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| HEALTH SYSTEMS DIVISIONMedicaid Programs | **Oregon Health Authority wordmark** |
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Fee-for-Service Provider Stability Payments

Fully Reconciled Interim Payment Application Form

Complete this form and submit to: Medicaid.StabilityLoan@dhsoha.state.or.us.

# Point of Contact (required)

OHA will follow up with the designated point of contact if there are any questions about this application, or payment processing. Please provide a point of contact for this application, including:

**Name:** Click or tap here to enter text. **Position:** Click or tap here to enter text.

**Organization:** Click or tap here to enter text.

**Phone:** Click or tap here to enter text. **Email:** Click or tap here to enter text.

# Billing Provider(s) (required)

Please complete the tables below for each billing provider you are including in this application. Add new rows if needed.

## Step 1. Billing Providers

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Billing Provider ID** | **Billing Provider Name** | **Requesting Maximum Monthly Amount? (Y/N)** | ***If not requesting maximum amount, requested monthly$ amount*** | **Payback Option** **(100% or 50%)** |
| Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. |
| Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. |
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You can estimate the maximum monthly amount for each billing provider with the following formula:

 Sum of *monthly Medicaid FFS payments received in CY 2019* ÷ *number of months billed.*

OHA will calculate the maximum amount for each billing provider and will default to the maximum payment for each provider if a lesser amount is not specifically requested above. If a billing provider requests an amount greater than the maximum amount, OHA will only pay the maximum amount.

## Step 2. Requested Months

For each billing provider listed in Step 1, indicate which months in 2020 you are applying for.

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Billing Provider ID** | **March** | **Apr** | **May** | **June** | **July** | **Aug** | **Sept** | **Oct** | **Nov** | **Dec** |
| Click or tap here to enter text. |[ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]
| Click or tap here to enter text. |[ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]

 *The federal public health emergency declaration is currently set to expire at the end of October. If HHS does not extend, no payments can be made for months beyond October.*

*OHA will reconcile requested amounts. If a billing provider has already received payment for services furnished in a requested month, the interim stability payment to be issued for that month will be reduced to account for claims payments already made.*

# Attestation (Required)

|  |  |
| --- | --- |
| [ ]  | By checking this box, the billing providers included in this application agree to continue to provide Medicaid services to Oregon Health Plan members.  |

Billing providers included in this application agree to the terms of the Provider Stability Payment Program, including repaying funds based on later reconciliation.

## Signature

Name Date