain payment first from other resources. For the purposes of this rule, "reasonable efforts" include determining the existence of insurance or other resources on each date of service by:-¶
(A) Using an insurance database such as Electronic Verification System (EVS) available to the provider;-¶
(B) Using the Automated Voice Response (AVR) or secure provider web portal on each date of service and at the time of billing;¶
(C) Asking the Medicaid recipient at the point of service or prior to billing if they have other health insurance;-¶
(D) If the provider identifies from the client or other source third-party insurance that is unknown to the state or that is different from what is reported in one of the Division verification systems, the provider shall report the coverage to the Health Insurance Group (HIG) using the secure online form at www.reporttpl.org.¶
(c) Except as noted in section (10)(d)(A)-(E) of this rule, when third-party coverage is known to the provider prior to billing the Division, the provider shall:-¶
(A) Bill all third-party insurance the client is covered by, which could include Personal Insurance Protection (PIP) or Workers Compensation if the claim is related to a personal injury; and-¶
(B) Except for pharmacy claims billed through the Division's point-of-sale system, the provider shall wait 30 days from submission date of a clean claim and have not received payment from the third party; and-¶
(C) Comply with the insurer's billing and authorization requirements; and-¶
(D) Appeal a denied claim when the service is payable in whole or in part by an insurer.-¶
(d) In accordance with federal regulations, the provider shall bill the TPL prior to billing the Division, except under the following circumstances:-¶
(A) The covered health service is provided by an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/ID);-¶
(B) The covered health service is provided by institutional services for the mentally and emotionally disturbed;-¶
(C) The covered health services are prenatal and preventive pediatric services;-¶
(D) Services are covered by a third-party insurer through an absent parent where the medical coverage is administratively or court ordered;-¶
(E) When a negligent third party caused an injury or illness to a client, a provider may choose to bill the Liability Insurance (see Definitions), bill the liable third party, place a lien on a tort settlement or judgement, or bill the Division. The provider may not both place a lien against a settlement and bill the Division:¶
(i) The provider may withdraw their lien and bill the Division within 12 months of the date of service; however, the provider shall accept the Division payment as payment in full;¶
(ii) The provider may not return the payment made by the Division in order to place a lien or to accept payment from a liability settlement, judgement, liability insurer, or other source.-¶
(F) In the circumstances outlined in section (10)(d)(A)-(E) of this rule, the provider may choose to bill the primary insurance prior to billing the Division. Otherwise, the Division shall process the claim and, if applicable, pay the Division's allowable rate for these services and seek reimbursement from the liable third-party insurance plan;-¶
(G) In making the decision to bill the Division, the provider shall be cognizant of the possibility that the third-party payer may reimburse the service at a higher rate than the Division and that once the Division makes payment, no additional billing to the third party is permitted by the provider.-¶
(e) The provider may bill the Division directly for services that are never covered by Medicare or another insurer on the appropriate form identified in the relevant provider rules. Documentation shall be on file in the provider's records indicating this is a non-covered service for purposes of Third-Party Resources. See the individual provider rules for further information on services that shall be billed to Medicare first;-¶
(f) In the case of known third-party coverage, a provider may bill the Division if payment from the third-party coverage is not received within 30 days. If a payment is received from the third-party coverage after receiving the Division payment, the provider shall do the following within 30 days of receiving the payment:¶
(A) Submit an Individual Adjustment Request (OHP 1036) that shows the amount of the third-party payment as a credit in the appropriate field; or¶
(B) Submit a claim adjustment online at https://www.or-medicaid.gov/ProdPortal/ that shows the amount of the third-party payment as a credit in the appropriate field; or¶
(C) Refund the amount paid by the Division. The amount refunded shall be the lesser of the third-party payment or the amount paid by the Division. The check to repay the Division shall include the reason the payment is being made and either:¶
(i) An Individual Adjustment Request that identifies the original claim, name and number of the client, date of service, and items or services for which the repayment is made; or¶
(ii) A copy of the Remittance Advice showing the original Division payment.¶
(D) Failure to submit the Individual Adjustment Requests within 30 days of receipt of the third-party payment or to refund the Division payment is considered concealment of material facts and is grounds for recovery and

sanction.;¶
(E) Any provider who accepts payment from a client or client's representative and is subsequently paid for the service by the Division shall reimburse the client or their representative the full amount of their payment.¶
(g) If the third-party coverage is not known by the Division or the provider at the time the Division makes payment, a provider may not return the Division payment in order to bill the third-party coverage if the third-party coverage becomes known after the Division payment;¶
(h) The Division may make a claim against any third-party payer after making payment to the provider of service. The Division may pursue alternate resources following payment if it deems this a more efficient approach. Pursuing alternate resources includes but is not limited to requesting the provider to bill the third party and to refund the Division in accordance with this rule;¶
(i) For services provided to a Medicare and Medicaid dual eligible client, the Division may request the provider to submit a claim for Medicare payment, except as noted in OAR 410-141-3565, and the provider shall honor that request. Claims submitted to Medicare shall include the Medicaid information necessary to enable electronic crossover to the Authority or contracted health plan. Under federal regulation, a provider may not charge a beneficiary (or the state as the beneficiary's subrogee) for services for which a provider failed to file a timely claim (42 CFR 424) with Medicare despite being requested to do so;¶
(j) If Medicare is the primary payer and Medicare denies payment, Medicare appeals shall be timely pursued, and Medicare denial must be obtained prior to submitting the claim for payment to the Division. Medicare denial on the basis of failure to submit a timely appeal may result in the Division reducing from the amount of the claim any amount the Division determines could have been paid by Medicare.¶
(11) Full use of alternate resources:¶
(a) The Division shall generally make payment only when other resources are not available for the client's medical needs. Full use must be made of reasonable alternate resources in the local community;¶
(b) Except as provided in section (12) of this rule, alternate resources may be available:¶
(A) Under a federal or state worker's compensation law or plan;¶
(B) For items or services furnished by reason of membership in a prepayment plan;¶
(C) For items or services provided or paid for directly or indirectly by a health insurance plan or as health benefits of a governmental entity such as:¶
(i) Armed Forces Retirees and Dependents Act (CHAMPVA);¶
(ii) Armed Forces Active Duty and Dependents Military Medical Benefits Act (CHAMPUS); or¶
(iii) Medicare Parts A and B.¶
(D) To residents of another state under that state's Title XIX or state funded medical assistance programs; or¶
(E) Through other reasonably available resources.¶
(12) Exceptions:¶
(a) Indian Health Services or Tribal Health Facilities. Pursuant to 42 CFR 136.61 subpart G and the Memorandum of Agreement in OAR 410-146-0020, Indian Health Services facilities and Tribal facilities operating under Public Law 93, Section 638 agreement are payers of last resort and are not considered an alternate resource or TPL;¶
(b) Veterans Administration. Veterans who are also eligible for Medicaid benefits are encouraged to utilize Veterans' Administration facilities whenever possible. Veterans' benefits are prioritized for service-related conditions and as such are not considered an alternate or TPL.¶
(13) Table 120-1280 - TPR codes.¶
(14) Table - OHP Client Agreement to Pay for Health Services, OHP 3165 and, 3166 or 4109.
Statutory/Other Authority: ORS 413.042
Statutes/Other Implemented: ORS 414.025, 414.065, 414.066

RULE ATTACHMENTS DO NOT SHOW CHANGES. PLEASE CONTACT AGENCY REGARDING CHANGES.

Table 120-1280 – Third Party Resource (TPR) Explanation Codes

Use in Field "9" on the CMS-1500

Single Insurance Coverage Use when the client has only one insurance policy in addition to DMAP coverage.	
UD	Service Under Deductible
NC	Service Not Covered by Insurance Policy
PN	Patient Not Covered by Insurance Policy
IC	Insurance Coverage Cancelled/Terminated
IL	Insurance Lapsed or Not in Effect on Date of Service
IP	Insurance Payment Went to Policyholder
PP	Insurance Payment Went to Patient
NA	Service Not Authorized or Prior Authorized by Insurance
NE	Service Not Considered Emergency by Insurance
NP	Service Not Provided by Primary Care Provider/Facility
MB	Maximum Benefits Used for Diagnosis/Condition
RI	Requested Information Not Received by Insurance from Client
RP	Requested Information Not Received by Insurance from Policy holder
MV	Motor Vehicle Accident Fund Maximum Benefits Exhausted
AP	Insurance mandated under administrative/court order through an absent parent not paid within 30 days
OT	Other (if above codes do not apply, include detailed information of why no TPR payment was made)
Multiple Insurance Coverage Use when the client has more than one insurance policy in addition to DMAP coverage.	
MP	Primary Insurance Paid-Secondary Paid
SU	Primary Insurance Paid - Secondary Under Deductible
MU	Primary and Secondary Under Deductible
PU	Primary Insurance Under Deductible - Secondary Paid
SS	Primary Insurance Paid - Secondary Service Not Covered
SC	Primary Insurance Paid - Secondary Patient Not Covered
ST	Primary Insurance Paid - Secondary Insurance Cancelled/Terminated
SL	Primary Paid - Secondary Lapsed or Not in Effect
SP	Primary Paid - Secondary Payment Went to Patient
SH	Primary Paid - Secondary Payment Went to Policyholder
SA	Primary Paid - Secondary Denied - Service Not Authorized or Prior Authorized
SE	Primary Paid - Secondary Denied - Service Not Considered Emergency
SF	Primary Paid - Secondary Denied - Service Not Provided by Primary Care Provider/Facility
SM	Primary Paid - Secondary Denied - Maximum Benefits Used for Diagnosis/Condition
SI	Primary Paid - Secondary Denied - Requested Information Not Received from Policyholder
SR	Primary Paid - Secondary Denied - Requested Information Not Received from Patient
MC	Service Not Covered by Primary or Secondary Insurance
MO	Other (if above codes do not apply, include detailed information of why no TPR payment was made)

OHP Client Agreement to Pay for Health Services

This is an agreement between a *Client* and a *Provider*, as defined in OAR 410-120-0000. The client agrees to pay for service(s) not covered by the Oregon Health Plan (OHP), the Oregon Health Authority (OHA) or OHA-contracted managed care entities (MCEs).

Provider section

① Provider completing this form is *(check one):*

☐ Rendering provider *(the person providing the service)* ☐ Prescribing provider

☐ Hospital ☐ Pharmacy ☐ Ancillary *(other)* provider:

② Services requested. These include, but are not limited to, treatment, equipment, supplies and medications.

Service codes *(CDT/CPT/HCPCS/NDC)*:

③ Expected date(s) of service *(if services will occur over several months, please say how often, with start and end dates):*

④ Condition being treated:

⑤ Estimated fees $ To $. *Check one of the following statements about these fees:*

☐ There are no other costs that are part of the service(s).

☐ There may be other costs. You may have to pay for them, too. Other costs may be for (*check all that apply):*

☐ Lab ☐ X-ray ☐ Hospital ☐ Anesthesia ☐ Other:

⑥ ☐ As the rendering or prescribing provider:

- I tried all reasonable covered treatments for your condition.
- I confirmed that the proposed service(s) are not covered for your condition.
- I informed you of covered treatments for your condition, and you chose a treatment that is not covered.

☐ As any other provider *(check one of the following statements):*

☐ I understand that your provider has talked with you about other choices and completed a separate *Agreement to Pay* form.

☐ Please see your provider to ask about other choices and to complete a separate *Agreement to Pay* form.

Provider name: NPI:

Provider signature: Date:

OHP client section

⑦ Client name: DOB: Client ID#:

⑧ I understand the following, and still choose to get the service(s) listed above:

- The services listed above are not covered for payment by OHP or my plan.
- If I get the services I agree to pay the costs. After having the services, I will get bills for them that I must pay.
- My other options, which are written on the back of this form and were explained by my provider.
- The medically appropriate treatment I can have, including services that OHA or my MCE may pay for.

Client (or representative's) signature – *Representative must have proof of legal authority to sign for this client* Date

If signed by the client's representative, print their name here:

⑨ Witness signature: Date:

Witness name:

This agreement is valid only if the estimated fees listed above do not change and the services are scheduled within 30 days of the member's signature.

