TEMPORARY FILING
INCLUDING STATEMENT OF NEED & JUSTIFICATION
For internal agency use only.

Department of Human Services, Aging and People with Disabilities (APD)		411
Agency and Division Name		Administrative Rules Chapter Number
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FILING CAPTION
(Must be 15 words or fewer)

Extends dialysis services and increases in nursing facility basic and pediatric rates due to COVID-19

Agency Approved Date: [03/09/2022]

Effective Date: [03/28/2022] through [09/23/2022]

RULEMAKING ACTION
List each rule number separately (000-000-0000). Attach clean text for each rule at the end of the filing

AMEND:

411-070-0091; 411-070-0442; 411-070-0452

RULE SUMMARY:
Include a summary for each rule included in this filing.

The Department of Human Services, Aging and People with Disabilities Program is immediately amending rules in OAR chapter 411, division 70 to extend COVID-19 related rate changes to nursing facilities. The Program is also extending dialysis to include Hemodialysis. The amendments include the following:

Amend: 411-070-0091
Rule Title: Complex Medical Add-on Services
Rule Summary: Amends rule to include in-house Hemodialysis in the medication procedures of Complex Medical Add-on services.

Amend: 411-070-0442
Rule Title: Calculation of the Basic Rate, Complex Medical Rate, Bariatric Rate and Ventilator Assisted Program Rate
Rule Summary: Extends the 5% COVID-19 increase from January 1, 2021 through June 30, 2023, for the Medicaid Basic rate.

Amend: 411-070-0452
Rule Title: Pediatric Nursing Facilities
Rule Summary: Extends the 5% COVID-19 increase from January 1, 2021 through June 30, 2023, for the Medicaid Pediatric rate.

STATEMENT OF NEED AND JUSTIFICATION

Need for the Rule(s):

Due to the extraordinary expenses incurred because of the COVID-19 crisis, the Legislature and the Executive Branch extended the five percent rate increase for nursing facilities from March 31, 2022, to June 30, 2023. The Department is amending OAR chapter 411, division 070 to include hemodialysis as a complex medical add-on service and extend increased rates to assist with extraordinary business costs associated with the COVID-19 pandemic.

Justification of Temporary Filing:

Failure to act promptly and immediately amend OAR chapter 411, division 70 could result in death to those severely affected by the COVID-19 virus. To be in compliance with 2022 legislatively approved funding, these rules need to be adopted promptly so that Oregon can serve our vulnerable adults in this pandemic.

Documents Relied Upon, and where they are available:

None.

/s/ Mike McCormick, Interim Director, Aging and People with Disabilities 03/09/2022
Signature Date

OREGON DEPARTMENT OF HUMAN SERVICES
AGING AND PEOPLE WITH DISABILITIES
OREGON ADMINISTRATIVE RULES

CHAPTER 411
DIVISION 70

NURSING FACILITIES/MEDICAID – GENERALLY AND REIMBURSEMENT

Nursing Facilities/Medicaid – Generally

411-070-0091 Complex Medical Add-On Services
(Temporary effective 03/28/2022 through 09/23/2022)

(1) LICENSED NURSING SERVICES. If a Medicaid resident qualifies for payment at the basic rate and if the resident's condition or service needs are determined to meet one or more of the procedures, routines, or services listed in this rule, and the nursing facility maintains documentation per OAR 411-070-0027, APD may pay a complex medical add-on payment (in addition to the basic rate) for the additional licensed nursing services needed to meet the resident's increased needs.

(a) Medication Procedures.

(A) M-1 -- Administration of medication, at least daily, requiring skilled observation and judgment for necessity, dosage, and effect, for example new anticoagulants. (This category is limited to non-routine subcutaneous injections and does not include insulin, or the infrequent adjustments of current medications). The facility must maintain a daily nursing note.

