Division 120 and 141 Draft Rule Language

Rule(s)	Description of proposed changes
410-120-0000	Updating Definitions, including care coordination, 'Licensed practitioner of the healing arts" (LPHA), to align language and content with CCO contract agreements for HRSN benefits.
410-120-1280	Cleaning up language around 340B entities, and clarifying confusing language
410-120-0045	Clean up confusing language in Section (9)
410-120-1195	No Text. Repeal the rule when no longer needed for anyone wo was on OSIP-MN Medically Needy Program as of January 21, 2003
410-120-1340	Rate increases for OHP providers
410-120-1870	No Text. Repeal Rule, we no longer require Client Premium Payments
410-120-2000	Updates Service Delivery, and Provider Contracting and Credentialing to align with CCO contract agreements for HRSN benefits.
410-141-3510	Updates Service Delivery, and Provider Contracting and Credentialing to align with CCO contract agreements for HRSN benefits.

410-120-0000 Definitions

Summary of Change: Updating Definitions, including care coordination, 'Licensed practitioner of the healing arts" (LPHA), to align language and content with CCO contract agreements for HRSN benefits.

(X) "Adults and Youths Released from Incarceration" means Members released from incarceration within the past 365 calendar days~~-~~, including those released from state and federal prisons, local correctional facilities, juvenile detention facilities, Oregon Youth Authority closed custody corrections, or tribal correctional facilities~~, or immigration detention facilities~~. Eligibility for HRSN Services shall expire on the 366th calendar day after release from a carceral facility.

(X) “Care Coordination” means the act and responsibility of CCOs to deliberately organize a members service, care activities and information sharing among all participants involved with a members care according to the physical, developmental, behavioral, dental and social needs (including Health Related Social Needs and Social Determinants of Health and Equity) of the member.

(X) “HRSN Climate Device Social Risk Factor” means an individual who resides in their own home or non-institutional~~, non-congregate~~ primary residence and for whom an ~~who has a need that will be aided by one of the following devices:~~ air conditioner~~s~~, heater~~s~~, air filtration device~~s~~, portable power ~~supplies~~ supply (PPS~~s~~), and/or mini refrigeration unit~~s~~ is Clinically appropriate as a component of health services, treatment, or prevention.

(X) “HRSN Outreach and Engagement Services” means the activities performed by HRSN Service Providers or Contractor for the purpose of identifying OHP enrolled individuals presumed eligible for HRSN Climate-Related Services.
(a) At a minimum, HRSN Outreach and Engagement Services must include
(A) Contacting and engaging Members who belong to one or more HRSN Covered Populations who are presumed to be eligible for HRSN Climate-Related Services; and
(B) Determining whether the Member is enrolled in the FFS Program or a CCO and, if a CCO, which one.
(b) HRSN Outreach and Engagement activities may also include:
(A) transmitting to the Member’s CCO or to OHA’s FFS Program (or its designated third-party contractor) the partial or complete HRSN Request Form, or information contained within, for HRSN eligibility determination and HRSN Service authorization, and/or
(B) providing HRSN Eligible Members who may have a need for medical, peer, social, educational, legal, or other related services with information and logistical support necessary to connect them with the needed resource and services.

(X) “HRSN Request” means a request from an HRSN Connector organization or individual made to an MCE for the purpose of requesting that the MCE~~-~~ perform an HRSN Eligibility Screening. An HRSN Request is comprised of, at minimum, the name and contact information of the individual being recommended and identification of the anticipated HRSN ~~service~~ Service need. An HRSN Request may

also include confirmation of OHP Medicaid enrollment or confirmation the individual is a Member enrolled in the MCE's CCO (or both), as well as any other information regarding the individual's potential HRSN Eligibility. The MCE's CCO will be required to document its attempts to collect the information needed to determine eligibility.

(X) "HRSN Covered Populations" means Members, except for individuals receiving the BRG service package defined in OAR 410-135-0030, who belong to one or more of the following populations, as further specified in the HRSN Guidance Document:
(a) Adults and Youth Discharged from an Institution for Mental Diseases (IMD);
(b) Adults and Youth Released from Incarceration;
(c) Individuals currently or previously involved in Oregon's Child Welfare system;
(d) Individuals Transitioning to Dual Medicaid and Medicare Status;
(e) Individuals who meet the definitions of either "HUD Homeless" or "At Risk of Homelessness," as such terms are defined by HUD in 24 CFR § 91.5.

(X) "HRSN Eligible" means a Member, except for individuals receiving the BRG service package defined in OAR 410-135-0030, who meets all of the following criteria:
(a) Belongs to at least one of the HRSN Covered Populations;
(b) Has at least one HRSN Clinical Risk Factor applicable to the HRSN Services for which they are being screened;
(c) Has at least one HRSN Social Risk Factor applicable to the HRSN Services for which they are being screened; and
(d) Meets any additional eligibility criteria and requirements that may apply in connection with the specific HRSN Services.

(X) "Individuals Involved with Child Welfare" means Members who are currently, or have previously been, involved in Oregon's Child Welfare System including members who are currently or have previously been:
(a) In foster/substitute care;
(b) Receiving adoption or guardianship assistance or family preservation services; or
(c) The subject of an open child welfare case in any court.

~~(d) This definition is more fully described in the HRSN Guidance Document.~~

(165) "Individuals Transitioning to Dual Status" means Members enrolled in Medicaid who are transitioning to dual status with Medicare and Medicaid coverage. Members shall be included in HRSN Covered Population for the ninety (90) calendar days preceding the date Medicare coverage is to take effect and 270 calendar days after it takes effect. Eligibility for services must be determined within 270 calendar days after transition to dual status.~~means Members enrolled in Medicaid who are transitioning to dual status with Medicare and Medicaid coverage. Members shall be included in HRSN Covered Population for the ninety (90) calendar days (3 months) preceding the date Medicare coverage is to take effect and the nine (9) months after it takes effect. Eligibility for services must be determined within nine (9) months after transition to dual status.~~

(X) "Licensed practitioner of the healing arts" (LPHA) means any health practitioner who is licensed in the State to diagnose and treat individuals with the physical or mental disability or functional limitations at issue, and operating within the scope of practice defined in State law.

410-120-0045 Applications for Medical Assistance at Provider locations
Summary of Change: Clean up confusing language in Section (9)

(1) The Oregon Health Authority (Authority) allows Division enrolled providers the opportunity to assist patients applying for public and private health coverage offered through the Authority and the Oregon Health Insurance Exchange (OHIX). To apply for this opportunity, providers fill out and submit form OHA 3128, Application Assistance by Provider Staff; this is an addendum to the provider's agreement to provide Medicaid reimbursed services. Once the provider is determined certified by the Authority to provide application assistance, providers shall receive an approval letter, requirements for assister certification, training requirements, and other information.