Client – Keep a copy of this form for your records.

Attention OHP Client – Read this information carefully before you sign.

Before you sign you should be sure each service is not covered by OHP or your coordinated care organization (CCO) or managed care plan. Here are some things you can do:

① ***Check to make sure the service is not covered***

OHA, your CCO or plan will send you a Notice of Action if they do not cover a service that your provider requests. If you did not receive a Notice of Action, ask your CCO, plan or provider to send you one so you can be sure the service is not covered by OHP.

② ***Request an Appeal and or Hearing***

Once you have a Notice of Action, you can request an Appeal or Hearing. Read the Notice of Action carefully. It will explain why the service was denied. It will also give you information about your right to appeal the denial or ask for a hearing.

If you also have Medicare, you may have other Appeal rights. If you have both OHP and Medicare, call 800-Medicare (800-633-4227) or TTY 711.

③ ***Check to see if there are other ways to get the service***

Ask your provider if:

- They have tried all other covered options available for treating your condition.
- There is a hospital, medical school, service organization, free clinic or county health department that might provide this service, or help you pay for it.

Will your OHP benefits, or any other health insurance you may have, change soon? If so, try to find out if this service will be covered when your benefits change.

④ ***Ask about reduced rates and discounts***

Ask your provider if they can offer you a reduced rate for the service or if they offer discounts for people who pay for services privately. They may have nothing to offer you, but you won't know unless you ask.

⑤ ***Get a second opinion***

You may find another provider who will charge you less for the service.

Additional costs

There may be services from other providers – like hospital, anesthesia, therapy or laboratory services – that go with the service you want. You will have to pay for these, too. Ask your provider for the names and phone numbers of the other providers. Contact those providers to find out what their charges will be.

Questions?

- Call your plan or CCO's Customer Service department, or
- Call the OHP Client Services Unit at 800-273-0557, TTY 711
- Call the Public Benefits Hotline at 800-520-5292 if you would like legal advice about OHP benefits and paying for services.

Attention Provider – Relevant Oregon Administrative Rules (OARs)

Requirements of this Agreement are outlined in OAR 410-120-1280, Billing, and 410-141-3540, Member Protections. These rules can be found online at https://secure.sos.state.or.us/oard/displayChapterRules.action?selectedChapter=87.

OHP Client Agreement to Pay for Pharmacy Services

This is an agreement between a *Client* and a *Provider*, as defined in OAR 410-120-0000, for the following prescription:

① Dispensing pharmacy's contact information:

NPI:	Address:	Phone number:

② Prescription information:

Rx number:	Drug name:	Quantity/day supply:
NDC:	Date dispensed:	Billed amount:

③ Client information:

Name:	Date of birth:	Client ID:

The client agrees to pay for this prescription, for one of the reasons listed below. **Please complete ONE of these sections:**

I. Medication is not covered by the Oregon Health Plan

☐ Pharmacy representative:
- I have confirmed that the Oregon Health Plan (OHP) does not cover this prescription.
- I have confirmed that the billed amount listed above is no greater than our usual and customary rate.

☐ Client:
- I understand that because OHP does not cover this prescription, the Oregon Health Authority (OHA) or my coordinated care organization (CCO) cannot pay for it.
- I understand that if I get this prescription, I agree to pay the costs and will not be paid back.
- I have read the back of this form and understand my other options. I still choose to get this prescription.

II. Medication requires prior approval

☐ Pharmacy representative:
- I have confirmed that OHP will only cover this prescription if approved by OHA or the CCO.
- I have confirmed that this prescription does not qualify for an emergency temporary supply.
- I have confirmed that the billed amount listed above is no greater than our usual and customary rate.
- I understand the pharmacy must refund the billed amount to the client if OHP pays for this prescription later.

☐ Client:
- I understand that OHA or my CCO has to approve this prescription before OHP can cover it.
- I understand that if I get this prescription now, I agree to pay the costs.
- I understand that if OHA or my CCO approves the prescription, I can ask the pharmacy to bill OHP.
- I understand that the pharmacy will repay me only if OHP pays for the prescription.
- I have read the back of this form and understand my other options. I still choose to get this prescription.

III. Client wants to pay for a covered medication

☐ Pharmacy representative:
- I have confirmed that OHP will cover this prescription, but the client does not want it billed to OHP.

☐ Client:
- I understand that OHP can cover this prescription. I do not want this prescription billed to OHP.
- I understand that if I get this prescription, I will pay the costs and will not be paid back.
- I understand that I am paying the pharmacy's usual and customary charge, which is higher than what OHP would pay.
- I have read the back of this form and understand my other options. I still choose to get this prescription.

Both the client and pharmacy representative must read and sign the back of this form, and keep a copy for their records. Pharmacies must keep completed forms on file for at least five years.

Attention OHP client – Read this information carefully before you sign.

Before you sign, make sure that the Oregon Health Plan (OHP) does not cover the prescription. If OHP does not cover the prescription, the Oregon Health Authority (OHA) or your coordinated care organization (CCO) cannot pay for it. Here are some things you can do:

Make sure the service is not covered
If the prescription must be approved by OHA or your CCO, you will get a Notice of Action – Benefit Denial (NOABD) if the prescription cannot be approved. This Notice explains why the prescription was not approved. It also explains how you can ask OHA or your CCO to change the decision by asking for an Appeal or Hearing.

- If you did not receive a Notice of Action, ask OHA or your CCO to send you one.
- Read the Notice of Action carefully. It will also give you information about how to ask for an Appeal or Hearing.

If you also have Medicare, you may have other Appeal rights. Call 800-Medicare (800-633-4227) or TTY 711.

If you have Medicare, see if your Medicare Part D plan covers the prescription
If you need help with Medicare Part D, call Oregon's Medicare Medication Assistance (MMA) line at 877-585-0007.

Check to see if there are other ways to get the prescription

- Ask your provider if they have tried all other covered medications that could treat your condition.
- There may be service organizations, free clinics, county health departments, prescription assistance programs, and manufacturer's coupons or discounts that might help you pay for it.
- Will your OHP benefits, or any other health insurance, change soon? If so, try to find out if they will cover the prescription.

Questions?

- Call your CCO's Customer Service department, or
- Call the OHP Client Services Unit at 800-699-9075, TTY 711.
- Call the Public Benefits Hotline at 800-520-5292 if you would like legal advice about OHP and paying for services.

Attention Provider – Relevant Oregon Administrative Rules (OARs)

Requirements of this Agreement are in OAR 410-120-1280, Billing; 410-120-1360, Requirements for Financial, Clinical and Other Records; and 410-141-3540, Member Protections. These rules can be found online at https://secure.sos.state.or.us/oard/displayChapterRules.action?selectedChapter=87.

Signatures

Pharmacy representative's signature _____ Date _____

Pharmacy representative's name: _____

Client (or representative's) signature – *Representative must have proof of legal authority to sign for this client* _____ Date _____

If signed by the client's representative, print their name here: _____

You can get this form in another language, large print, or another way that is best for you. Call 800-699-9075 (TTY 711).

OHP Client Agreement to Pay for Planned Community (Out-of-Hospital) Birth Services

This is an agreement between a *Client* and a *Provider*, as defined in OAR 410-120-0000. The client agrees to pay for Planned Community (out-of-hospital) birth services that the Oregon Health Authority (OHA) did not approve for Oregon Health Plan (OHP) coverage by OHA or the member's OHA-contracted coordinated care organization (CCO). OHA did not approve these services because the client's pregnancy is not low-risk as defined in OAR 410-130-0240(4) and Prioritized List Guideline Note 153.

Provider section

① Provider completing this form is *(check one):*

☐ Rendering provider *(the provider who is providing the service)* ☐ Freestanding birth center

☐ Other provider:

② **Services requested**	**CPT/HCPCS/NDC codes**	**Estimated fees**
☐ Global maternity care (prenatal care, birth, postpartum care)		
☐ Associated supplies		
☐ Birth attendant (second midwife when applicable)		
☐ Newborn exam		
☐ Birth center facility fees		
☐ Other:		

③ Expected date(s) of service *(start/end dates):* Expected due date:

④ Check one of the following statements about the estimated fees:

☐ There are no other costs.

☐ There may be other costs. You may have to pay for them, too. Other costs may be for (*check all that apply):*

☐ Lab ☐ Ultrasound ☐ Hospital ☐ Anesthesia ☐ Other:

⑤ ☐ As the rendering or prescribing provider:

- I submitted all information required to request OHA approval of planned community (out-of-hospital) birth coverage.
- I confirmed that OHA will not cover a planned community (out-of-hospital birth) for this pregnancy.
- I informed you these services would be covered if provided in a hospital setting, but not in a community setting, and you still choose to receive these services outside the hospital setting.
- I cannot bill for more than the amount OHA or the CCO would pay, as required by OAR 410-120-1280.

Provider name:

National Provider Identifier (NPI):

Provider signature: Date:

Client — Keep a copy of this form for your records.

Attention OHP Client — Read this information carefully before you sign.

Before you sign you should be sure each service is not covered by OHP or your CCO. Here are some things you can do:

① ***Check to make sure the service is not covered***

OHA, your CCO or your plan will send you a Notice of Action if they do not cover a service that your provider requests. If you did not receive a Notice of Action, ask your CCO, plan or provider to send you one so you can be sure the service is not covered by OHP.

② ***Request an appeal and or hearing***

Once you have a Notice of Action, you can request an appeal or hearing. Read the Notice of Action carefully. It will explain why the service was denied. It will also give you information about your right to appeal the denial or ask for a hearing.

If you also have Medicare, you may have other appeal rights. If you have both OHP and Medicare, call 800-Medicare (800-633-4227) or TTY 711.

③ ***Check to see if there are other ways to get the service***

Ask your provider:

- If they have tried all other covered options available for treating your condition, and
- If there is a hospital, medical school, service organization, free clinic or county health department that might provide this service or help you pay for it.

④ ***Ask about reduced rates and discounts***

Ask your provider if they can offer you a reduced rate for the service or if they offer discounts for people who pay for services privately. They may have nothing to offer you, but you won't know unless you ask.

⑤ ***Get a second opinion***

You may find another provider who will charge you less for the service.

Additional costs

There may be services from other providers — such as hospital, anesthesia, therapy or laboratory services — that go with the service you want. You will have to pay for these, too. Ask your provider for the names and phone numbers of the other providers. Contact those providers to find out what their charges will be.

Questions?

- Call your plan or CCO's customer service department, or
- Call the OHP Client Services Unit at 800-273-0557, TTY 711
- Call the Public Benefits Hotline at 800-520-5292 if you would like legal advice about OHP benefits and paying for services.

OHP client section

⑦ Client name: DOB: Client ID#:

⑧ I understand the following, and still choose to get the service(s) listed above:

- Planned community (out-of-hospital birth services) are not covered for this pregnancy by OHP, OHA or my coordinated care organization (CCO). This means that no coverage will be provided and I may be responsible to pay for community birth services out of pocket, at a rate not to exceed what OHA or the CCO would pay if they had provided coverage.
- These services would be covered if provided in a hospital. I still choose to receive these services outside a hospital, knowing that I may have to pay for these services out of pocket.
- If I receive community birth services, I will receive bills for the community birth services provided. I understand that I may have to pay for the services that have been provided.
- I have other options concerning receiving community birth services and/or coverage for these services as explained on the back of this form in sections 1-5 and as explained by my provider.

Client (or representative's) signature – *Representative must have proof of legal authority to sign for this client* Date

If signed by the client's representative, print their name here:

⑨ Witness signature: Date:

Witness name:

This agreement is valid only if the estimated fees listed above do not change and is good only for the current pregnancy at the time of the member's signature.

Attention provider – Relevant Oregon Administrative Rules (OARs)

Requirements of this Agreement are outlined in OAR 410-120-1280, Billing, and 410-141-3540, Member Protections. These rules can be found online at https://secure.sos.state.or.us/oard/displayChapterRules.action?selectedChapter=87.