(B) M-2 -- Intravenous injections or infusions, heparin locks used daily or continuously for hydration or medication. The facility must maintain a daily nursing note. For total parenteral nutrition (TPN) the facility must maintain daily documentation on a flow sheet and must maintain a weekly nursing note.

(C) M-4 -- Intramuscular medications for unstable condition used at least daily. The facility must maintain a daily nursing note.

(D) M-5 -- External infusion pumps used at least daily. This does not include external infusion pumps when the resident is able to self bolus. The facility must maintain a daily nursing note.

(E) M-6 -- Hypodermoclysis - daily or continuous use. The facility must maintain a daily nursing note.

(F) M-7 -- Peritoneal dialysis, daily, and Hemodialysis, 2-3 times a week for in-house dialysis. ~~.~~ This does not include residents who can do their own exchanges. The facility must maintain a daily nursing note.

(b) Treatment Procedures.

(A) T-1 -- Nasogastric, Gastrostomy or Jejunostomy tubes used daily for feedings. The facility must maintain daily information on a flow sheet and a weekly nursing note.

(B) T-2 -- Nasopharyngeal suctioning, twice a day or more. Tracheal suctioning, as required, for a resident who is dependent on nursing staff to maintain airway. The facility must maintain a daily nursing note.

(C) T-3 -- Percussion, postural drainage, and aerosol treatment when all three are performed twice per day or more. The facility must maintain a daily nursing note.

(D) T-4 -- Ventilator dependence. Services for a resident who is dependent on nursing staff for initiation, monitoring, and maintenance. The facility must maintain a daily nursing note.

(c) Skin or Wound.

(A) S-1 -- Is limited to visible Stage III or IV pressure ulcers that require aggressive treatment with documented

expectation of ulcer resolution. The facility must maintain a weekly wound assessment and a weekly nursing note. A healing Stage III or IV pressure ulcer that has the visual appearance of a Stage II pressure ulcer cannot be considered eligible for purposes of complex medical criteria.

The pressure ulcer is eligible for add-on until the last day the ulcer is visibly a Stage III pressure ulcer. For complex medical add-on, facilities must stage the ulcer as it is visualized in appearance in accordance to the below definitions for determining if a resident's needs meet or continue to meet complex medical add-on criteria.

(i) Pressure ulcer means any skin ulcer caused by pressure resulting in damage of underlying tissues. Other terms used to indicate this condition include decubitus ulcers.

(ii) Stage II means a partial thickness loss of skin layers that presents clinically as an abrasion, blister, or shallow crater.

(iii) Stage III means a full thickness of skin is lost, exposing the subcutaneous tissues. Presents as a deep crater with or without undermining adjacent tissue.

(iv) Stage IV means a full thickness of skin and subcutaneous tissue is lost, exposing muscle or bone.

(B) S-2 -- Open wounds as defined by dehisced surgical wounds or surgical wounds not closed primarily that require aggressive treatment and are expected to resolve. The facility must maintain a weekly wound assessment and a weekly nursing note.

(C) S-3 -- Deep or infected stasis ulcers with tissue destruction equivalent to at least a Stage III. The facility must maintain a weekly wound assessment and a weekly nursing note. The stasis ulcer is eligible for add-on until the last day the ulcer is visually equivalent to a Stage III, or if the stasis ulcer is an

infected, chronic Stage III or IV, it is eligible for add-on until it is no longer infected and returns to previous chronic Stage III or IV state. For complex medical add-on, facilities must stage the ulcer as it is visualized in appearance in accordance to the below definitions for determining if a resident's needs meet or continue to meet complex medical add-on criteria.

(i) Stasis ulcer means a skin ulcer, usually in the lower extremities, caused by altered blood flow from chronic vascular insufficiency, also referred to as venous insufficiency, lymphedema, arterial insufficiency, or peripheral vascular disease.

(ii) Stage II means a partial thickness loss of skin layers that presents clinically as an abrasion, blister, or shallow crater.