(2) For purposes of this rule, the provider's practice shall be referred to as a site. Sites can be, but are not limited to, the following:

(a) Hospitals;

(b) Federally qualified health centers/rural health clinics (FQHC/RHCs);

(c) County health departments;

(d) Substance Use Disorder adult and adolescent treatment and recovery centers;

(e) Tribal health clinics;

(f) Family Planning clinics;

(g) Other primary care clinics as approved by the Authority.

(3) The site may sign the Application Assistance by Provider Staff (OHA 3128) addendum indicating the site's willingness to provide on-site application assistance. The addendum outlines site and application assister standards as well as conflict of interest protections. The site shall require employees that will be assisting to participate in mandatory training sessions for application assistance certification. Employees must pass tests before initiating application assistance service. Sites shall ensure that individuals performing application assistance are recertified at appropriate times as set forth by the Authority. For purposes of this rule, certified staff shall be referred to as "application assisters."

(4) Application assisters shall utilize authorized methods to provide enrollment assistance. Regardless of which form of application is used, the application assister shall write the date the application was started and the assister's assigned assister identification number in the appropriate space on the application. Application assisters shall maintain copies of all eligibility verification documents and all records related to enrollment assistance, including the required, current OHA-provided Consent Form for six years, whether in paper, electronic, or other forms in a secure and locked location. Assistance will support patients potentially eligible for public and private health coverage offered through the Authority and OHIX. Sites are not under an obligation to provide application assistance to individuals other than those for whom they are providing service. Once written on the application, the date can never be changed, altered, or backdated.

(5) The application assister shall encourage applicants to provide accurate and truthful information, assist in completing the application and enrollment process, and shall assure that the information contained on the application is complete.

The application assister shall not attempt to pre-determine applicant eligibility or make any assurances regarding the eligibility for public or private health coverage offered through the Authority and OHIX.

(6) The application assister shall provide information to applicants about public medical programs and private insurance products so each applicant can make an informed choice when enrolling into a health insurance product. Language interpreters or interpreter services or referrals must be provided if requested by applicants including linguistically and culturally appropriate materials:

(a) The information given to the applicant shall, at a minimum, include an explanation of the significance of the date of request on the application and a review of public medical programs and private insurance products that are available, provide unbiased health coverage choices and information provided by the Authority or OHIX during the enrollment process, answer questions, and assist in filling out online or paper application forms. The information provided at these sessions may include, but is not limited to, the following:

(A) General eligibility criteria for public and private coverage accessible through the Authority and OHIX;

(B) Health plan choices, criteria, and how to enroll in public medical programs or OHIX private insurance product choices.

(b) The application assister shall make copies of the original eligibility verification documentation required to accompany the application, but not uploaded to ONE applicant portal.

(7) Providers, staff, contracted employees, and volunteers are subject to all applicable provisions under General Rules OAR chapter 410, division 120, and Application Assistance by Provider Staff addendum (OHP 3128):

(a) The application assister shall treat all information they obtain for public medical programs and private insurance as confidential and privileged communications. The application assister may not disclose such information without the written consent of the individual, their delegated authority, attorney, or responsible parent of a minor child or child's guardian. Nothing prohibits the disclosure of information in summaries, statistical or other form, that does not identify particular individuals;

(b) The Authority and sites shall share information as necessary to effectively serve public medical programs and OHIX eligible or potentially eligible individuals;

(c) Personally identifiable health information about applicants and recipients shall be subject to the transaction, security, and privacy provisions of the Health Insurance Portability and Accountability Act (HIPAA) and the administrative rules there under. Sites shall cooperate with the Authority in the adoption of policies and procedures for maintaining the privacy and security of records and for conducting transactions pursuant to HIPAA requirements.

(8) The Authority shall be responsible for the following:

(a) The Authority shall provide training to application assisters on public medical programs and private insurance products, eligibility and enrollment, application procedures, and documentation requirements. The Authority shall set dates and times for these additional training classes as needed, following changes in policy or procedure;

(b) The Authority shall make available public medical programs application forms online and in hard copy (in English, translated languages, and alternative formats), health insurance coverage options, assister identification number instructions, reporting guidance, and other necessary forms;

(c) The Authority shall process all applications in accordance with Authority and OHIX standards;

(d) The Authority shall process completed applications that have satisfactory verification information within the time requirements set forth in the Authority and OHIX policy. In the event of a change in policy, the time for completion of processing shall be changed to the new time requirements.

(9) The Authority shall provide all necessary forms and applications as referenced above at no cost to the site. There are no monetary provisions in this rule for any payment for the performance of work by the site, except for those costs provided under OAR 410-147-0400 and 410-146-0460~~.~~, because there is compensation for Outstationed Outreach Worker (OSOW) activities outlined in OAR 410-147-0400 for FQHC's and RHC's and 410-146-0460 for Indian Health Care Providers (IHCPs). However, the parties acknowledge the exchange and receipt of other valuable considerations in the spirit of cooperation to the benefit of all by collaborating

and authorizing the performance of the work. The Authority does not guarantee a particular volume of business under these rules.

(10) The provider may terminate enrollment at any time as outlined in OAR 410-120-1260(15).

Statutory/Other Authority: ORS 413.042
Statutes/Other Implemented: ORS 414.041

410-120-1280 Billing
Summary of Change: Cleaning up language around 340B entities, and clarifying confusing language

(1) A provider enrolled with the Authority or providing services to a client in an Managed Care Entity (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 (TPL). 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:

Commented [GL1]: Is it possible to be consistent in using either may, shall or must?

Commented [KN2R1]: @Green Maya Theresa- Louise yes! The DOJ Manual gives advice on this, and I can email you

Commented [GL3]: Recommend using either patient, member or client

Commented [GL4]: Would recommend providing definitions for how this rules is using may, shall, and must.

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(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~~ a valid claim (OAR 410-120-0000) 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 (OHP 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 (OAR 410-120-0000~~(254)~~) 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 this rule. Examples of provider error could be things such as required documentation not submitted for a prior

Commented [TM5]: The claim submitted must be a valid claim - if the claim has technical errors it will not pay.

Some provider appear to be interpreting a claim denied due to technical error(s) as the 'service is not a covered service.' the provider then waits the 90-days and bills the OHP client.

Provider's are responsible for reviewing and correcting any errors in a claim.

Commented [TM6]: to improve understanding of this rule, recommend HSD select a term and use it consistently throughout the rule. Some places in the rule use 'agreement to pay' others use 'agreement to pay form' and others include the form numbers.

authorization, or a prior authorization not submitted, or an error in the information or billing codes the provider listed on the claim.