AMEND: 410-121-0147

RULE SUMMARY: The Authority is updating sections 0000,1210, and 1280 of division 120, to move the CWM program rules to its own division. The Authority is creating a new rule division in Chapter 410, division 134 to define CWM emergency and State funded wrap-around supplemental benefits for recipients. Division 141, revised to add Healthier Oregon Program (HOP) to MCE. Division 200, sections 0015 and 0240, revised to clarify definitions and eligibility criteria related to HOP. Division 125, section 0230, revised to address appropriate funding. Division 121 revised to include emergency medication for CWM.

CHANGES TO RULE:

410-121-0147
Exclusions and Limitations ¶

(1) The following items are not covered for payment by the Division of Medical Assistance Programs (Division) Pharmaceutical Services Program:¶
(a) Drug products for diagnoses below the funded line on the Health Services Commission Prioritized List or an excluded service under Oregon Health Plan (OHP) coverage;¶
(b) Home pregnancy kits;¶
(c) Fluoride for individuals over 18 years of age;¶
(d) Expired drug products;¶
(e) Drug products from non-rebatable manufacturers, with the exception of selected oral nutritionals, vitamins, and vaccines;¶
(f) Active Pharmaceutical Ingredients (APIs) and Excipients as described by Centers for Medicare and Medicaid (CMS);¶
(g) Drug products that are not assigned a National Drug Code (NDC) number;¶
(h) Drug products that are not approved by the Food and Drug Administration (FDA);¶
(i) Drug products dispensed for Citizen~~/Alien-Waived Emergency~~ship Waived Medical (CWM) client benefit type~~;~~ except when prescribed as an emergency medical service as defined by OAR 410-134-0003.¶
(j) Drug Efficacy Study Implementation (DESI) drugs (see OAR 410-121-0420);¶
(k) Medicare Part D covered drugs or classes of drugs for fully dual eligible clients (see OAR 410-121-0149, 410-120-1200 & 410-120-1210).¶
(2) Effective on or after April 1, 2008, Section 1903(i) of the Social Security Act requires that written (nonelectronic) prescriptions for covered outpatient drugs for Medicaid clients be executed on a tamper-resistant pad in order to be eligible for federal matching funds. To meet this requirement, the Division shall only reimburse for covered Medicaid outpatient drugs only when the written (nonelectronic) prescription is executed on a tamper-resistant pad, or the prescription is electronically submitted to the pharmacy.¶
(3) Drugs requiring a skilled medical professional for safe administration will be billed by the medical professional's office; unless otherwise specified by the Division.
Statutory/Other Authority: ORS 413.042, 414.065
Statutes/Other Implemented: ORS 414.065

AMEND: 410-125-0230

RULE SUMMARY: The Authority is updating sections 0000,1210, and 1280 of division 120, to move the CWM program rules to its own division. The Authority is creating a new rule division in Chapter 410, division 134 to define CWM emergency and State funded wrap-around supplemental benefits for recipients. Division 141, revised to add Healthier Oregon Program (HOP) to MCE. Division 200, sections 0015 and 0240, revised to clarify definitions and eligibility criteria related to HOP. Division 125, section 0230, revised to address appropriate funding. Division 121 revised to include emergency medication for CWM.

CHANGES TO RULE:

410-125-0230
Qualified Directed Payments
Qualified Directed Payments (QDP) are payments made by the Oregon Health Authority (Authority) to Coordinated Care Organizations (CCOs) from three Quality and Access pools for distinct provider classes: one for Rural Type A and Type B hospitals; one for Public Academic Health Centers; and one for DRG hospitals. Each provider class is defined in 438.6(c) Preprint forms approved by the U.S. Department of health and Human Services Centers for Medicare and Medicaid Services. QDPs are tied to inpatient and outpatient encounters by Medicaid and Children's Health Insurance Program members enrolled in a Coordinated Care Organization except for encounters for Citizenship Waived Medical (CWM) or CWM Plus services as defined in OAR 410-120-1210(4)(d) and OAR 410-120-1210(4)(e).¶
(1) Type A and Type B hospitals:¶
(a) The Authority shall make a qualified directed payment only if the Type A or Type B hospital meets criteria established by the Authority for the Type A or Type B hospital Quality and Access program in accordance with applicable federal requirements, which may be updated from time to time.¶
(b) The Authority shall make a qualified directed payment for each inpatient and outpatient encounter; one encounter per member, per day, per facility;¶
(c) QDP amounts shall be at two separate rates; one for inpatient encounters and one for outpatient encounters;¶
(d) Payment rates shall be set by the Authority and may be adjusted based on actual utilization and available Quality and Access funds;¶
(e) The Authority shall create a monthly report to assist CCOs in distributing funds to the appropriate hospital. The report shall be distributed to each CCO and each Type A and Type B hospital;¶
(f) Within five business days after receipt of the monthly report, the CCO shall submit an electronic payment to an account established by the hospital for the amount indicated on the report;¶
(g) Adjustments shall be processed weekly through the Medicaid payment system and included in the monthly report.¶
(2) Public Academic Health Centers:¶
(a) The Authority shall make a qualified directed payment only if the public academic medical center meets criteria established by the Authority for the Public Academic Medical Center Quality and Access program in accordance with applicable federal requirements, which may be updated from time to time.¶
(b) The Authority shall make a qualified directed payment for each inpatient and outpatient encounter; one encounter per member, per day, per facility;¶
(c) QDP amounts shall be at two separate rates; one for inpatient encounters and one for outpatient encounters;¶
(d) Payment rates shall be set by the Authority and may be adjusted based on actual utilization and available Quality and Access Funds;¶
(e) The Authority shall combine the weekly encounters into a monthly report to assist CCOs in distributing the funds to the appropriate hospital. The report shall be distributed to each CCO and each public academic health center;¶
(f) Within five business days after receipt of the monthly report, the CCO shall submit an electronic payment to an account established by each public health center for the amount indicated on the report;¶
(g) Adjustments shall be processed weekly through the Medicaid payment system and included in the monthly report.¶
(3) DRG Hospitals:¶
(a) The Authority shall make a qualified directed payment only if the DRG Hospital meets criteria established by the Authority for the DRG Hospital Quality and Access Pool program in accordance with applicable federal requirements, which may be updated from time to time.¶
(b) The Authority shall make a qualified directed payment for each inpatient and outpatient encounter; one encounter per member, per day, per facility;¶

(c) QDP amounts shall be at two separate rates; one for inpatient encounters and one for outpatient encounters;¶
(d) Payment rates shall be set by the Authority and may be adjusted based on actual utilization and available Quality and Access Funds;¶
(e) The Authority shall create a monthly report to assist CCOs in distributing funds to the appropriate hospital. The report shall be distributed to each CCO and each DRG hospital;¶
(f) Within five business days after receipt of the monthly report, the CCO shall submit an electronic payment to an account established by the hospital for the amount indicated on the report;¶
(g) Adjustments shall be processed weekly through the Medicaid payment system and included in the monthly report.¶
(4) If an error is identified in the monthly report, the CCO shall make the payment based on the original amount provided in the report. The Authority shall identify separately the correction in the following month's report and adjust the total payment amount to account for the error.
Statutory/Other Authority: ORS 413.042
Statutes/Other Implemented: 2017 HB 2391

ADOPT: 410-134-0000

RULE SUMMARY: The Authority is updating sections 0000,1210, and 1280 of division 120, to move the CWM program rules to its own division. The Authority is creating a new rule division in Chapter 410, division 134 to define CWM emergency and State funded wrap-around supplemental benefits for recipients. Division 141, revised to add Healthier Oregon Program (HOP) to MCE. Division 200, sections 0015 and 0240, revised to clarify definitions and eligibility criteria related to HOP. Division 125, section 0230, revised to address appropriate funding. Division 121 revised to include emergency medication for CWM.

CHANGES TO RULE:

410-134-0000
Purpose
The rules in OAR Chapter 410, division 134 is specific to the Citizenship Waived Medical (CWM) program coverages and its State-funded supplemental wraparound benefits. The CWM program is emergency only coverage (see OAR 410-134-0003) that includes CWX along with State-funded supplemental wraparound services. CWX is a benefit provided to CWM pregnant people, when reported appropriately (see OAR 410-200-0240), to provide prenatal services at an Oregon Health Plan (OHP) Plus level of coverage, intended for the CWM recipient's unborn child. This division includes CWM program related acronyms and definitions, criteria to assist with determining when a client has medical assistance coverage, CWM program benefit plans and its State-funded supplemental wraparound services, and CWM specific billing criteria.
Statutory/Other Authority: ORS 413.042
Statutes/Other Implemented: ORS 413.042, 414.025, 414.065, 414.231, 414.312, 414.430, 414.432, 414.706

ADOPT: 410-134-0001

RULE SUMMARY: The Authority is updating sections 0000,1210, and 1280 of division 120, to move the CWM program rules to its own division. The Authority is creating a new rule division in Chapter 410, division 134 to define CWM emergency and State funded wrap-around supplemental benefits for recipients. Division 141, revised to add Healthier Oregon Program (HOP) to MCE. Division 200, sections 0015 and 0240, revised to clarify definitions and eligibility criteria related to HOP. Division 125, section 0230, revised to address appropriate funding. Division 121 revised to include emergency medication for CWM.

CHANGES TO RULE:

410-134-0001
Acronyms and Definitions
Identification of acronyms and definitions within this rule specifically pertain to their use within the Citizenship Waived Medical (CWM) program in its entirety. This rule does not include an exhaustive list of Division acronyms and definitions. For more information, see Oregon Health Plan (OHP) program OAR 410-141-3500 Definitions; 410-120-0000 Medical Assistance Programs acronyms and definitions; 410-200-0015 General Definitions; and any appropriate governing acronyms and definitions in the Department of Human Services (Department) chapter 411, 413, or 461 administrative rules; or contact the Division.¶
(1) "Citizenship Waived Medical (CWM)" means "means granted lawful temporary resident status or lawful permanent resident status under the Immigration and Nationality Act are eligible only for emergency services and limited service for pregnant people." (OAR 410-120-0000).¶
(2) "Citizenship Waived Medical plus (CWX)" means a person eligible for the CWM pregnancy benefit package as defined in OAR 410-134-0003.¶
(3) "CWM Reproductive Health Equity Act (RHEA)" means a person eligible for CWM Reproductive Health Equity Act as defined in OAR 410-134-0003.¶
(4) "CWX RHEA" means a person eligible for CWX and RHEA as defined in OAR 410-134-0003.¶
(5) "Emergency Medical Condition" meaning as defined in OAR 410-134-0003.¶
(6) "Cover All Kids (CAK)" or "Healthier Oregon Program (HOP) children" (see OAR 410-200-0240 and 410-134-0003).¶
(7) "HOP Non-Pregnant Adult" (see OAR 410-200-0240 and 410-134-0003).¶
(8) "HOP Pregnant Adult" (see OAR 410-200-0240 and 410-134-0003).
Statutory/Other Authority: ORS 413.042, 414.065
Statutes/Other Implemented: ORS 413.042, 414.065, 414.025, 414.231, 414.312, 414.430, 414.432, 414.706

ADOPT: 410-134-0002

RULE SUMMARY: The Authority is updating sections 0000,1210, and 1280 of division 120, to move the CWM program rules to its own division. The Authority is creating a new rule division in Chapter 410, division 134 to define CWM emergency and State funded wrap-around supplemental benefits for recipients. Division 141, revised to add Healthier Oregon Program (HOP) to MCE. Division 200, sections 0015 and 0240, revised to clarify definitions and eligibility criteria related to HOP. Division 125, section 0230, revised to address appropriate funding. Division 121 revised to include emergency medication for CWM.