(iii) Stage III means a full thickness of skin is lost, exposing the subcutaneous tissues. Presents as a deep crater with or without undermining adjacent tissue.

(iv) Stage IV means a full thickness of skin and subcutaneous tissue is lost, exposing muscle or bone.

(v) A healing Stage III or IV stasis ulcer that has the visual appearance of a Stage II stasis ulcer cannot be considered eligible for purposes of complex medical criteria.

(vi) A chronic Stage III or IV stasis ulcer that is no longer infected and has returned to previous chronic Stage III or IV status cannot be considered eligible for purposes of complex medical criteria.

(d) O-4 – Insulin Dependent Diabetes Mellitus (IDDM).

(A) Unstable IDDM in a resident who requires sliding scale insulin; and

(i) Exhibits signs or symptoms of hypoglycemia or hyperglycemia, or both;

(ii) Requires nursing or medical interventions such as extra feeding, glucagon, or additional insulin, and transfer to emergency room; and

(iii) Is having insulin dosage adjustments.

(B) The facility must maintain a daily nursing note. A Medication Administration Record is required when sliding scale insulin or other medication related to the IDDM has been administered. While all three criteria do not need to be present on a daily basis, the resident must be considered unstable. A resident with erratic blood sugars, without a need for further interventions, does not meet this criteria.

(e) Other.

(A) O-1 -- Professional Teaching. Short term, daily teaching pursuant to discharge or a self-care plan. The facility must maintain a teaching plan and a weekly nursing note.

(B) O-2 -- Emergent medical or surgical problems, requiring short term licensed nursing observation and assessment. Eligibility for the add-on will be until the resident no longer requires additional licensed nursing observation and assessment for this medical or surgical problem. The facility must maintain a nursing note every shift.

(C) O-3 -- Emergent Behavior Problems -- Emergent behavior is a sudden, generally unexpected change or escalation in behavior of a resident that poses a serious threat to the safety of self or others and requires immediate intervention, consultation, and a care plan. Eligibility for the add-on will be until the resident no longer requires additional licensed nursing observation and assessment for this medical problem. The facility must maintain a nursing note every shift.

(f) Effective September 1, 2012, the Department shall no longer provide the complex medical add-on for Provider Preventable Conditions (PPC).

(A) Nursing facilities may not receive complex medical add-on if the need for the complex medical add-on was caused by a PPC and the need for complex medical add-on did not exist prior to treatment or intervention.

(B) No reduction in payment for a PPC shall be imposed on a provider when the condition defined as a PPC for a particular individual occurred outside of the nursing facility or prior to admission.

(C) Regardless of payment requests, a nursing facility must report each PPC event to the Department through a Department approved reporting system.

(2) R-1 -- REHABILITATION SERVICES.

(a) Physical Therapy -- At least five days every week. The facility must maintain the therapist's notes and a weekly nursing progress note related to the rehabilitation services being provided.

(b) Speech Therapy -- At least five days every week. The facility must maintain the therapist's notes and a weekly nursing progress note related to the rehabilitation services being provided.

(c) Occupational Therapy -- At least five days every week. The facility must maintain the therapist's notes and a weekly nursing progress note related to the rehabilitation services being provided.

(d) Any combination of physical therapy, occupational therapy, and speech therapy at least five days every week qualifies. The facility must maintain the therapist's notes and a weekly nursing progress note related to the rehabilitation services being provided.

(e) Respiratory Therapy -- At least five days every week by a respiratory therapist. These services must be authorized by Medicare, Medicaid Oregon Health Plan, or a third party payor. The

facility must maintain the therapist's notes and a weekly nursing progress note.

Stat. Auth.: ORS 410.070
Stats. Implemented: ORS 410.070, 414.065

411-070-0442 Calculation of the Basic Rate, Complex Medical Rate, Bariatric Rate and Ventilator Assisted Program Rate
(Temporary effective 03/28/2022 through 09/23/2022)

(1) The rates are determined annually and referred to as the Rebasing Year.