(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; therefore, the provider is now unable to ~~may 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 to the appropriate payor has passed. The provider shall verify eligibility of the client 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 each attempt~~s~~ 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) Citizenship Waived Medical (CWM) Benefits Package recipients prior to June 30, 2023, that received services that are not part of the CWM emergency only benefits, must have signed the provider-completed Agreement to Pay OHP form 3165, 3166 or 4109. CWM Benefits Package coverage, limitations, and billing guidance found in OAR 410-134-0005.

(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 agreement to pay form OHP 3165 pursuant to section (5)(h) of this rule before providing these services to the client;

(f) The client has requested to privately pay for services denied as not meeting the prior authorization, HERC or other criteria. The provider shall ~~Refer to~~ provide to

Commented [KN7]: AT-_Several recommendations added to paragraph (5) for HSD consideration.
Edits are technical corrections to preserve the intent of the requirements in this section.

Recommend HSD consider a more comprehensive rule review/update and RAC process in 2024 to make improvements to this section. There are many in member/advocate community who have very strong opinions about these requirements. There are many providers who abuse and fail to follow these requirements.

Rule update process will need adequate time to consider how to address community needs, balance provider needs, and not overreach OHA authority.
JA- Its is up to HSD if they want to have this with a deeper review however I want to remind you that this was changed when the legislature passed a law that resulted in ORS 414.066 so I'm not sure which aspects OHA could take input on. OHA would have no authority to alter the specifics from that law regardless of provider/advocate input and DOJ was involved when we made the changes because of the law change. That being said I don't have an opinion on whether you want to have it reviewed based upon the law.RgeT

Commented [KN8]: The language can be more clear, and still comply with statute. "If DOJ wanted to clarify, then it wasn't clear to begin with." AT

Commented [KN9]: Since the provider missed the opportunity, the provider cannot bill

Commented [KN10]: "The provider is unable to bill"

Commented [TM11]: client must give the TPL payment to the provider. provider must accept this as payment in full. no bill can be submitted to client or OHA for any additional payment.

the client all required information for a ~~-~~non-covered service~~s~~ 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 the following:

(A) The requested service is a covered service, and the appropriate payer (the Authority, MCE, or third-party payer) may pay the provider in full for the covered service; and

(B) The estimated total cost of the covered service, including all related charges and~~,~~ the amount that the appropriate payer (Authority or MCE) ~~may~~ pays for the covered service, and that the provider ~~may~~ shall not bill the client for an amount greater than the amount the appropriate payer ~~may~~ pays; and

(C) That the client knowingly and voluntarily agrees to pay for the covered service; and

(D) The provider shall document~~s~~ in writing the date and time in the client's medical record ~~, signed by the client or the client's representative~~, indicating that:

(i) The provider gave the client or the client's authorized representative the information described in section (5)(g)(A-C) of this rule; and

(ii) The client had an opportunity to ask questions, obtain additional information, and consult with the client's caseworker or client representative; and

(iii) The client agreed to privately pay for the covered service by signing an agreement to pay form (OHP 3165, 3166, 4109) ~~and provider assures they have given all of the information described above~~; and

(iv) The provider ~~must~~ shall give a copy of the signed and dated agreement to pay form (OHP 3165, 3166, 4109) to the client and keep a copy of the form in the client's medical record. A provider ~~may~~ shall not submit a claim for payment for covered services to the Authority or to the client's MCE or a third-party payer that is subject to the agreement.

Commented [KN12]: The word may is legally correct per the DOJ Manual appendix b - if we are not going to use the word "may" what is an alternative that is not confusing? "would otherwise" is a too confusing/ wordy. What is another option?

Commented [TM13]: AT - Paragraphs (g) (A) through (C) are the required information that the provider must give each client. This is documented by the client signing the agreement to pay form (addressed in (D)).

JA- Not clear what the recommendation is here but it is correct that it outlines what is now on the forms. The rule was promulgated before HSD had a specific form so we needed to specify what was required to be in their chart in order to bill a Medicaid client. I would leave it as it is until/unless HSD is going to require the specific forms for non covered and a specific form for covered but request for private pay services.

Commented [TM14]: AT- If HSD wants to include a clarification on the translation requirement - this requirement could be incorporated into the (g) and (h) subparagraphs for the covered and the non-covered services and the CWM (d).

Alternative approaches may include adding the requirement as its own subparagraph under paragraph (3) or (5). Or as its own numbered paragraph.

JA- It could also be a check box included in the forms themselves. There is already a rule that requires interpreter services 410-120-0001 so seems redundant to add it into 1280 rule again. If you wanted to keep (I) you could simply say At a minimum you could just reflect Before billing a client the provider shall provide translation or interpretation services subject to OAR 410-120-0001.

Commented [TM15R14]: Jessie's recommendation would definitely work for translation services; however, it would not address getting a translated copy of the OHP form. recommend rule also address forms provided in other languages.

Commented [TM16]: I did not double check the form numbers. are these still current?

Commented [TM17]: AT -- this agreement (g)(D) *is* the form OHP 3165, 3166, or 4109. The member cannot be required by a provider to sign any other 'agreement' to pay form or document. Only the form OHP 3165, 3166, or 4109 (created by OHA) is considered valid.

may create a loophole that would allow a provider to require the member to sign *another* or *alternate* document in which the member is "agreeing" to pay for a service.

JA- I agree, The request to privately pay should be left as it is until HSD decides to have a required form for these or revises the non covered form to incorporate both.

(h) the services is a ~~N~~non-covered service~~s~~ 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 provider shall provide to the client of all of the following:
(A) The information in this rule section (5)(g)(A-C) for the non-covered service; and
(D) the provider shall document in writing in the clients record that:
(i) The provider gave the client the information described in section (5)(g)(A-C) of this rule; and
(E) the client must sign and date the provider-completed a~~A~~greement to p~~P~~ay form (OHP 3165, 3166, or 4109) or a facsimile containing all of the information and elements of the 3165 or 3166 as shown in Table 3165, 3166, or 4109 of this rule~~:~~.
(i) The completed agreement to pay form (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.
(ii) For some long-term services, such as labor and delivery, a single form can span the duration of the pregnancy.
(iii) Providers must make a copy of the completed agreement to pay form (OHP 3165, 3166 or 4109) ~~form~~ or facsimile available to the Authority or MCE upon request.

(i) For clients agreeing to pay for services under this rule section (5) who are limited English proficient, who are deaf, or hard of hearing, the provider shall provide translation or interpretation services. This includes but is not limited to providing the following without limitation:
a) Written documents in appropriate languages; and
b) Interpreter services consistent with OAR 410-120-0001.