CHANGES TO RULE:

410-134-0002
Determining When A Client Has Medical Assistance
(1) The Medical Card has the client's name as listed with the OHP and their alpha-numeric prime number.¶
(2) Eligibility may change monthly. In some instances, eligibility will change during the month. Eligibility should be verified each time services are provided to assure that the client is eligible for date(s) of service (see OAR 410-120-1140).¶
(3) Providers must verify the client's eligibility on the date of service, regardless of if the client is anticipated to have PHP, CCO, FFS, or no Medicaid coverage. It is not required but recommended to print the client's eligibility verification to include within the client's chart.
Statutory/Other Authority: ORS 413.042
Statutes/Other Implemented: ORS 413.042

ADOPT: 410-134-0003

RULE SUMMARY: The Authority is updating sections 0000,1210, and 1280 of division 120, to move the CWM program rules to its own division. The Authority is creating a new rule division in Chapter 410, division 134 to define CWM emergency and State funded wrap-around supplemental benefits for recipients. Division 141, revised to add Healthier Oregon Program (HOP) to MCE. Division 200, sections 0015 and 0240, revised to clarify definitions and eligibility criteria related to HOP. Division 125, section 0230, revised to address appropriate funding. Division 121 revised to include emergency medication for CWM.

CHANGES TO RULE:

410-134-0003
CWM Benefit Plans And State-Funded Supplemental Wraparound Services
CWM eligible recipients must report pregnancy and end of pregnancy to the Authority, timely, to receive appropriate benefit packages and related wraparound services (see OAR 410-200-0240 and 410-134-0003).¶
(1) Citizenship Waived Medical (CWM):¶
(a) Benefit Package identifier CWM;¶
(b) Eligibility criteria: Eligible clients are non-qualified recipients not eligible for other Medicaid programs solely because these individuals do not meet the citizen and immigration status requirement pursuant to OAR 410-200-0215;¶
(c) Coverage. Coverage is limited to emergency medical services as defined by 42 CFR 440.255:¶
(A) Sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in: placing the patient's health in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.¶
(i) The Authority determines if the admitting diagnosis requiring treatment, meets the definition of an emergency medical condition in 42 CFR 440.255;¶
(ii) Provider must also use appropriate emergency admit type or indicator on the claim.¶
(iii) Some diagnosis/conditions have been pre-determined to always fit the emergency definition and those can be found at https://data.oregon.gov/Health-Human-Services/Oregon-Medicaid-CWM-Emergency-Diagnosis-Codes/4ppf-rfju/data.¶
(iv) Other diagnosis/conditions are confirmed through clinical records review.¶
(B) The Division pays for all related, medically necessary health care services and professional services provided. These services include anesthesia, surgical, and recovery services, emergency medical transportation, laboratory, x-ray and other diagnostics, medications, medical equipment and supplies; this also includes associated professional interpretations;¶
(C) Labor and Delivery;¶
(D) Behavioral health crisis, as defined in OAR chapter 309 division 19;¶
(E) Emergency and outpatient dialysis to treat acute renal failure or end stage renal disease (ESRD) and anti-rejection medications post kidney transplant (see Chapter 410, division 124 for transplant rules);¶
(F) Cancer treatment as specified in OAR 410-134-0004;¶
(G) Outpatient drugs or over-the-counter products associated with the qualifying emergency service.¶
(d) Exclusion: The CWM benefit package does not reimburse or provide services within the following exclusions, even if they are sought as emergency services. These services are covered and available to CWX recipients and recipients of related state-only funded supplemental benefit packages, as referenced in the exclusions listed below:¶
(A) Abortion services (See OAR chapter 333, division 004);¶
(B) Sterilization (See OAR chapter 333, division 004);¶
(C) Prenatal or postpartum care (See OAR chapter 333, division 004 and chapter 410, division 134);¶
(D) Family Planning (See OAR chapter 333, division 004);¶
(E) Preventive care (see OAR 410-134-0003);¶
(F) Organ transplants, including pre-evaluations and post-operative care;¶
(G) Hospice;¶
(H) Home health;¶
(I) Private duty nursing;¶
(J) Eyeglasses and exams (see OAR 410-134-0003);¶
(K) Dental services provided outside of an emergency department or hospital setting (see OAR 410-134-0003); ¶
(L) Non-emergency medical transportation (see OAR 410-134-0003);¶

(M) Therapy services (see OAR 410-134-0003);¶
(N) Durable medical equipment and medical supplies (see OAR 410-134-0003);¶
(O) Rehabilitation services (see OAR 410-134-0003).¶
(2) CWM Reproductive Health Equity Act (RHEA) benefit: ¶
(a) Benefit Package identifier CWM;¶
(b) Eligibility criteria: Eligible clients are individuals eligible under the CWM benefit in OAR 410-134-0003;¶
(c) Coverage: This is a state-funded supplemental reproductive health benefit administered by the Public Health Division. For full coverage and criteria, refer to OAR chapter 333, division 004. The Division administers a subset of the benefits described in OAR chapter 333, division 004 as follows: ¶
(A) Abortion services occurring in a hospital; and¶
(B) Sterilization; and¶
(C) Family planning.¶
(3) Citizenship Waived Medical Plus:¶
(a) Benefit Package identifier code CWX;¶
(b) Eligibility criteria: As defined in federal regulations and in the Children's Health Insurance Program (CHIP) state plan, eligible clients are non-qualified recipients that are pregnant people at or below 185 percent FPL, and not eligible for other Medicaid programs solely because these individuals do not meet the citizen and immigration status requirement, pursuant to OAR 410-200-0215;¶
recipients receive OHP level benefits with specific exclusions as defined in OAR 410-120-1210.¶
(c) Coverage includes: Services equal to OHP Plus level benefits as described in OAR 410-120-1210(4)(a).¶
(d) Exclusions: The following services are not covered for this program:¶
(A) Postpartum care (except when provided and billed as part of a global obstetric package code, which includes the delivery procedure) (See OAR chapter 333, division 004 for supplemental coverage);¶
(B) Sterilization (See OAR chapter 333, division 004 for supplemental coverage);¶
(C) Family planning (See OAR chapter 333, division 004 for supplemental coverage);¶
(D) Abortion (See OAR chapter 333, division 004 for supplemental coverage);¶
(E) Death with dignity services;¶
(F) Hospice.¶
(e) The day after pregnancy ends, eligibility for medical services shall be based on eligibility categories established in OAR chapters 461 and 410 (See OAR chapter 333, division 004 for supplemental coverage).¶
(4) CWX RHEA benefit:¶
(a) Benefit Package identifier code CWX;¶
(b) Eligibility criteria: Eligibility begins the day after pregnancy ends for CWM pregnant people not eligible for Medicaid based on immigration status, at or below 185 percent of the Federal Poverty Level (FPL). These qualified recipients are eligible for State-funded benefits pursuant to ORS 414.432;¶
(c) Coverage includes:¶
(A) Postpartum care delivered outside of the global obstetric package not included under the CWX benefit. This includes 60 days of supplemental coverage, following the pregnancy end date, equal to services covered by OHP Plus (see OAR 410-120-1210); and¶
(B) The postpartum eligibility period is as described in OAR 410-200-0240.¶
(5) Cover All Kids (CAK) or Healthier Oregon Program (HOP) children:¶
(a) Benefit Package identifier code BMH;¶
(b) Eligible clients are non-qualified recipients that are age 18 or younger, not eligible for other Medicaid programs solely because these individuals do not meet the citizen and immigration status requirement pursuant to (OAR) 410-200-0215. Coverage is a state-funded wrap-around medical benefit pursuant to ORS 414.231;¶
(c) Coverage includes: OHP Plus equivalent benefits (see OAR 410-120-1210), including supplemental benefits defined in chapter 333, section 0004. ¶
(6) HOP non-pregnant Adult:¶
(a) Benefit Package identifier code BMH;¶
(b) Eligible clients are non-qualified recipients that are age 19 to 26 or 55 and older, not eligible for other Medicaid programs solely because these individuals do not meet the citizen and immigration status requirement pursuant to OAR 410-200-0215;¶
(c) Coverage is a state-funded, wrap-around, OHP equivalent medical benefit (see OAR 410-120-1210), and includes supplemental benefits defined in OAR chapter 333, section 0004;¶
(d) Limitations: The following services have limited coverage for non-pregnant adults age 21 and older, not within the protected postpartum period (see OAR 410-200-0135):¶
(A) Selected dental (OAR chapter 410, division 123 and 200); and¶
(B) Vision services such as frames, lenses, contacts corrective devices and eye exams for the purpose of prescribing glasses or contacts (OAR chapter 410, division 140 and 200).¶

(7) HOP pregnant Adult:¶
(a) Benefits Package identifier code BMP.¶
(b) Eligible clients are pregnant people and people within 12 months following the end of pregnancy who are age 19 to 26 or 55 and older, not eligible for other Medicaid programs solely because these individuals do not meet the citizen and immigration status requirement pursuant to OAR 410-200-0215. Coverage is a state-funded wrap-around medical benefit.¶
(c) Coverage includes:¶
(A) An OHP equivalent benefit (see OAR 410-120-1210); and¶
(B) Supplemental benefits pertaining to CWX RHEA (see this rule, OAR 410-134-0003); and¶
(C) A protected post-partum coverage period of ten months (see OAR 410-200-0135).
Statutory/Other Authority: ORS 413.042, 414.065
Statutes/Other Implemented: ORS 413.042, 414.065, 414.025, 414.231, 414.312, 414.430, 414.432, 414.706

ADOPT: 410-134-0004

RULE SUMMARY: The Authority is updating sections 0000,1210, and 1280 of division 120, to move the CWM program rules to its own division. The Authority is creating a new rule division in Chapter 410, division 134 to define CWM emergency and State funded wrap-around supplemental benefits for recipients. Division 141, revised to add Healthier Oregon Program (HOP) to MCE. Division 200, sections 0015 and 0240, revised to clarify definitions and eligibility criteria related to HOP. Division 125, section 0230, revised to address appropriate funding. Division 121 revised to include emergency medication for CWM.

CHANGES TO RULE:

410-134-0004
Billing
For information about fraud and abuse refer to OAR 410-120-1510. Providers must use appropriate diagnosis codes for billing. There is a list of approved conditions that can be found at: https://data.oregon.gov/Health-Human-Services/Oregon-Medicaid-CWM-Emergency-Diagnosis-Codes/4ppf-rfju/data. Providers must also use the appropriate emergency admit type 1 for inpatient and outpatient claims or check the appropriate emergency indicator on a professional claim. ¶
(1) The Authority will reimburse behavioral health crisis providers (see OAR 309 division 19) for services, when all billing requirements are met pursuant to OAR 410-120-1280. Providers must use appropriately identified crisis CPT codes 90839 or 90840.¶
(2) Emergency and outpatient Dialysis as defined in OAR 410-134-0003.¶
(3) Inpatient and outpatient Cancer treatment as covered by the OHP including:¶
(a) Radiation therapy;¶
(b) Surgery;¶
(c) Lab tests and radiology to measure and track treatment;¶
(d) Medications that treat cancer side effects;¶
(e) Chemotherapy;¶
(f) Oncology office visits; and¶
(g) Inpatient treatment and recovery.¶
(4) Medication coverage for Dialysis, Cancer and Behavioral Health:¶
(a) Requires prior authorization; and¶
(b) Must be a current PMPDP preferred drug as listed at www.orpdl.org and per OAR 410-121-0030.¶
(4) Emergency Dental Services defined in OAR 410-120-0000 and pursuant to OAR 410-123-1540 and must include appropriate diagnosis and emergency indicator.¶
(5) For CWM eligible clients receiving RHEA services, find full coverage and criteria at OAR Chapter 333, Division 004 (for modifiers required for FQHC or RHC clients, see OAR 410-147-0160).¶
(6) Prior Authorization (PA) must be appropriately obtained for services requiring PA (see OAR 410-134-0005).
Statutory/Other Authority: ORS 413.042, 414.065
Statutes/Other Implemented: ORS 413.042, 414.065, 414.025, 414.231, 414.312, 414.430, 414.432, 414.706

ADOPT: 410-134-0005

RULE SUMMARY: The Authority is updating sections 0000,1210, and 1280 of division 120, to move the CWM program rules to its own division. The Authority is creating a new rule division in Chapter 410, division 134 to define CWM emergency and State funded wrap-around supplemental benefits for recipients. Division 141, revised to add Healthier Oregon Program (HOP) to MCE. Division 200, sections 0015 and 0240, revised to clarify definitions and eligibility criteria related to HOP. Division 125, section 0230, revised to address appropriate funding. Division 121 revised to include emergency medication for CWM.