(a) The basic rate is based on the statements received by the Department by October 31 for the fiscal reporting period ending on June 30 of the previous year. For example, for the year beginning July 1, 2018, statements for the period ending June 30, 2017 are used. The Department desk reviews or field audits these statements and determines the allowable costs for each nursing facility. The costs include both direct and indirect costs. The costs and days relating to pediatric beds and Ventilator Assisted Program beds are excluded from this calculation. The Department only uses financial reports of facilities that have been in operation for at least 180 days and are in operation as of June 30.

(b) For each facility, its allowable costs, less the costs of its self-contained pediatric unit (if any), or the Ventilator Assisted Program Unit, are inflated by the DRI Index, or its successor index. The DRI table as published in the fourth quarter of the year immediately preceding the beginning of the payment year will be used. Costs will be inflated to reflect projected changes in the DRI Index from the mid-point of the fiscal reporting period to the mid-point of the payment year (e.g., for the July 1, 2018 rebase, the midpoint of the fiscal reporting period is December 31, 2016 and the mid-point of the payment year is December 31, 2018).

(c) For each facility, its allowable costs per Medicaid day is determined using the allowable costs as inflated and resident days, excluding pediatric and ventilator days as reported in the statement.

(d) The facilities are ranked from highest to lowest by the facility's allowable costs, per Medicaid day.

(e) The basic rate is determined by ranking the allowable costs per Medicaid day by facility and identifying the allowable cost per day at the applicable percentage. If there is no allowable cost per day at the applicable percentage, the basic rate is determined by interpolating the difference between the allowable costs per day that are just above and just below the applicable percentage to arrive at a basic rate at the applicable percentage. The applicable percentage for the period beginning July 1, 2018 is at the 62nd percentile.

(2) Due to the COVID-19 pandemic, a temporary 10% increase to the basic rate has been authorized for nursing facilities for services provided April 1, 2020 thru June 30, 2020.

(3) Due to the extraordinary expenses incurred as a result of the COVID-19 pandemic, a 5% increase to the basic rate has been authorized for nursing facilities for services provided January 1, 2021 thru ~~March 31, 2022~~June 30, 2023.

(4) The Department provides an augmented rate to nursing facilities who qualify under the Quality and Efficiency Incentive Program as described in OAR 411-070-0437. An acquisition plan must be submitted to the Department on or after October 7, 2013 and on or before June 30, 2016. The purchasing operator must meet all requirements in OAR 411-070-0437(3) in order to receive the augmented rate. The qualifying nursing facility is paid the augmented rate for each Medicaid-eligible resident.

(5) Nursing facility bed capacity in Oregon shall be reduced by 1,500 beds by December 31, 2015, except for bed capacity in nursing facilities operated by the Department of Veteran's Affairs and facilities that either applied to the Oregon Health Authority for a certificate of need between August 1, 2011 and December 1, 2012, or submitted a letter of intent under ORS 442.315(7) between January 15, 2013 and January 31, 2013. An official bed count measurement shall be determined and issued by the Department as of July 1, 2016 and each quarter thereafter if the goal of reducing the nursing facility bed capacity in Oregon by 1,500 beds is not achieved.

(a) For the period beginning July 1, 2013 and ending June 30, 2016, the Department shall reimburse costs as set forth in section (1) of this rule at the 63rd percentile.

(b) For each three-month period beginning on or after July 1, 2016 and ending June 30, 2018, in which the reduction in bed capacity in licensed facilities is less than the goal described in this section, the Department shall reimburse costs at a rate not lower than the percentile of allowable costs according to the following schedule:

(A) 63rd percentile for a reduction of 1,500 or more beds.

(B) 62nd percentile for a reduction of 1,350 or more beds but less than 1,500 beds.

(C) 61st percentile for a reduction of 1,200 or more beds but less than 1,350 beds.