(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, code guidelines, and parentheticals related to the code. Federal Code Set

Commented [TM18]: AT- The information required for billing a client for non-covered services should be identical to the information provided to a client for a covered service. Recommend HSD ensure that the rule is clear that the information required is the same.

JA- as stated earlier the request to privately pay for a covered service is rule language included before the forms were developed and required to be used. You may want to consider developing a form for these and yest the specifics should be the same with the exception that one is for a non covered service and the other is specific to those services that a client request to privately pay.

Commented [TM19R18]: suggested language for adding reference to the information required to be provided for covered services to ensure clients get the same information regardless of whether the service is covered or not.

Commented [TM20]: is there another word that OHA could select that is better aligned with current speech/terminology?

based on internal questions from HSD staff and DOJ - there may be some misunderstanding of what facsimile means in this context.

Commented [TM21]: AT-These forms are used in investigations and audits by OPI, MCEs and other state and federal regulators. Recommend the rule require the provider to keep a copy of the form in the client's medical records.

JA-The intent is for the provider to keep it with their records in case of an audit and this is generally verbalized but I agree it would be good to have it in writing within the rule.

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requirements are mandatory as part of the National Correct Coding Initiative (NCCI), 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. Providers billing the Authority shall use codes in the appropriate sequency and highest degree of specificity, append the appropriate modifiers, and indicate the appropriate and most specific place of services;

(d) Only codes with limitations or requiring prior authorization are noted in 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 shall 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 as required by OAR 410-120 and program specific rules;

(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 Third Party Liability (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.

(m) 340B covered entities that bill Fee for Service (FFS) or a Coordinated Care Organization (CCO) shall follow OHA's 340B policy in order to avoid "duplicate discounts".

(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 shall 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 shall be supported by the client's medical record and shall ~~must~~ be the code that most accurately describes the services provided. All Providers, including 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, 3166 or 4109.

[ED. NOTE: To view attachments referenced in rule text, click here for PDF copy.]

Statutory/Other Authority: ORS 413.042
Statutes/Other Implemented: ORS 414.025, 414.065 & 414.066

410-120-1340 Payment
Summary: redline for the rate increases for OHP providers that are in 410-120-1340

(1) The Division shall make payment only to the enrolled provider (see OAR 410-120-1260) who actually performs the service or to the provider's enrolled billing provider for covered services rendered to eligible clients.

(2) Division reimbursement for services may be subject to review prior to reimbursement.

(3) The Division sets fee-for-service (FFS) payment rates for the billed services or items. The FFS payment rates are the Division's maximum allowable rates for billed services or items.

(4) The Division reimburses providers for billed services or items at the lesser of:

(a) The amount billed;

(b) The Division's FFS payment rate in effect on the date of service; or

(c) The rate specified in the individual program provider rules.

(5) The amount billed may not exceed the provider's "usual charge" (see definitions 410-120-0000).

(6) The Division's maximum allowable rate setting process uses the following methodology for:

(a) Relative Value Unit (RVU) weight-based rates. The Division updates all CPT/HCPCS codes assigned an RVU weight effective January 1 of each year, based on the annual RVU updates published in the Federal Register:

(A) The Division applies RVU weights as follows:

(i) The Non-Facility Total RVU weight, to professional services not typically performed in a facility;

(ii) The Facility Total RVU weight, to professional services typically performed in a facility.

(B) The Division applies the following conversion factors:

(i) $40.79 for labor and delivery codes (59400-59622);

(ii) $38.76 for neonatal intensive care and pediatric intensive care professional service codes (99468-99480);

(iii) $28.50 for Oregon primary care providers. A current list of primary care CPT, HCPCs, and provider types and specialties ("Oregon Primary Care Providers and Procedure Codes") is available at http://www.oregon.gov/OHA/HSD/OHP/Pages/Providers.aspx;

(iv) $27.11~~25.48~~ for all remaining RVU weight-based CPT/HCPCS codes.

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(C) The Division calculates rates using statewide Geographic Practice Cost Indices (GPCIs) as follows:

(i) (Work RVU) X (Work GPCI) + (Practice Expense RVU) X (Practice GPCI) + (Malpractice RVU) X (Malpractice GPCI). The formula used to create the statewide GPCI is (3*(Portland GPCI) + 33* (Rest of State GPCI))/36 = GPCI.

(ii) The sum in paragraph (C)(i) is multiplied by the applicable conversion factor in section (B) to calculate the rate;

(b) Non-RVU-weight-based rates:

(A) $21.12~~20.78~~ is the base rate for anesthesia service codes 00100-01996. The rate is based on per unit of service;

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(B) Clinical lab codes are 80~~70~~ percent of the Medicare clinical lab fee schedule effective on the date of service;

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(C) All approved Ambulatory Surgical Center procedures are 80 percent of the Medicare fee schedule effective on the date of service;

(D) Physician-administered drugs billed under a HCPCS code are 100 percent of the Medicare rate. The Medicare rate is equal to Average Sales Price (ASP) plus six percent;

(c) When no ASP rate is available, the rate is based upon the Wholesale Acquisition Cost (WAC) provided by First Data Bank;

(d) If no WAC is available, then the rate is the Acquisition Cost. These rates may change periodically based on drug costs;

(e) All procedures used for vision materials and supplies are contracted rates that include acquisition cost plus shipping and handling;

(f) Individual provider rules may specify rates for particular services or items.

(7) The Division reimburses inpatient hospital services under the DRG methodology, unless specified otherwise in the Hospital Services program administrative rules (chapter 410, division 125). Reimbursement for services,

including claims paid at DRG rates, may not exceed any upper limits established by federal regulation.

(8) The Division reimburses all out-of-state hospital services at Oregon DRG or FFS rates as published in the Hospital Services program rules (chapter 410, division 125) unless the hospital has a contract or service agreement with the Division to provide highly specialized services.

(9) Payment rates for in-home services provided through Department of Human Services (Department) Aging and People with Disabilities (APD) may not exceed the costs of nursing facility services unless the criteria in OAR 411-027-0020 have been met.

(10) For services provided by out-of-state institutions and facilities such as skilled nursing care facilities, psychiatric facilities and rehabilitative care facilities, the Division sets rates that are:

(a) Consistent with the rate for similar services provided in Oregon; and

(b) The lesser of the rate paid to the most similar licensed Oregon facility or the rate paid by the other state's Medicaid program; or

(c) Consistent with the rate established by APD for out-of-state nursing facilities.