CHANGES TO RULE:

410-134-0005
Prior Authorization
(1) Prior Authorization (PA) is defined in OAR 410-120-0000. When providers must obtain a PA from the:¶
(a) Enrolled member's Prepaid Health Plan (PHP) or Coordinated Care Organization (CCO); or¶
(b) The Division for clients who receive services on a fee-for-services basis and are not enrolled with a PHP or CCO.¶
(2) A PA does not guarantee eligibility or reimbursement. Providers must verify the client's Medicaid eligibility on the date of service. It is in the providers best interest to print the client's eligibility verification to include within the client's chart.¶
(3) A PA is not required for clients with both Medicare and Division coverage when the service or item is covered by Medicare.¶
(4) Providers shall determine if a PA is required and comply with all PA requirements outlined in these rules.¶
(5) Providers shall ensure:¶
(a) That all PA requests are completed and submitted correctly. The Division does not accept PA requests via the phone. (See CWM Services Supplemental Information Guide found at www.oregon.gov/OHA/HSD/OHP/pages/Policy-CWM.aspx.)¶
(b) PA requests shall include:¶
(A) A statement of medical appropriateness showing the need for the item or service, and why other options are inappropriate; and¶
(B) Diopter information and appropriate International Classification of Diseases, 10th revision, Clinical Modification (ICD-10-CM) diagnosis codes; and¶
(C) All relevant documentation that is needed for Division staff to make a determination for authorization of payment, including clinical data or evidence, medical history, any plan of treatment, or progress notes.¶
(c) The service is adequately documented. (See OAR 410-120-1360 Requirements for Financial, Clinical and Other Records.) Providers must maintain documentation to adequately determine the type, medical appropriateness, or quantity of services provided; and¶
(d) The services or items provided are consistent with the information submitted when authorization was requested; and¶
(e) The services billed are consistent with the services provided; and¶
(f) The services are provided within the timeframe specified on the PA document.¶
(6) Providers shall comply with the Division's PA requirements or other policies necessary for reimbursement before providing services to any CWM client who is not enrolled in a PHP.
Statutory/Other Authority: ORS 413.042
Statutes/Other Implemented: ORS 414.065, 414.231, 414.066, 414.072

AMEND: 410-141-3805

RULE SUMMARY: The Authority is updating sections 0000,1210, and 1280 of division 120, to move the CWM program rules to its own division. The Authority is creating a new rule division in Chapter 410, division 134 to define CWM emergency and State funded wrap-around supplemental benefits for recipients. Division 141, revised to add Healthier Oregon Program (HOP) to MCE. Division 200, sections 0015 and 0240, revised to clarify definitions and eligibility criteria related to HOP. Division 125, section 0230, revised to address appropriate funding. Division 121 revised to include emergency medication for CWM.

CHANGES TO RULE:

410-141-3805
Mandatory MCE Enrollment Exceptions
(1) In addition to the definitions in OAR 410-120-0000, the following definitions apply:¶
(a) "Eligibility Determination" means an approval or denial of eligibility and a renewal or termination of eligibility as set forth in OAR 410-200-0015;¶
(b) "Newly Eligible" means recently determined through the eligibility determination process as having the right to obtain state health benefits, satisfying the appropriate conditions;¶
(c) "Renewal" means a regularly scheduled periodic review of eligibility resulting in a renewal or change of program benefits, including the assignment of a new renewal date or a change in eligibility status.¶
(d) "Citizenship Waived Medical (CWM)" means any of the benefit packages described in OAR 410-134-0003.¶
(e) "Cover All Kids (CAK)" or "HOP Child", "HOP non-pregnant Adult", and "HOP pregnant Adult" means the benefit packages described in OAR 410-134-0003.¶
(2) CCO enrollment is mandatory in all areas served by a CCO. A client eligible for or receiving health services shall enroll in a CCO as required by ORS 414.631, except as provided in ORS 414.631(2), (3), (4), and (5) and this rule.¶
(3) MCE enrollment is mandatory in service areas with adequate access and capacity to provide health care services through an MCE. If upon application or redetermination a client does not select an MCE, the Authority shall auto-assign the client and the client's household to an MCE that has adequate access and capacity. Enrollment may vary depending on which options are available in the member's service area at the time of enrollment:¶
(a) The member shall be enrolled with a CCO that offers bundled physical health, behavioral health, and oral health services; or¶
(b) The member shall be enrolled with a CCO for physical health and behavioral health services and with a DCO for oral health services; or¶
(c) The member shall be enrolled with a CCO for behavioral health and oral health services and shall remain FFS for physical health services; or¶
(d) The member shall be enrolled with a CCO for behavioral health services and with a DCO for oral health services and shall remain FFS for physical health services; or¶
(e) The member shall be enrolled with a DCO for oral health services and with an MHO for behavioral health services and shall remain FFS for physical health services; or¶
(f) The member shall be enrolled with a DCO for oral health services and remain FFS for physical health and behavioral health services; or¶
(g) The member shall remain FFS for health care services if no MCE is available.¶
(4) MCE enrollment is voluntary in service areas without adequate access and capacity to provide health care services through an MCE.¶
(5) If a service area changes from mandatory enrollment to voluntary enrollment while a member is enrolled with an MCE, the member shall remain enrolled with the MCE for the remainder of their eligibility period or until the Authority or Department redetermines their eligibility, whichever comes first, unless the member is otherwise eligible to disenroll pursuant to OAR 410-141-3810.¶
(6) Members who are exempt from physical health services shall receive behavioral health services and oral health services through an MCE:¶
(a) The member shall be enrolled with a CCO that offers behavioral health and oral health services; or¶
(b) The member shall be enrolled with a DCO for oral health services and with an MHO for behavioral health services; or¶
(c) The member shall be enrolled with a DCO for oral health services and shall remain FFS for behavioral health services if an MHO is not available; or¶
(d) The member shall remain FFS for both behavioral health and oral health services if neither a DCO nor an MHO

is available.¶
(7) The following pertains to the effective date of the enrollment. If the member qualifies for enrollment into an MCE, the effective date of enrollment occurs:¶
(a) On or before Wednesday, the date of enrollment shall be the following Monday; or¶
(b) After Wednesday, the date of enrollment shall be one week from the following Monday.¶
(8) Coordinated care services shall begin as of the effective date of enrollment with the MCE except for:¶
(a) A newborn's services shall begin on the date of birth if the mother was a member of a CCO at the time of birth;¶
(b) For adopted children or children placed in an adoptive placement, the date of enrollment shall be the date specified by the Authority.¶
(9) ~~Pursuant to ORS 414.631, t~~The following populations may not be enrolled into a~~n MCE for any type of health care coverage:¶~~
~~(a) Individuals who are non-citizens and are Citizen/Alien Waivered-Emergency Medical program eligible for labor and delivery services and emergency treatment services~~ CCO or DCO or both, as indicated below in this rule, for any type of health care coverage or for the type of coverage specified:¶
(a) Individuals who are non-citizens and eligible for any of the CWM benefit packages described in OAR 410-134-0003, including , but not eligible for the CAK/HOP Children, HOP non-pregnant Adult, or HOP pregnant Adult benefit package described in OAR 410-134-0003;¶
(b) Individuals eligible for the CAK/HOP Children, HOP non-pregnant Adult, or HOP pregnant Adult benefit package may not be enrolled into a DCO;¶
(c) Individuals eligible for the CAK/HOP Children, HOP non-pregnant Adult, or HOP pregnant Adult benefit package but for whom the Authority has not provided capitation or other payment rates in the applicable CCO contract;¶
(~~b~~d) Clients with Medicare receiving premium assistance through the Specified Low-Income Medicare Beneficiary, Qualified Individuals, Qualified Disabled Working Individuals and Qualified Medicare Beneficiary programs without another Medicaid;¶
(~~c~~e) Individuals who are dually eligible for Medicare and Medicaid and enrolled in a program of all-inclusive care for the elderly (PACE).¶
(10)-If enrollment action coincides with an individual's Continuous Inpatient Stay as defined in OAR 410-141-3500, the following enrollment rules apply:¶
(a) A newly eligible OHP client who became eligible while admitted as an inpatient is exempt from enrollment with a CCO for physical health and behavioral health services, but not exempt from MCE enrollment oral health services with a DCO. The client shall receive health care services on a fee-for-service (FFS) basis until the individual is discharged from the continuous inpatient stay;¶
(b) In settings where the CCO is fully responsible for covered services, such as an acute care hospital, acute care psychiatric hospital, skilled nursing facility specific to the Post-Hospital Extended Care (PHEC) benefit, Psychiatric Residential Treatment Facility (PRTF), or a residential Behavioral Health or Substance Use Disorder treatment facility that is not considered a Home and Community-Based Services (HCBS) setting as described in OAR 410-173-0035:¶
(A) The CCO is responsible for covered services if the individual is enrolled as of the date they are admitted to the inpatient setting. No enrollment changes shall be made (CCO-to-FFS, CCO-to-CCO, or FFS-to-CCO) until the member is discharged from their continuous inpatient stay to ensure continuity of care and care coordination, and to mitigate billing confusion;¶
(B) If the individual is enrolled in a CCO after the first day of admission to the inpatient setting, the enrollment will be cancelled as never effective and the date of enrollment shall be the next available enrollment date following discharge from the continuous inpatient stay to ensure continuity of care and care coordination, and to mitigate billing confusion,¶
(C) When a justice-involved individual, meeting the definition for Inmate stated within OAR 410-200-0015, is admitted to an inpatient setting with an expected stay of at least 24 hours, the individual temporarily resumes OHP eligibility and the inpatient stay is covered by FFS; CCO enrollment shall be the next available enrollment date following release from the penal facility as consistent with OAR 410-200-0140, OAR 461-135-0950, and OAR 410-141-3810, and based on the service area of the member's current permanent residence.¶
(c) In settings where the CCO is responsible for care coordination but not health services, including, but not limited to Medicaid-Funded Long Term Services and Supports (LTSS) or Behavioral Health Carve-Out Services:¶
(A) Contractor is responsible for care coordination if the individual is enrolled as of the date they are admitted to the inpatient setting. No enrollment changes shall be made (CCO-to-FFS, CCO-to-CCO, or FFS-to-CCO) until the member is discharged from their continuous inpatient stay to ensure continuity of care coordination;¶
(B) If the individual is enrolled in a CCO after the first day of admission to the inpatient setting, the enrollment will be cancelled as never effective, and the date of enrollment shall be the next available enrollment date following