(D) 60th percentile for a reduction of 1,050 or more beds but less than 1,200 beds.

(E) 59th percentile for a reduction of 900 or more beds but less than 1,050 beds.

(F) 58th percentile for a reduction of 750 or more beds but less than 900 beds.

(G) 57th percentile for a reduction of 600 or more beds but less than 750 beds.

(H) 56th percentile for a reduction of 450 or more beds but less than 600 beds.

(I) 55th percentile for a reduction of 300 or more beds but less than 450 beds.

(J) 54th percentile for a reduction of 150 or more beds but less than 300 beds.

(K) 53rd percentile for a reduction of 1 to 149 beds.

(c) For the period beginning July 1, 2018 and ending June 30, 2026, the Department shall reimburse costs, as set forth in section (1) of this rule, at the 62nd percentile.

(6) The complex medical rate is 140% percent of the basic rate.

(7) The Ventilator Assisted Program rate is 235% of the established basic rate.

(8) The bariatric rate is 185% of the established basic rate.

Stat. Auth.: ORS 410.070
Stats. Implemented: ORS 410.070, OL 2003 ch. 736, OL 2007 ch. 780, OL 2009 ch. 827, OL 2011 ch. 630, OL 2013 ch. 608, OL 2018 ch. 66

411-070-0452 Pediatric Nursing Facilities
(Temporary effective 03/28/2022 through 09/23/2022)

(1) PEDIATRIC NURSING FACILITY.

(a) A pediatric nursing facility is a licensed nursing facility at least 50 percent of whose residents entered the facility before the age of 14 and all of whose residents are under the age of 21.

(b) A nursing facility that meets the criteria of subsection (1)(a) of this section is reimbursed as follows:

(A) The pediatric rate is a prospective rate and is not subject to settlement. The Department uses financial reports of facilities that have been in operation for at least 180 days and are in operation as of June 30.

(B) The facility specific pediatric cost per resident day is inflated as described in OAR 411-070-0442(1)(b). The Oregon Medicaid pediatric days are multiplied by the inflated facility specific cost per resident day for each pediatric facility. The totals are summed and divided by total Oregon Medicaid days to establish the weighted average cost per pediatric resident day. The rebase relationship percentage of 93 percent is

applied to the weighted average cost to determine the pediatric rate.

(c) Due to the COVID-19 pandemic, a temporary 10% increase to the pediatric rate has been authorized for nursing facilities for services provided April 1, 2020 thru June 30, 2020.

(d) Due to the extraordinary expenses incurred as a result of the COVID-19 pandemic, a 5% increase to the pediatric rate has been authorized for nursing facilities for services provided January 1, 2021 thru ~~March 31, 2022~~June 30, 2023.

(e) Even though pediatric facilities are reimbursed in accordance with subsection (1)(b) of this section, pediatric facilities must comply with all requirements relating to the timely submission of Nursing Facility Financial Statements.

(2) LICENSED NURSING FACILITY WITH A SELF-CONTAINED PEDIATRIC UNIT.

(a) A nursing facility with a self-contained pediatric unit is a licensed nursing facility that provides services for pediatric residents (individuals under the age of 21) in a separate and distinct unit within or attached to the facility with staffing costs separate and distinct from the rest of the nursing facility. All space within the pediatric unit must be used primarily for purposes related to the services of pediatric residents and alternate uses may not interfere with the primary use.

(b) A nursing facility that meets the criteria of subsection (2)(a) of this section is reimbursed for pediatric residents served in the pediatric unit as described in section (1) of this rule.

(c) Licensed nursing facilities with a self-contained pediatric unit must comply with all requirements relating to the timely submission of Nursing Facility Financial Statements and must file a separate attachment, on forms prescribed by the Department, related to the costs of the self-contained pediatric unit.

Stat. Auth.: ORS 410.070
Stats. Implemented: ORS 410.070, OL 2011 ch. 630, OL 2013 ch. 608