(11) The Division may not make payment on the following claims:

(a) Assigned, sold or otherwise transferred claims; or

(b) Claims where the billing provider, billing agent, or billing service receives a percentage of the amount billed, amount collected or payment authorized. This includes, but is not limited to, claims transferred to a collection agency or individual who advances money to a provider for accounts receivable.

(12) Nursing facility payments:

(a) The Division may not make a separate payment to a nursing facility or other provider for services included in the nursing facility's all-inclusive rate (OAR 411-070-0085).

(b) The following services are not in the all-inclusive rate and may be reimbursed separately:

(A) Legend drugs, biologicals and hyperalimentation drugs and supplies, and enteral nutritional formula as addressed in the Pharmaceutical Services program administrative rules (chapter 410, division 121) and Home Enteral/Parenteral Nutrition and IV Services program administrative rules (chapter 410, division 148);

(B) Physical therapy, speech therapy, and occupational therapy provided by a non-employee of the nursing facility within the appropriate program administrative rules (chapter 410, division 129 and 131);

(C) Continuous oxygen that exceeds 1,000 liters per day by lease of a concentrator or concentrators as addressed in the Durable Medical Equipment, Prosthetics, Orthotics and Supplies program administrative rules (chapter 410, division 122);

(D) Influenza immunization serum as described in the Pharmaceutical Services program administrative rules (chapter 410, division 121);

(E) Podiatry services provided under the rules in the Medical-Surgical Services program administrative rules (chapter 410, division 130);

(F) Medical services provided by a physician or other provider of medical services, such as radiology and laboratory, as outlined in the Medical-Surgical Services program rules (chapter 410, division 130);

(G) Certain custom fitted or specialized equipment as specified in the Durable Medical Equipment, Prosthetics, Orthotics and Supplies program administrative rules (chapter 410, division 122).

(13) The Division reimburses hospice services based on CMS Core-Based Statistical Areas (CBSAs). A separate payment may not be made for services included in the core package of services as outlined in chapter 410, division 142.

(14) For payment for Division clients with Medicare and full Medicaid:

(a) The Division limits payment to the Medicaid allowed amount, less the Medicare payment, up to the Medicare co-insurance and deductible, whichever is less. The Division's payment may not exceed the co-insurance and deductible amounts due;

(b) The Division pays the allowable rate for covered services that are not covered by Medicare.

(15) For clients with third-party resources (TPR), the Division pays the allowed rate less the TPR payment but not to exceed the billed amount.

(16) The Division payments including contracted Managed Care Entity (MCE) payments, unless in error, constitute payment in full, except in limited instances involving allowable spend-down. For the Division, payment in full includes:

(a) Zero payments for claims when a third party or other resource has paid an amount equivalent to or exceeding Division allowable payment; and

(b) Denials of payment for failure to submit a claim in a timely manner, failure to obtain payment authorization in a timely and appropriate manner, or failure to follow other required procedures identified in the individual provider rules.

(17) Payment by the Division does not restrict or limit the Authority or any state or federal oversight entity's right to review or audit a claim before or after the payment. Claim payment may be denied or subject to recovery if medical review, audit, or other post-payment review determines the service was not provided in accordance with applicable rules or does not meet the criteria for quality of care or medical appropriateness of the care or payment.

410-120-2000
HEALTH RELATED SOCIAL NEEDS SERVICES DELIVERY

Commented [WJL22]: Entirely new rule.

Summary: Updates Service Delivery, and Provider Contracting and Credentialing to align with CCO contract agreements for HRSN benefits.

The purpose of this rule is to establish the processes, standards, and obligations required to be followed or met in administering and delivering Health Related Social Needs (HRSN) Services.
(1)HRSN Services General Requirements; Notices of Availability. HRSN Services are similar to Covered Services (as such word is defined in OAR 410-120-0000); however, HRSN Services are not subject to the medically necessary and appropriate standard for coverage under Oregon Health Plan (OHP) but instead are included in and paid for under OHP in accordance with this rule.
(a) Similarities between HRSN Services and Covered Services include the right of Managed Care Entitiey's (MCEs) to be compensated for the provision of HRSN Services (in accordance with the HRSN Services Fee Schedule) and when Members request HRSN Services eligibility and authorization, the MCE's obligation to provide Members with:
(A) Notices outlined in this rule as well as the same notices, in form and content, that are required for Covered Services such as, for example, notices of Adverse Benefit Determinations under 42 CFR 438.404, and that comply with accessibility requirements under OARs 410-141-3580 and 410-141-3585, and 42 CFR 438.10;
(B) Service Authorizations in accordance with OAR 410-141-3835 (7), (8), (9)(d), (10), (11);
(C) Grievance and Appeal rights under OARs 410-141-3875 through OAR 410-141-3915, OAR 410-120-1860, and 42 CFR Subpart F; and
(D) HRSN Services delivery that complies with the State 1115 Waiver, and in keeping with National Culturally and Linguistically Appropriate Services (CLAS) Standards at https://thinkculturalhealth.hhs.gov/clas/standards.
(b) MCEs shall notify all Members of the availability of HRSN Services, and the process by which they may obtain an HRSN Eligibility Screening, and the standards for authorization of HRSN Services.
(2) Identifying Members of HRSN Covered Populations. The MCE and the Authority shall ensure multiple pathways for Members to be identified as potentially eligible for HRSN Services.
(a) Pathways for identifying potentially eligible Members for HRSN Services must include:

(A) Proactively identifying Members who belong to an HRSN Covered Population and who have at least one HRSN Clinical Risk Factor for an HRSN Service through a review of the MCE or Authority's encounter and claims data.
(B) ~~Engaging~~ Contracting with HRSN Service Providers to conduct HRSN Outreach and Engagement Services to identify Members who belong to an HRSN Covered Population and who also have at least one HRSN Clinical Risk Factor for an HRSN Service and make HRSN Requests;
(C) Engaging with and ~~R~~receiving HRSN Requests from other entities and individuals; and
(D) Accepting the Members' Self-Attestations or referrals.

(b) The MCE and the Authority shall not require HRSN Connectors or HRSN Service Providers to use the MCE's or the Authority's HRSN Request Form template. Instead, the MCE and the Authority must accept the HRSN Request Form used by HRSN Connectors and HRSN Service Providers so long as the HRSN Request Form includes the information necessary for the MCE or, as applicable, the Authority to contact or otherwise determine whether the individual would like to receive HRSN Services and is interested in participating in an HRSN Eligibility Screening.

(3) Screening Members for HRSN Eligibility.
(a) The MCE and the Authority shall make good faith efforts to ensure that all Members who have been identified as potentially eligible for HRSN Services are offered an HRSN Eligibility Screening.