discharge from the continuous inpatient stay to ensure continuity of care coordination;¶
(C) When a resident of a public institution, as defined in OAR 461-135-0950, is voluntarily or involuntarily admitted to the Oregon State Hospital, OHP eligibility is suspended and any associated CCO enrollment is ended with an effective date of the inpatient admission; however, the CCO is responsible for care coordination.¶
(d) If an individual is currently experiencing an extended but temporary hold within an Emergency Department due to unavailability of inpatient placement or delay in secure transportation to a facility that can evaluate appropriate psychiatric referrals, no enrollment changes shall be made (CCO-to-FFS or CCO-to-CCO) until the individual is no longer in the Emergency Department or, if subsequent action is admission to an inpatient setting, until the individual is discharged from their continuous inpatient stay.¶
(11) A client may not be enrolled with a CCO if the client is covered under a major medical insurance policy, Third Party Liability (TPL), or other Third-Party Resource (TPR) that covers the cost of services to be provided by a CCO as specified in ORS 414.631 and except as provided for children in Child Welfare through the Behavior Rehabilitation Services (BRS) and Psychiatric Residential Treatment Services (PRTS) programs outlined in OAR 410-141-3800:¶
(a) A client shall be enrolled with a DCO for oral health services even if they have a dental TPR;¶
(b) At the Authority's discretion, a client shall be enrolled with the highest level of CCO coverage, including physical health, behavioral health, and oral health services, if coverage through the TPR poses a safety risk to the member, specific to Good Cause determination as described in OAR 461-120-0350(1) and OAR 410-200-0220(6). In these situations:¶
(A) Recovery of third-party insurance should not be pursued; and¶
(B) Explanation of Benefits (EOB) should be suppressed.¶
(12) Individuals who are documented American Indian and Alaskan Native (AI/AN) beneficiaries are exempt from mandatory enrollment into an MCE, as specified in 42 USC 1932, 2 (C), but may elect to be manually enrolled.¶
(13) A child in the legal custody of the Department or where the child is expected to be in a substitute care placement for less than 30 calendar days is exempt from mandatory enrollment for physical health services from a CCO but is subject to mandatory enrollment into both behavioral and oral health services as available in the member's service area unless:¶
(a) Access to health care on an FFS basis is not available; or¶
(b) Enrollment preserves continuity of care. In these cases, the member may be manually enrolled into a physical health plan or remain enrolled as deemed appropriate by the Authority.¶
(14) Clients who are dually eligible for Medicare and full Medicaid but not enrolled in a program of all-inclusive care for the elderly (PACE) may be automatically enrolled into an MCE. The following apply to automated duals enrollment:¶
(a) The dually eligible Medicare and Medicaid client shall receive choice counseling on Medicare-Medicaid options at their request from a local APD/AAA office or other Department or Authority designated entity, as well as information on the benefits for clients in aligning Medicare and Medicaid;¶
(b) If a client is already enrolled in a Medicare Advantage or Dual Special Needs Plan (D-SNP), the member shall be enrolled into an affiliated CCO if one exists. Otherwise the client shall be enrolled in a CCO available to the member based on the member's residential address or home geographic region;¶
(c) A full Medicare and Medicaid dually eligible member may request to opt out of enrollment for physical health services from a CCO, but is subject to mandatory enrollment into both behavioral and oral health services as available in the member's service area. Disenrollment requests are subject to review or delay as deemed appropriate by the Authority when:¶
(A) Access to health care on an FFS basis is not available; or¶
(B) Enrollment preserves continuity of care. In these cases, the member has a condition, treatment, or specialized consideration that requires individual care transition, members may not be disenrolled without review and approval by the Authority. The Authority will consider the following in its review;¶
(i) The development of a prior-authorized treatment plan;¶
(ii) Care management requirements based on the beneficiary's medical condition;¶
(iii) Transitional care planning including but not limited to hospital admissions/discharges, palliative and hospice care, long-term care and services; and¶
(iv) Need for individual case conferences to ensure a "warm hand-off."¶
(d) The following choices of plans shall be extended to dually eligible Medicare-Medicaid clients or members with full Medicaid as follows:¶
(A) The option to enroll in a CCO regardless of whether they are enrolled in an affiliated Medicare Advantage, enrolled in Medicare Advantage with another entity, or if the member remains in FFS Medicare;¶
(B) The option to enroll in a CCO when enrolled in Medicare Advantage, whether or not they pay their own premium, even if the MCE does not have a corresponding Medicare Advantage plan;¶
(C) The option to enroll with a CCO even if the client withdrew from the CCO's Medicare Advantage plan.¶

(e) The CCO shall accept the client's enrollment if the CCO has adequate health access and capacity;¶
(f) CCO care coordination and communication requirements to reduce duplication of care planning activities in OAR 410-141-3860 and 410-141-3870 are required regardless of the member's choices in Medicare and Medicaid enrollments.¶
(15) The Authority may temporarily exempt clients for other just causes as determined by the Authority through medical review. The Authority may set an exemption period on a case-by-case basis for those as follows:¶
(a) Children under 19 years of age who are medically fragile and who have special health care needs. The Authority may enroll these children in CCOs on a case-by-case basis. Children not enrolled in a CCO shall continue to receive services on a FFS basis;¶
(b) The following apply to clients and exemptions relating to organ transplants:¶
(A) Newly eligible clients are exempt from enrollment with a CCO if the client is newly diagnosed and under the treatment protocol for an organ transplant;¶
(B) Newly eligible clients with existing transplants are not exempt from enrollment unless the Authority determines there are other just causes to preserve the continuity of care.¶
(16) MCE enrollment standards:¶
(a) MCEs shall remain open for enrollment unless the Authority has closed enrollment. Reasons for closing enrollment may include:¶
(A) The MCE has exceeded its enrollment limit or does not have sufficient capacity to provide access to services, as mutually agreed upon by the Authority and the MCE;¶
(B) Closed enrollment as a sanction for MCE misconduct.¶
(b) MCEs shall accept all eligible potential members, regardless of health status at the time of enrollment, subject to the stipulations in contracts/agreements with the Authority to provide covered services;¶
(c) MCEs may confirm the enrollment status of a client by one of the following:¶
(A) The individual's name appears on the monthly or weekly enrollment list produced by the Authority;¶
(B) The individual presents a valid medical care identification that shows the ~~or she is~~y are enrolled with the MCE;¶
(C) The Automated Voice Response (AVR) verifies that the individual is currently eligible and enrolled with the MCE;¶
(D) An appropriately authorized staff member of the Authority states that the individual is currently eligible and enrolled with the MCE.¶
(d) MCEs shall have open enrollment for 30 continuous calendar days during each 12-month period of January through December, regardless of the MCE's enrollment limit. The open enrollment periods for consecutive years may not be more than 14 months apart.¶
(17) If the Authority permits an MCE to assign its contract to another MCE, members shall be automatically enrolled in the MCE that has assumed the contract:¶
(a) Each member will have 30 calendar days from the date of notice of enrollment to request disenrollment from the MCE that has assumed the contract;¶
(b) If the MCE that has assumed the contract is a Medicare Advantage plan, those members who are Medicare beneficiaries shall not be automatically enrolled but shall be offered enrollment in the succeeding MCE.¶
(18) If an MCE engages in an activity such as the termination of a participating provider or participating provider group that has significant impact on access in that service area such that the MCE cannot meet the access to care requirements set forth in OAR 410-141-3515 and which necessitates either transferring members to other providers or the MCE withdrawing from part or all of a service area, the MCE shall provide the Authority at least 90 calendar days written notice prior to the planned effective date of such activity:¶
(a) An MCE may provide less than the required 90-calendar-day notice to the Authority upon approval by the Authority when the MCE must terminate a participating provider or participating provider group due to problems that could compromise member care, or when such a participating provider or participating provider group terminates its contract with the MCE and refuses to provide the required 90-calendar-day notice;¶
(b) The MCE shall provide members with at least a 30-calendar-day notice of such changes. In the event the MCE is not available to provide members with notice of a change in participating providers or MCE, the Authority shall instead notify members of a change in participating providers or MCEs. In such instances the MCE shall provide the Authority with the name, prime number, and address label of the members affected by such changes at least 30 calendar days prior to the planned effective date of such activity.
Statutory/Other Authority: ORS 413.042, ORS 414.065
Statutes/Other Implemented: ORS 414.065, 414.727

AMEND: 410-200-0015

RULE SUMMARY: The Authority is updating sections 0000,1210, and 1280 of division 120, to move the CWM program rules to its own division. The Authority is creating a new rule division in Chapter 410, division 134 to define CWM emergency and State funded wrap-around supplemental benefits for recipients. Division 141, revised to add Healthier Oregon Program (HOP) to MCE. Division 200, sections 0015 and 0240, revised to clarify definitions and eligibility criteria related to HOP. Division 125, section 0230, revised to address appropriate funding. Division 121 revised to include emergency medication for CWM.

CHANGES TO RULE:

410-200-0015
General Definitions ¶

(1) "Action" means a termination, suspension, denial, or reduction of Medicaid or CHIP eligibility or covered services.¶
(2) "Active renewal" means the renewal process for cases that are not processed via automated renewal wherein a prepopulated renewal notice is sent to the head of household and authorized representative, if applicable. The active renewal notice is populated with the most current case information relevant to renewal.¶
(3) "Address Confidentiality Program (ACP)" means a program of the Oregon Department of Justice that provides a substitute mailing address and mail forwarding service for ACP participants who are victims of domestic violence, sexual assault, or stalking.¶
(4) "AEN" means Assumed Eligible Newborn (OAR 410-200-0115).¶
(5) "Affordable Care Act" means the Patient Protection and Affordable Care Act of 2010 (Pub. L. 111-148), as amended by the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111-152), as amended by the Three Percent Withholding Repeal and Job Creation Act (Pub. L. 112-56).¶
(6) "Agency" means the Oregon Health Authority and Department of Human Services.¶
(7) "Applicant" means an individual who is seeking an eligibility determination for themselves or someone for whom they are applying through an application submission or a transfer from another agency, insurance affordability program, or the FFM.¶
(8) "Application" means:¶
(a) The single streamlined application for all insurance affordability programs developed by the Authority or the FFM; or¶
(b) An application designed specifically to determine eligibility on a basis other than the applicable MAGI standard, submitted by or on behalf of the individual who may be eligible or is applying for assistance on a basis other than the applicable MAGI standard.¶
(9) "APTC" means advance payments of the premium tax credit, which means payment of the tax credits specified in section 36B of the Internal Revenue Code (as added by section 1401 of the Affordable Care Act) that are provided on an advance basis to an eligible individual enrolled in a QHP through an Exchange in accordance with sections 1402 and 1412 of the Affordable Care Act.¶
(10) "Assumed eligibility" means an individual is deemed to be eligible for a period of time based on receipt of another program benefit or because of another individual's eligibility.¶
(11) "Authorized Representative" means an individual at least 18 years of age or organization that acts on behalf of an applicant or beneficiary in assisting with the individual's application and renewal of eligibility and other on-going communications with the Agency (OAR 410-200-0111).¶
(12) "Automated renewal" means a renewal of eligibility, initiated by the Agency, based on reliable information contained in the beneficiary's case record, using the Federal Data Services Hub and automated electronic verification sources available to the agency to perform data matches for the sake of verifying eligibility criteria.¶
(13) "Beneficiary" means an individual who has been determined eligible and is currently receiving HSD Medical Program benefits, Aging and People with Disability medical program benefits, or APTC.¶
(14) "BRS" means Behavior Rehabilitation Services.¶
(15) "Budget month" means the calendar month from which financial and nonfinancial information is used to determine eligibility.¶
(16) "Caretaker" means a parent, caretaker relative, or non-related caretaker who assumes primary responsibility for a child's care.¶
(17) "Caretaker relative" means an individual with whom the child is living who assumes primary responsibility for the child's care, and who is one of the following:¶
(a) A relative of the dependent child, as follows:¶

(A) A blood or half-blood relative, including parents, siblings, first cousins, nephews, nieces, and individuals of preceding generations as denoted by prefixes of grand, great, or great-great.¶
(B) Stepfather, stepmother, stepbrother, and stepsister.¶
(C) An individual who legally adopts the child and any individual related to the individual adopting the child.¶
(b) The spouse of the parent or relative even after the marriage is terminated by death or divorce;¶
(18) "C~~AWE~~WM" means Citizen~~/Alien-Waived Emergency~~ship Waived Medical, which is Medicaid coverage for emergency medical needs (410-134-0003(1)) for individuals who otherwise meet the financial and non-financial eligibility requirements for an HSD Medical Program, except they do not meet citizenship and/or non-citizen status requirements (OAR 410-200-0240).¶
(19) "C~~AWE~~WM Plus" means medical services for pregnant C~~AWE~~WM beneficiaries (OAR 410-200-0240) and includes:¶
(a) C~~AWE~~WM Plus coverage (410-134-0003(3)) for the duration of the individual's pregnancy; and¶
(b) Reproductive Health Equity ~~Fund~~Act (RHE~~F~~A) coverage (410-134-0003(4)through the end of the calendar month in which the 60th day following the last day of the pregnancy falls.¶
(20) "Child" means an individual including minor parent, under the age of 19. Child does not include an unborn.¶
(21) "Children's Health Insurance Program" also called "CHIP" means Oregon medical coverage under Title XXI of the Social Security Act.¶
(22) "Citizenship" includes status as a "national of the United States" defined in 8 U.S.C. 1101(a) (22) that includes both citizens of the United States and non-citizen nationals of the United States.¶
(23) "Claim" means a legal action or a demand by, or on behalf of, an applicant or beneficiary for damages for or arising out of a personal injury that is against any person, public body, agency, or commission other than the State Accident Insurance Fund Corporation or Worker's Compensation Board.¶
(24) "Claimant" means an individual who has requested a hearing or appeal.¶
(25) "Code" means Internal Revenue Code.¶
(26) "Combined Eligibility Notice" means an eligibility notice that informs an individual, or multiple family members of a household when feasible, of eligibility for each of the HSD Medical Programs for which a determination or denial was made by the Authority.¶
(27) "Community partner" means an individual affiliated with a contracted organization who is trained and certified by the Community Partner Outreach Program to provide free assistance to Oregonians with health coverage application and enrollment.¶
(28) "Coordinated content" means information included in an eligibility notice regarding the transfer of the individual's or household's electronic account to another insurance affordability program for a determination of eligibility.¶
(29) "Custodial Parent" means, for children whose parents are divorced, separated, or unmarried, the parent with whom the child lives, with the following considerations:¶
(a) If the child lives part-time with both parents, the parent with whom the child spends most nights is the custodial parent; or¶
(b) If section (a) of this part cannot be determined due to the child spending equal nights with both parents, a court order or binding custody agreement establishing physical custody is used to identify the custodial parent.¶
(30) "Cover All Kids" refers to the OHP Plus-equivalent benefit (410-134-0003(5)) provided to children who meet all eligibility requirements for MAGI Medicaid/CHIP, except they do not meet the citizen and non-citizen status requirements (OAR 410-200-0240).~~¶~~
(31) "Date of Request" (DOR) means the date on which the applicant or an individual authorized to act on behalf of the applicant contacts the Authority, the Department, or the FFM to request medical benefits.¶
(a) For new applicants, the DOR is established as follows:¶
(A) The date the request for medical benefits is received by the Agency, the FFM, or a community partner; or¶
(B) The date the applicant received a medical service, if the request for medical benefits is received by midnight of the following business day.¶
(b) For current beneficiaries of HSD Medical Programs, the Date of Request is:¶
(A) The date the beneficiary or someone authorized to act on the beneficiary's behalf reports a change requiring a redetermination of eligibility;¶
(B) The month an individual ages off a medical program.¶
(C) For Automated Renewals the Date of Request is the date the Agency initiates the Automated Renewal if there is no RFI generated; or¶
(D) For Active Renewals, and for Automated Renewals which result in the generation of an RFI, the Date of Request is the date on which the Agency receives a response to the Active renewal or RFI.¶
(c) The request may be submitted via the Internet, by telephone, community partner, by mail, by electronic communication, or in person.¶
(32) "Decision notice" means a written notice of a decision made regarding eligibility for an HSD Medical Program

benefit. A decision notice may be a:¶
(a) "Basic decision notice" mailed no later than:¶
(A) The date of action given in the notice; or¶
(B) When suspending benefits due to incarceration (OAR 410-200-0140), the effective date is the day following the date on which the individual became incarcerated.¶
(b) "Combined decision notice" informs an individual or multiple family members of a household, when feasible, of the eligibility decision made for each of the MAGI insurance affordability programs;¶
(c) "Timely continuing benefit decision notice" informs the client of the right to continued benefits and is mailed no later than ten calendar days prior to the effective date of the change, except for clients in the Address Confidentiality Program, for whom it shall be mailed no later than 15 calendar days prior to the effective date of the change.¶
(33) "Department" means the Department of Human Services.¶
(34) "Dependent child" means an individual who:¶
(a) Is under the age of 18 or age 18 and a full-time student in a secondary school or equivalent vocational or technical training, if the individual may reasonably be expected to complete the school or training before attaining age 19.¶
(b) Lives in the home of the parent or caretaker relative; and¶
(c) Is not absent from the home for more than 30 days due to being in foster care while foster care payments are being made.¶
(35) "ELA" (Express Lane Agency)" means the Department of Human Services making determinations regarding one or more eligibility requirements for the MAGI Child or MAGI CHIP programs.¶
(36) "ELE" (Express Lane Eligibility) means the Oregon Health Authority's option to rely on a determination made within a reasonable period by an ELA finding that a child satisfies the requirements for MAGI Child or MAGI CHIP program eligibility.¶
(37) "Electronic account" means an electronic file that includes all information collected and generated by the Agency regarding each individual's Medicaid or CHIP eligibility and enrollment, including all documentation and information collected or generated as part of a fair hearing process conducted by the Authority or the FFM appeals process.¶
(38) "Electronic application" means an application electronically signed and submitted through the Internet.¶
(39) "Eligibility determination" means an approval or denial of eligibility and a renewal or termination of eligibility.¶
(40) "Eligibility Determination Group" (EDG) means all persons whose financial and non-financial information is considered in determining each medical applicant's eligibility as defined in OAR 410-200-0305.¶
(41) "Expedited appeal" also called "expedited hearing" means a hearing held within five working days of the Agency's receipt of a hearing request, unless the claimant requests more time.¶
(42) "Family Size" means the number of individuals used to compare to the income standards chart for the applicable program. The family size consists of all members of the EDG and each unborn child of any pregnant members of the EDG.¶
(43) "Federal Data Services Hub" means an electronic service established by the Secretary of the Department of Health and Human Services through which all insurance affordability programs can access specified data from pertinent federal agencies needed to verify eligibility, including the Social Security Administration composite, the Department of Treasury, and the Department of Homeland Security.¶
(44) "Federal Poverty Level (FPL)" means the federal poverty level updated periodically in the Federal Register by the Secretary of the Department of Health and Human Services under the authority of 42 U.S.C. 9902(2) as in effect for the applicable budget period used to determine an individual's eligibility in accordance with 42 CFR 435.603(h).¶
(45) "Federally Facilitated Marketplace" also called "FFM" means the online marketplace operated by the US Department of Health and Human Services which determines eligibility for Advanced Premium Tax Credit (APTC) and Cost Sharing Reductions (CSR). The FFM also performs eligibility assessments for Oregon Medicaid/CHIP and refers to the Agency electronic accounts of individuals who are found potentially eligible.¶
(46) "Head of household" (HOH) means the primary person the Agency shall communicate with and:¶
(a) Is listed as the case name; or¶
(b) Is the individual named as the primary contact on the application.¶
(47) "Health Systems Division Medical Programs" means all programs under the Health Systems Division including:¶
(a) "EXT" means Extended Medical Assistance. The Extended Medical Assistance program provides medical assistance for a period of time after a family loses its eligibility for the MAA, MAF, or PCR program due to an increase in their spousal support or earned income;¶
(b) "Substitute Care" means medical coverage for children in BRS or PRTF;¶

(c) "BCCTP" means Breast and Cervical Cancer Treatment Program;¶
(d) "FFCYM" means Former Foster Care Youth Medical;¶
(e) "MAGI Medicaid/CHIP" means HSD Medical Programs for which eligibility is based on MAGI methodology, including:¶
(A) MAGI Child;¶
(B) MAGI Parent or Caretaker Relative;¶
(C) MAGI Pregnant Woman;¶
(D) MAGI Children's Health Insurance Program (CHIP);¶
(E) MAGI Adult.¶
(48) "Healthier Oregon Program (HOP)" means an OHP Plus-equivalent benefit (410-134-0003(5) through (7)) for individuals described in 410-200-0240.¶
(49) "Hearing request" means a clear expression, oral or written, by an individual or the individual's representative that the individual wishes to appeal an Authority or FFM decision or action.¶
~~(49) "HSD" means Health Systems Division, Medical Assistance Programs (Division) under the Oregon Health Authority.¶~~
(50) "Inmate" means:¶
(a) An individual residing in a public institution that is:¶
(A) Confined involuntarily in a local, state, or federal prison, jail, detention facility, or other penal facility, including being held involuntarily in a detention center awaiting trial or serving a sentence for a criminal offense;¶
(B) Residing involuntarily in a facility under a contract between the facility and a public institution where, under the terms of the contract, the facility is a public institution;¶
(C) Residing involuntarily in a facility that is under governmental control; or¶
(D) Receiving care as an outpatient while residing involuntarily in a public institution.¶
(b) An individual is not considered an inmate when the individual is:¶
(A) Released on parole, probation, or post-prison supervision;¶
(B) On home- or work-release, unless the individual is required to report to a public institution for an overnight stay;¶
(C) Receiving inpatient care at a medical institution not associated with the public institution where the individual is an inmate. An individual is an inpatient when they've been admitted to a medical institution on the recommendation of a physician, and:¶
(i) Expects to receive room, board, and professional services in the medical institution for a 24-hour period or longer; or¶
(ii) Is expected to meet the criteria outlined in (i) of this part, but later dies, is discharged, or is transferred to another medical or extended care facility and does not actually stay in the medical institution for 24 hours.¶
(D) Residing voluntarily in a detention center, jail, or county penal facility after ~~his or he~~their case has been adjudicated and while other living arrangements are being made for the individual~~;~~¶
(E) Residing in a public institution pending other arrangements as defined in 42 CFR 435.1010; or¶
(F) Residing in an Institution for Mental Disease (IMD), including the Oregon State Hospital and:¶
(i) Is under age 21;¶
(ii) Is 21 but was admitted to the IMD before their 21st birthday; or¶
(iii) Is age 65 or older.¶
(51) "Insurance affordability program" means a program that is one of the following:¶
(a) Medicaid;¶
(b) CHIP;¶
(c) A program that makes coverage available in a qualified health plan through the FFM with advance payments of the premium tax credit established under section 36B of the Internal Revenue Code available to qualified individuals;¶
(d) A program that makes coverage available in a qualified health plan through the FFM with cost-sharing reductions established under section 1402 of the Affordable Care Act.¶
(52) "Legal argument" has the meaning given that term in OAR 137-003-0008(c).¶
(53) "Medicaid" means Oregon's Medicaid program under Title XIX of the Social Security Act.¶
(54) "MAGI" means Modified Adjusted Gross Income and is used in determining eligibility based on annual income as described in 410-200-0310(4). MAGI has the meaning provided at IRC 36B(d)(2)(B) and generally means federally taxable income with the following exceptions:¶
(a) The income of the following individuals is excluded when they are not expected to be required to file a tax return for the tax year in which eligibility is being determined. This subsection applies whether or not the child or tax dependent actually files a tax return:¶
(A) Children, regardless of age, who are included in the household of a parent;¶
(B) Tax dependents.¶