(b) When a Member is referred to an MCE or the Authority by an HRSN Service Provider or Connector that has submitted an HRSN Request Form, the MCE, or as applicable, the Authority, shall conduct HRSN Eligibility Screenings of Members who have been identified as potentially eligible for HRSN Services by collecting the information necessary to determine whether the Member:
(A) Is enrolled in OHP, except not receiving the BRG service package defined in OAR 410-135-0030,
(B) Would like to receive HRSN Services,
(C) Belongs to an HRSN Covered Population,
(D) ~~Has at least one~~Meets Social Risk Factor criteria applicable to the HRSN Services for which they are being screened,
(E) ~~Has at least one~~Meets Clinical Risk Factor criteria applicable to the HRSN Services for which they are being screened, and

(F) Is not receiving the same or substantially similar service from another state, local, or federally funded program

(c) For Members who provide the MCE or the Authority with a Self-Attestation, the MCE and the Authority shall rely on the Self-Attestation to complete the HRSN Eligibility Screening. If the Self-Attestation does not include all the information necessary to complete the HRSN Eligibility Screening the MCE and the Authority shall use good faith efforts to obtain and, as applicable, verify all information necessary to complete the HRSN Eligibility Screening by documenting the Member:

(A) Is enrolled in OHP, except not receiving the BRG service package defined in OAR 410-135-0030,
(B) Would like to receive HRSN Services,
(C) Belongs to an HRSN Covered Population,
(D) ~~Has at least one~~Meets Social Risk Factor criteria applicable to the HRSN Services for which they are being screened,
(E) ~~Has at least one~~Meets Clinical Risk Factor criteria applicable to the HRSN Services for which they are being screened, and
(F) Is or is not receiving the same or substantially similar service from another state, local, or federally funded program.

(d) All efforts to collect information needed to determine HRSN Eligibility must be documented. If the information included in a Member's Self-Attestation cannot, using good faith efforts, be verified within a reasonable period of time the MCE and the Authority shall authorize the identified HRSN Services need(s) if the MCE or, as applicable, the Authority, has a reasonable basis for concluding the Self-Attestation is truthful.

(e) If the potentially eligible individual is not a Member of the OHP, the MCE or the Authority shall connect individuals to resources to determine OHP Eligibility as requested or consented to by the Member
(6) Authorization HRSN Services.
(a) An MCE shall authorize its own Members, and the Authority shall authorize its Fee-for-Service (FFS) Members, to receive HRSN Services if the MCE or, as appliable, the Authority has completed the HRSN Services Screening and determined and documented that the applicable Member:

(A) Is enrolled in OHP, except not receiving the BRG service package defined in OAR 410-135-0030,

(B) Would like to receive HRSN Services,

(C) Belongs to an HRSN Covered Population,

(D) Has determined the HRSN Services are Clinically Appropriate,

(E) ~~Has an~~Meets HRSN Social Risk Factor, criteria and,

(E) Is not receiving the same or substantially similar service from another state, local, or federally funded program.

(b) The Authorization must identify service duration, as appropriate, not to exceed twelve (12) months for an initial authorization, as well as amount and scope in accordance with 42 CFR §438.210.
(c) MCEs and the Authority shall use reasonable efforts to ensure they do not knowingly authorize an HRSN service that is duplicative of a state or federally funded service or other HRSN Service the Member is already receiving.

(d) Document the approval or denial of HRSN Services.

(A) MCEs shall ensure the HRSN Services are furnished to all OHP Members in an amount, duration, and scope that is no less than the amount, duration, and scope for the same HRSN Services furnished to all OHP Members under the Authority's FFS delivery system;

(B) The MCE or, as applicable, the Authority is required to notify the Member of the approval or denial of HRSN Services within fourteen (14) days of the completing the HRSN Services Eligibility Screening.

(C) HRSN Services must be denied if the individual does not meet all the HRSN Eligibility Criteria for the HRSN Services for which they are screened.

(D) All notices of Service Authorization and Denials must:

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Commented [WJL24R23]: OK. Thank you for the info.

(i) State the basis for the approval along with any utilization limitations based on amount, duration, or scope;

(ii) State the basis for denial;

(iii) Comply with OAR 410-141-3835(7), (8), (10), (11); and

(iv) Inform the Member of their Grievance and Appeal rights under OARs 410-141-3875 through 410-141-3915, 410-120-1860, and 42 CFR Subpart F.

(E) The MCE, or as applicable, the Authority is required to notify the HRSN Connector who submitted the HRSN Request of the approval or denial of the HRSN Request through a Closed Loop Referral if the HRSN Connector will be or would have been the HRSN Service Provider.

(e) If an HRSN Eligible Member is authorized for an HRSN Service (HRSN-Authorized Member), then, unless the HRSN-Authorized Member objects to the sharing of their personal information, the MCE or as applicable, the Authority must refer the HRSN-Authorized Member to an HRSN Service Provider that provides the Member's HRSN Service need. The referral must be made through a Closed Loop Referral. If the HRSN-Authorized Member objects to the sharing of their personal information with an HRSN Service Provider, then the HRSN-Authorized Member must be provided with a written referral that they may deliver to the HRSN Service Provider to which they have been referred.

(A) The MCE or, as applicable, the Authority must:

(i) To the extent capacity permits, support the HRSN-Authorized Member's choice of HRSN Service Provider;

(ii) Identify and refer the HRSN-Authorized Member to alternative HRSN Service Providers if needed and available;[1]

(iii) Inform the HRSN-Authorized Member they have the right to direct the MCE or, as applicable, the Authority, to use a different means of communicating with

[1] In accordance with ~~forthcoming~~ Care Coordination requirements ~~to be~~ outlined in OAR 410-141-3860, 410-141-3865, 410-141-3870.

HRSN Service Providers other than technology, like CIE, and still receive HRSN Services; and

(iv) Ensure and document the Member's HRSN Service needs are being and have been met by the HRSN Service Provider in compliance with the Member's HRSN Person-Centered Service Plan.
(7) Confirmation of Climate-Related Supports Required. Prior to making a Closed Loop Referral, the MCE or, as applicable, the Authority must determine availability of the Climate-Related Supports (either devices or any necessary installation or other related service supports, or both) and notify the HRSN-Authorized Member of the anticipated date or time frame that the Climate-Related Supports shall be available. If for any reason there is limited availability of either devices or necessary installation or other related service supports, the MCE shall notify the State of the following information:

(a) There is a limitation of availability of the Climate-Related Supports,

(b) The reason for the limitation, and
(c) The MCE's plan to obtain additional equivalent devices or related service supports or both.
(8) No Subcontracting or Delegation of HRSN Service Authorization and Planning. The MCE shall not subcontract or otherwise Delegate the responsibility for HRSN Service authorization or service planning to an HRSN Service Provider or any other third-party that has involvement in, or responsibility for, denying or authorizing HRSN Services, or service planning for Members. However, for HRSN Climate-Related Support Services only, MCEs may conduct HRSN Eligibility Screening, HRSN Authorization, and HRSN Service planning and provision so long as the MCE has a documented policy and process for safeguarding against conflicts of interest in keeping with the standards set out in 42 CFR 441.730(b)(5)(A).
(9) Person-Centered Service Plan (PCSP). Upon authorization of HRSN Services, the MCE or, as applicable, the Authority and the Member shall update the HRSN-Authorized Member's Care Plan as outlined in OAR 410-141-3870[2] to include an HRSN PCSP for authorized the HRSN Service(s).
(a) The HRSN PCSP shall be in writing and developed with and agreed upon by the Member, the Member's guardian, or both, as applicable.
(b) The HRSN PCSP must include all of the following:

[2] ~~. Revised OAR 410-141-3870 forthcoming~~

(A) The recommended HRSN Service(s),
(B) The authorized HRSN Service duration,
(C) The HRSN Service Provider, supporting member choice of provider
(D) The goals of the HRSN Service(s), identifying other HRSN Services and other OHP services the Member may need, and
(E) The anticipated follow-up and transition plan

(c) The MCE's, or as applicable, the Authority's care management team is responsible for managing the member's HRSN services.~~.~~

(~~a~~d) The MCE or, as applicable, the Authority, shall, at a minimum, have as many meetings as may be necessary to develop the PCSP, but in no event less than one meeting with the Member (or the Member's guardian, or both, as applicable) during development of the PCSP. The meeting with the Member may be held in person, by telephone, or via videoconference. If efforts to have a meeting are unsuccessful, or if the Member declines participation, the MCE or, as applicable, the Authority shall document the attempts and barriers to having a meeting, and justification for continued provision of HRSN Service. At a minimum, MCE or, as applicable, the Authority, will conduct a six (6) month check-in to evaluate or understand whether (a) the HRSN services are meeting the Member's needs, (b) additional/new services are needed if the service duration is longer than six (6) months, and (c) HRSN services are duplicating other services they are receiving.
(f) Regardless of whether the Member participates in the development of the PCSP, they are still entitled to receive the HRSN Services for which they have been authorized.
(g~~c~~) A parent, guardian, or caregiver of a ~~child~~ member may receive HRSN Service(s) on ~~their~~ such ~~child's~~ member's behalf if the parent, guardian, or caregiver lives with the ~~child~~ member and it is in the best interest of the ~~child~~ member as determined through the PSCP.

Missing statutory authorities

410-141-3510
Provider Contracting and Credentialing
Summary: Updates Service Delivery, and Provider Contracting and Credentialing to align with CCO contract agreements for HRSN benefits.

(1) Managed Care Entity's (MCEs) ~~MCEs~~ shall develop policies and procedures for credentialing providers to include quality standards and a process to remove providers from their provider network if they fail to meet the objective quality standards.~~:~~
(a) MCEs shall ensure that all participating providers as defined in OAR 410-141-3500 providing coordinated care services to members are credentialed upon initial contract with the MCE and re-credentialed no less frequently than every three (3) years. The credentialing and re-credentialing process shall include review of any information in the National Practitioners Databank. MCEs shall accept both the Oregon Practitioner Credentialing Application and the Oregon Practitioner Recredentialing Application;
(b) MCEs shall screen their participating providers to be in compliance with 42 CFR 455 Subpart E (42 CFR 455.410 through 42 CFR 455.470) and retain all resulting documentation for audit purposes, except in the following circumstances for credentialing COVID-19 vaccine administration providers for the sole purpose of administering COVID-19 vaccines or the administration of the flu vaccine when administered in conjunction with the COVID-~~-~~19 vaccination. For the purpose of this rule, COVID-19 vaccination administration provider means a healthcare provider that has successfully enrolled with the Authority's Public Health Division to be a COVID-19 vaccination administration provider, completed all required training, and has agreed to all terms of program participation.
(A) MCE~~CCO~~s may rely upon the most recent weekly update of the Authority's active file of vaccine administration providers to meet contractual and regulatory requirements for credentialing COVID-19 vaccine administration providers.
(B) MCE~~CCO~~s may enroll COVID-19 vaccine administration providers who are included in the Authority's most recent active file of vaccine administration providers.
(C) MCE~~CCO~~s shall monitor changes in the Authority's weekly active file of vaccine administration providers for terminations and changes.
(c) MCEs shall screen their contracted HRSN Services Providers to be in compliance with 42 CFR §§ 455.410 through 455.436, 455.450, 455.452, and 455.470, and retain all resulting documentation for audit purposes.

(d) MCEs may elect to contract for or ~~to~~ delegate responsibility for the credentialing and screening processes; however, MCEs~~CCOs~~ shall be solely and ultimately responsible for adhering with all terms and conditions held in its contract with the state. For the following activities including oversight of the following processes regardless of whether the activities are provided directly, contracted, or delegated, MCEs shall:
(A) Ensure that coordinated care services are provided within the scope of license or certification of the participating provider or facility and within the scope of the participating provider's contracted services. They shall ensure participating providers are appropriately supervised according to their scope of practice;
(B) Provide training for MCE staff and participating providers and their staff regarding the delivery of coordinated care services, applicable administrative rules, and the MCEs administrative policies.
(d) The MCE shall provide accurate and timely information to the Authority about:
(A) License or certification expiration and renewal dates;
(B) Whether a provider's license or certification is expired or not renewed or is subject to licensing termination, suspension, or certification sanction;
(C) If an MCE knows or has reason to know that a provider has been convicted of a felony or misdemeanor related to a crime or violation of federal or state laws under Medicare, Medicaid, or Title XIX (including a plea of "nolo contendere");
(D) If an MCE removes a provider or fails to renew a provider's contract if the provider fails to meet objective quality standards.
(e) MCEs may not refer members to or use providers that:
(A) Have been terminated from Medicaid;
(B) Have been excluded as a Medicaid provider by another state;
(C) Have been excluded as Medicare/Medicaid providers by CMS; or
(D) Are subject to exclusion for any lawful conviction by a court for which the provider may~~could~~ be excluded under 42 CFR 1001.101.
(f) MCEs may not accept billings for services to members provided after the date of the provider's exclusion, conviction, or termination. MCEs shall recoup any monies paid for services to members provided after the date of the provider's exclusion, conviction, or termination;
(g) MCEs shall require each atypical provider to be enrolled with the Authority. MCEs shall also require each atypical provider, except HRSN Service Providers, to obtain and use registered National Provider Identifiers (NPIs), and taxonomy codes reported to the Authority in the Provider Capacity Report for purposes of encounter data submission prior to submitting encounter data in connection with