(b) In applying subsection (a) of this section, IRC 6012(a) (1) is used to determine who is required to file a tax return.¶
(55) "MAGI-based income" means income calculated using the same financial methodologies used to determine MAGI as defined in section 36B(d)(2)(B) of the Code with the following exceptions:¶
(a) An amount received as a non-recurring lump sum, if taxable, is counted as income only in the month received.¶
(b) Scholarships, awards, or fellowship grants used for education purposes and not for living expenses are excluded;¶
(c) Income from the following American Indian and Alaska Native sources is excluded:¶
(A) Distributions from Alaska Native Corporations and Settlement Trusts;¶
(B) Distributions from any property held in trust, subject to federal restrictions, located within the most recent boundaries of a prior federal reservation or otherwise under the supervision of the Secretary of the Interior;¶
(C) Distributions and payments from rents, leases, rights of way, royalties, usage rights, or natural resource extraction and harvest, including farming, from:¶
(i) Rights of ownership or possession in any lands described in subsection (c)(B) of this part; or¶
(ii) Federally protected rights regarding off-reservation hunting, fishing, gathering, or usage of natural resources.¶
(D) Distributions resulting from real property ownership interests related to natural resources and improvements:¶
(i) Located on or near a reservation or within the most recent boundaries of a prior federal reservation; or¶
(ii) Resulting from the exercise of federally protected rights relating to such real property ownership interests.¶
(E) Payments resulting from ownership interests in or usage rights to items that have unique religious, spiritual, traditional, or cultural significance or rights that support subsistence or a traditional lifestyle according to applicable tribal law or custom;¶
(F) Student financial assistance provided under the Bureau of Indian Affairs education programs.¶
(56) "Minimum Essential Coverage" (MEC) means medical coverage under:¶
(a) A government-sponsored plan, including Medicare Part A, Medicaid (excluding C~~AWE~~WM), CHIP, TRICARE, the veterans' health care program, and the Peace Corps program;¶
(b) Employer-sponsored plans with respect to an employee, including coverage offered by an employer that is a government plan, any other plan or coverage offered in the small or large group market within the state, and any plan established by an Indian tribal government;¶
(c) Plans in the individual market;¶
(d) Grandfathered health plans; and¶
(e) Any other health benefits coverage, such as a state health benefits risk pool, as recognized by the HHS secretary in coordination with the Treasury Secretary.¶
(57) "Non-applicant" means an individual not seeking an eligibility determination for themselves and is included in an applicant's or beneficiary's household to determine eligibility for the applicant or beneficiary.¶
(58) "Non-citizen" has the meaning given the term "alien" as defined in section 101(a)(3) of the Immigration and Nationality Act (INA), (8 U.S.C. 1101(a)(3)) and includes any individual who is not a citizen or national of the United States, defined at 8 U.S.C. 1101(a)(22).¶
(59) "OSIPM" means Oregon Supplemental Income Program Medical. Medical coverage for elderly and disabled individuals administered by the Department of Human Services, Aging and People with Disabilities and Developmental Disabilities.¶
(60) "Parent" means a natural or biological, adopted, or stepparent.¶
(61) "Personal Injury" means a physical or emotional injury to an individual including, but not limited to, assault, battery, or medical malpractice arising from the physical or emotional injury.¶
(62) "Primary Contact" has the same meaning given "head of household" in this rule.¶
(63) "PRTF" means Psychiatric Residential Treatment Facility.¶
(64) "Public institution" means any of the following:¶
(a) A state hospital (ORS 162.135);¶
(b) A local correctional facility (ORS 169.005), a jail, or prison for the reception and confinement of prisoners that is provided, maintained, and operated by a county or city and holds individuals for more than 36 hours;¶
(c) A Department of Corrections institution (ORS 421.005), a facility used for the incarceration of individuals sentenced to the custody of the Department of Corrections, including a satellite, camp, or branch of a facility;¶
(d) A youth correction facility (ORS 162.135):¶
(A) A facility used for the confinement of youth offenders and other individuals placed in the legal or physical custody of the youth authority, including a secure regional youth facility, a regional accountability camp, a residential academy and satellite, and camps and branches of those facilities; or¶
(B) A facility established under ORS 419A.010 to 419A.020 and 419A.050 to 419A.063 for the detention of children, wards, youth or youth offenders pursuant to a judicial commitment or order.¶
(e) As used in this rule, the term public institution does not include:¶

(A) A medical institution as defined in 42 CFR 435.1010 including the Secure Adolescent Inpatient Program (SAIP) and the Secure Children's Inpatient Program (SCIP);¶
(B) An intermediate care facility as defined in 42 CFR 440.140 and 440.150; or¶
(C) A publicly operated community residence that serves no more than 16 residents, as defined in 42 CFR 435.1009.¶
(65) "Qualified hospital" means a hospital that:¶
(a) Participates as an enrolled Oregon Medicaid provider;¶
(b) Notifies the Authority of their decision to make presumptive eligibility determinations;¶
(c) Agrees to make determinations consistent with Authority policies and procedures;¶
(d) Informs applicants for presumptive eligibility of their responsibility and available assistance to complete and submit the full Medicaid application and to understand any documentation requirements; and¶
(e) Are not disqualified by the Authority for violations related to standards established for the presumptive eligibility program under 42 CFR □ 435.1110(d).¶
(66) "Reasonable opportunity period:"¶
(a) May be used to obtain necessary verification or resolve discrepancy regarding US citizenship or non-citizen status;¶
(b) Begins on and shall extend 90 days from the date on which notice is received by the individual. The date on which the notice is received is considered to be five days after the date on the notice, unless the individual shows they did not receive the notice within the five-day period;¶
(c) May be extended beyond 90 days if the individual is making a good faith effort to resolve any inconsistencies or obtain any necessary documentation or the Agency needs more time to complete the verification process.¶
(67) "Redetermination" means a review of eligibility outside of regularly scheduled renewal. Redeterminations that result in the assignment of a new renewal date are considered renewals.¶
(68) "Renewal" means a regularly scheduled periodic review of eligibility.¶
(69) "Request for information (RFI)" means a notice sent by the agency to request additional information or verification of information. An RFI may be sent when attested information is not reasonably compatible with information obtained through an electronic data match, or when information or verification is needed that is not available through an electronic data match.¶
(70) "Secure electronic interface" means an interface which allows for the exchange of data between Medicaid or CHIP and other insurance affordability programs and adheres to the requirements in 42 CFR part 433, subpart C.¶
(71) "Shared eligibility service" means a common or shared eligibility system or service used by a state to determine individuals' eligibility for insurance affordability programs.¶
(72) "Sibling" means natural or biological, adopted, or half or step sibling.¶
(73) "Spouse" means an individual who is legally married to another individual under:¶
(a) The statutes of the state where the marriage occurred;¶
(b) The common law of the state in which two individuals previously resided while meeting the requirements for common law marriage in that state; or¶
(c) The laws of a country in which two individuals previously resided while meeting the requirements for legal marriage in that country.¶
(74) "SSA" means Social Security Administration.¶
(75) "Tax dependent" has the meaning given the term "dependent" under section 152 of the Internal Revenue Code, as an individual for whom another individual claims a deduction for a personal exemption under section 151 of the Internal Revenue Code for a taxable year.¶
(76) "Title IV-E" means Title IV-E of the Social Security Act (42 U.S.C. □□ 671-679b).
Statutory/Other Authority: ORS 411.095, 411.402, 411.404, 413.038, 414.025, 414.534
Statutes/Other Implemented: ORS 411.095, 411.402, 411.404, 413.038, 414.025, 414.534, 411.400, 411.406, 411.439, ~~411.443,~~ 413.032, 414.231, ~~414.447,~~ 414.536, 414.706

AMEND: 410-200-0240

RULE SUMMARY: The Authority is updating sections 0000,1210, and 1280 of division 120, to move the CWM program rules to its own division. The Authority is creating a new rule division in Chapter 410, division 134 to define CWM emergency and State funded wrap-around supplemental benefits for recipients. Division 141, revised to add Healthier Oregon Program (HOP) to MCE. Division 200, sections 0015 and 0240, revised to clarify definitions and eligibility criteria related to HOP. Division 125, section 0230, revised to address appropriate funding. Division 121 revised to include emergency medication for CWM.

CHANGES TO RULE:

410-200-0240
Eligibility for Individuals Who Do Not Meet the Citizen and Non-Citizen Status Requirements ¶

(1) Citizen~~/Alien~~ship Waived ~~Emergency~~ Medical (C~~AWEM) provides coverage for emergency services. ¶~~
~~(a) With the exception of subsection (b) below, t~~WM). To be eligible for CWM benefits, an individual must meet all eligibility requirements for an HSD Medical Program, except they do not meet the Citizen and Non-Citizen Status Requirements (OAR 410-200-0215).¶
(2) Citizenship Waived Medical Plus (CWM Plus). To be eligible for C~~AWEM~~WM Plus benefits, an individual must:¶
(~~A~~a) Be age 19 or older;¶
(b) Be pregnant; and¶
(~~B~~c) ~~Be ineligible for Plus level HSD Medical Program benefits solely because he or she does~~Meet all eligibility requirements for an HSD Medical Program, except they do not meet the Citizen and Non-Citizen Status Requirements (OAR 410-200-0215).¶
(~~b~~3) ~~Children under age 19 are eligible for CAWEM benefits through December 31, 2017, if the requirement outlined in section (1)(a)(B) is met.¶~~
~~(2) Citizen/Alien Waived Emergency Medical Plus (CAWEM Plus) provides: ¶~~
~~(a) CAWEM Plus benefits provide an enhanced benefit package (OAR 410-120-1210) for the duration of a recipient's pregnancy:¶~~
~~(A) To be eligible for the CAWEM Plus benefits~~over All Kids (CAK) or Healthier Oregon Program (HOP) children provides the OHP Plus-equivalent benefit package (OAR 410-134-0003). To be eligible, an individual must:¶
(~~i~~a) ~~With the exception of paragraph (B) of this part, b~~Be under the age ~~19 or older;¶~~
~~(ii) Be pregnant; and¶~~
~~(iii) Be ineligible for Plus level~~of 19; and¶
(b) Meet all eligibility requirements for an HSD Medical Program~~s solely because~~, except they do not meet the Citizen and Non-Citizen Status Requirements (OAR 410-200-0215).¶
(~~B~~4) ~~Children under age 19 are eligible for CAWEM Plus benefits through December 31, 2017, if the requirements outlined in (2)(a)(A) are met;¶~~
~~(C) CAWEM Plus benefits end as follows:¶~~
~~(i) CAWEM Plus benefits continue through and end on the last day of the pregnancy; and¶~~
~~(ii) Through March 31, 2018, the individual remains eligible for CAWEM benefits through the end of the calendar month in which the 60th day following the last day of the pregnancy falls (see~~ Healthier Oregon Program (HOP) benefits are available effective July 1, 2022.¶
(a) To be determined eligible for HOP benefits, an individual must:¶
(A) Be age 19 through age 25; or¶
(B) Be age 55 or older; and¶
(C) Meet all eligibility requirements for an HSD Medical Program, except they do not meet the Citizen and Non-Citizen Status Requirements (OAR 410-200-02~~13~~5).¶
(b) ~~Reproductive Health Equity Fund (RHEF) benefits, effective April 1, 2018, provide an enhanced benefit package (OAR 410-120-1210) and begin on the day following the pregnancy end-date:¶~~
~~(A) An individual is eligible for RHEF benefits through the end of the calendar month in which the 60th day following the last day of the pregnancy falls;¶~~
~~(B) An individual who is receiving CAWEM benefits under section (2)(a)(C)(ii) of this rule shall receive RHEF benefits effective April 1, 2018, through the end of the month in which the 60th day following the last day of the pregnancy falls.¶~~
~~(3) Effective January 1, 2018, Cover All Kids provides the OHP Plus-equivalent benefit package (OAR 410-120-1210). To be eligible for Cover All Kids~~HOP recipients who no longer meet the age requirements described in

section (a) of this part:¶
(A) Shall maintain HOP coverage if they continue to meet all other financial and non-financial eligibility criteria; or¶
(B) Who lose eligibility due to failure to respond at renewal, they may regain HOP eligibility if they respond within the 90-day reconsideration period (OAR 410-200-0110(g)) and meet all other financial and non-financial eligibility criteria.¶
(5) HOP pregnant Adult benefits are available effective July 1, 2022.¶
(a) To be determined eligible for HOP benefits, an individual must:¶
(~~a~~A) Be ~~under the age of 19~~age 19 through age 25; or¶
(B) Be age 55 or older; and¶
(~~b~~C) Meet all eligibility requirements for an HSD Medical Program, except they do not meet the Citizen and Non-Citizen Status Requirements (OAR 410-200-0215).¶
(b) If a HOP recipient described in section (a) of this part no longer meets the age requirement, they shall maintain HOP eligibility so long as they continue to meet all other financial and non-financial eligibility criteria.¶
(c) Be pregnant.
Statutory/Other Authority: ORS 414.534, ~~ORS 411.060, ORS~~411.402, 411.40~~2~~4, ORS 411.~~404~~060, 413.042, 414.025
Statutes/Other Implemented: ORS 414.534, ORS 411.400, 411.402, 411.404, 411.406, 411.439,~~411.443,~~ 413.032, 414.025, 414.231,~~414.447, 414.534,~~ 414.536, 414.706