services by the provider. MCEs shall require each qualified provider, except HRSN Service Providers, to have and use an NPI as enumerated by the National Plan and Provider Enumeration System (NPPES),;
(h) The provider enrollment request (for encounter purposes) and credentialing documents require the disclosure of taxpayer identification numbers. The Authority shall use taxpayer identification numbers for the administration of this program including provider enrollment, internal verification, and administrative purposes for the medical assistance program for administration of tax laws. The Authority may use taxpayer identification numbers to confirm whether the individual or entity is subject to exclusion from participation in the medical assistance program. Taxpayer identification number includes Employer Identification Number (EIN), Social Security Number (SSN), and Individual Tax Identification Number (ITIN) used to identify the individual or entity on the enrollment request form or disclosure statement. Disclosure of all tax identification numbers for these purposes is mandatory. Failure to submit the requested taxpayer identification numbers may result in denial of enrollment as a provider and denial of a provider number for encounter purposes or denial of continued enrollment as a provider and deactivation of all provider numbers used by the provider for encounters.
(2) An MCE may not discriminate with respect to participation in the MCE against any health care provider who is acting within the scope of the provider's license or certification under applicable state law on the basis of that license or certification. If an MCE declines to include individual or groups of providers in its network, it shall give the affected providers written notice of the reason for its decision. This rule may not be construed to:
(a) Require that an MCE contract with any health care provider willing to abide by the terms and conditions for participation established by the MCE; or
(b) Preclude the MCE from establishing varying reimbursement rates based on quality or performance measures. For purposes of this section, quality and performance measures include all factors that advance the goals of health system transformation including:
(A) Factors designed to maintain quality of services and control costs and are consistent with its responsibilities to members; or
(B) Factors that add value to the service provided including but not limited to expertise, experience, accessibility, or cultural competence.

(c) The requirements in subsection (2)(b) of this rule do not apply to reimbursement rate variations between providers with the same license or certification or between specialists and non-specialty providers.
(3) An MCE shall establish an internal review process for a provider aggrieved by a decision under section (2) of this rule including an alternative dispute resolution or peer review process. An aggrieved provider may appeal the determination of the internal review to the Authority.
(4) To resolve appeals made to the Authority under sections (2) and (3) of this rule, the Authority shall provide administrative review of the provider's appeal using the administrative review process established in OAR 410-120-1580. The Authority shall invite the aggrieved provider and the MCE to participate in the administrative review. In making a determination of whether there has been discrimination, the Authority shall consider the MCE's:
(a) Network adequacy;
(b) Provider types and qualifications;
(c) Provider disciplines; and
(d) Provider reimbursement rates.
(5) A prevailing party in an appeal under sections (3) through (4) of this rule shall be awarded the costs of the appeal.
(6) MCEs shall not apply any requirement that any entity operated by the IHS, an Indian tribe, tribal organization or urban Indian organization be licensed or recognized under the State or local law where the entity is located to furnish health care services, if the entity meets all the applicable standards for such licensure or recognition. This requirement is pursuant to 25 USC 1621t and 1647a.
(7) MCEs shall not require the licensure of a health professional employed by such an entity under the State or local law where the entity is located, if the professional is licensed in another State.
(8) MCEs shall offer contracts to all Medicaid eligible IHCPs and to provide timely access to specialty and primary care within their networks to MCE enrolled IHS beneficiaries seen and referred by IHCPs, regardless of the IHCPs status as contracted provider within the MCE network.
(9) MCEs shall ensure that all contracted HRSN Service Providers meet the specific provider qualifications to provide HRSN Services to Members who are authorized by the MCEs to receive HRSN Services (HRSN-Authorized Members). Contracted HRSN Service Providers must:
(a) Be accessible to Members, including having the operating hours and the staff necessary to meet the Members' needs.

(b) Demonstrate their ability or experience to effectively serve at least one of OHA's Priority Populations, as defined in ORS 413.042.
(c) Demonstrate they employ or contract with administrative and service delivery staff, who are, as reasonably determined by the MCE, qualified to perform and fulfill the responsibilities of their jobs.
(d) Demonstrate they provide culturally and linguistically appropriate, responsive and trauma-informed services, which includes the ability to:
(A)~~.~~ Supply (i) language interpretation and translation services to those Members who have limited English proficiency, and (ii) American Sign Language (ASL) services for to those Members who require ASL in order to communicate; and
(B) Respond to the cultural needs of the diverse populations they serve by performing services in accordance with National CLAS Standards.
(e) Documented demonstration of a history of responsible financial administration via recent annual financial reports, an externally conducted audit, or other similar documentation.
(f) Meet readiness standards defined by the Authority, including providing the MCE with an attestation of their agreement or ability (or both agreement and ability) to comply with all of the following:
(A) Reporting and oversight requirements established by the Authority or the MCE or, as applicable, both;
(B) All laws relating to information privacy and security applicable to their business;
(C) Compliance with the credentialing obligations under section (1)(c) of this rule;
(D) All obligations related to participating in the Closed Loop Referral process (acceptance and confirmation); and
(E) Invoicing for HRSN Services as agreed upon in their contract with the MCE to provide HRSN Services.
(g) Comply with oversight requirements established by the Authority, or the MCE, (or both as applicable), and all laws relating to privacy and security that are applicable to their business.
(h) Agree to be enrolled as "encounter only" providers in MMIS, OHA's electronic system that processes Medicaid claims. The MCE shall enroll their contracted HRSN Service Providers as "encounter only" providers in MMIS.
(10) It is preferred that MCEs contract with HRSN Service Providers providing Climate-Related Supports that are capable of both delivering and installing Climate-Related Devices. In the event an HRSN Service Provider does not provide

installation services, MCEs shall ensure installation services are also performed by a different qualified HRSN Services Provider or HRSN vendor(s).
(11) MCEs shall, and shall ensure that HRSN Service Providers providing HRSN Outreach and Engagement Services, assign the responsibility for performing HRSN Outreach and Engagement Services to only those staff who have knowledge of principles and methods, as well as the experience and skills that enables them to effectively engage with individuals who are the intended beneficiaries of HRSN Services for the purpose of connecting them to the HRSN Services and other benefits and services that shall meet their needs.

Statutory/Other Authority: ORS 413.042 & ORS 414.065
Statutes/Other Implemented: ORS 414.065 & 414.727