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NOTICE OF PROPOSED RULEMAKING
INCLUDING STATEMENT OF NEED & FISCAL IMPACT

FILED
02/29/2024 9:07 AM
ARCHIVES DIVISION
SECRETARY OF STATE

CHAPTER 309
OREGON HEALTH AUTHORITY
HEALTH SYSTEMS DIVISION: BEHAVIORAL HEALTH SERVICES

FILING CAPTION: Updates the Purpose, Statutory Authority and Definitions to include reference to the Basic Health Program.

LAST DAY AND TIME TO OFFER COMMENT TO AGENCY: 04/18/2024 5:00 PM

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

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Filed By:
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HEARING(S)

Auxiliary aids for persons with disabilities are available upon advance request. Notify the contact listed above.

DATE: 03/18/2024
TIME: 1:00 PM - 2:30 PM
OFFICER: Juan Rivera

REMOTE HEARING DETAILS
MEETING URL: Click here to join the meeting
PHONE NUMBER: 1-669-254-5252
CONFERENCE ID: 1612522091
SPECIAL INSTRUCTIONS:
https://www.zoomgov.com/j/1612522091?pwd=dTk0QUpnVnlPMEhhSXZuZ1Faa3pjQT09

Meeting ID: 161 252 2091
Passcode: 798116

NEED FOR THE RULE(S)

HB 4035 (2022) directed the Oregon Health Authority (OHA) to create a permanent coverage solution for adults 138-200% of the federal poverty level who regularly enroll and disenroll in the Oregon Health Plan (OHP) due to fluctuations in income. Following recommendations from the Bridge Health Care Program Task Force, OHA is pursuing federal authority under Section 1331 of the Affordable Care Act to establish a Basic Health Program (BHP), that will be administered by Coordinated Care Organizations (CCOs) and cover the CCO-administered OHP service package to qualifying adults at no cost to the enrollee. Many of the rules governing Medicaid will apply to the BHP. This rule change is needed to clarify that the Chapter 309 rules will apply to the Basic Health Program.

DOCUMENTS RELIED UPON, AND WHERE THEY ARE AVAILABLE

none

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

OHP Bridge will expand access to the Coordinated Care Organization (CCO) – administered Oregon Health Plan (OHP) service package to eligible adults aged 19-64 with incomes 138 – 200% of the federal poverty level (FPL) at no cost to the enrollee. In doing so, this program will improve health equity by providing a permanent coverage solution to a population that frequently cycles on and off OHP due to fluctuations in income. Due to federal regulations, OHP Bridge cannot cover people without documentation. This limits the program's ability to support Oregon's health equity goals. Prior to the Public Health Emergency (PHE), roughly 34% of people enrolling in OHP were returning after less than a year, and 25% were returning within 6 months.[1] During that time "lost OHP coverage" was the most commonly reported reason for being uninsured.[2] Studies show that individuals who move on and off coverage in this manner are more likely to be Black, Indigenous and other People of Color.[3] These gaps in coverage result in disruptions to care, worse health outcomes and higher administrative costs.[4]
Continuous coverage during the PHE led to significant increases in coverage for communities across the state, with notable coverage gains among adults 138-200%FPL. These gains were especially notable in communities of color. The overall insurance rate for Black/African American individuals increased from 91.8% to 95% between 2019 and 2021[5]. By covering this population at no cost to the enrollee, OHP Bridge will help maintain these coverage gains without leaving behind communities who face economic barriers to coverage that result from current and historical racism.

[1] Oregon Health Insurance Survey 2019
[2] Oregon Health Insurance Survey 2019
[3] Sugar S, Peters C, DeLew N, Sommers BD. Medicaid Churning and Continuity of Care: Evidence and Policy Considerations Before and After the COVID-19 Pandemic (Issue Brief No. HP-2021-10). Washington, DC: Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services. April 12, 2021
[4] https://aspe.hhs.gov/sites/default/files/private/pdf/265366/medicaid-churning-ib.pdf
[5] Oregon Health Insurance Survey 2021

FISCAL AND ECONOMIC IMPACT:

OHP Bridge will be funded primarily through the use of federal funds with State general fund being used to cover the state share of program costs for OHP Bridge – Basic Medicaid members, as well as for administrative costs and the costs of specific services carved out of the CCO contracts and/or ineligible for federal funds related to OHP Bridge – Basic Health Program. Federal funds for OHP Bridge – Basic Health Program will be deposited into the Bridge Plan Fund and used to pay for a majority of program services and costs with the exception of administrative costs and specific carve-out services. State general fund will be used to cover administrative costs and specific carve-out services and may be used to cover additional program services and costs if needed. Once approved by the federal government, OHP Bridge – Basic Health Program will be a permanent program with continued federal funding unless or until the State decides to update its application. Federal funding for OHP Bridge – Basic Medicaid will be renewed as part of Oregon's regular Medicaid waiver process every five years. Both programs will be integrated into The Oregon Health Authority's budget, which is renewed every two years.

COST OF COMPLIANCE:

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

The Chapter 309 rule changes do not have a cost of compliance.

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

None

WAS AN ADMINISTRATIVE RULE ADVISORY COMMITTEE CONSULTED? YES

RULES PROPOSED:

309-015-0000, 309-015-0005

AMEND: 309-015-0000

RULE SUMMARY: Adding language to include the Basic Health Program and clarify that these rules will apply to this new program.

CHANGES TO RULE:

309-015-0000
Purpose and Statutory Authority ¶

(1) Purpose. These rules prescribe the eligibility criteria, methods, and standards for payments to psychiatric hospitals through the Division of Medical Assistance Programs, Oregon Health Authority. The rules apply to provision of psychiatric hospital inpatient services for persons eligible for medical assistance under Medicaid (Title XIX of the Social Security Act) and the Basic Health Program (Section 1331 of the Affordable Care Act).¶
(2) Statutory Authority. These rules are authorized by ORS 413.042 and [HB 4035 (2022)] and carry out the provisions of ORS 414.025, 414.065, and 414.085 and Title XIX of the Social Security Act and 42 CFR 441, Subparts C and D and Section 1331 of the Affordable Care Act.
Statutory/Other Authority: ORS 413.042
Statutes/Other Implemented: ORS 414.025, 414.065

AMEND: 309-015-0005

RULE SUMMARY: Adding language to include the Basic Health Program and that these rules will apply to this new program.

CHANGES TO RULE:

309-015-0005
Definitions ¶

~~As used in these rules:¶~~
(1) "Active Treatment" means implementation of a professionally developed and supervised plan of care that is in effect within 14 days of admission and designed to achieve the patient's discharge at the earliest possible time. Custodial care is not active treatment.¶
(2) "Actual Costs" means all legitimate Medicaid expenditures. Since Oregon's Addictions and Mental Health Division utilizes Medicare cost finding principles, actual costs will be the same as "Medicaid Allowable Costs" as defined in this rule.¶
(3) "Allowable Costs" means the costs applicable to the provision of psychiatric inpatient services as described in OAR 309-015-0050(3). They are derived using the Medicare cost finding principles located in the Medicare Provide Reimbursement Manual.¶
(4) "Annual Cost Report" means a financial report submitted to the Medicare/Medicaid Fiscal Intermediary by a hospital, on forms provided by the Fiscal Intermediary. This report details the actual revenues and expenses of the hospital during the latest fiscal period.¶
(5) "Base Year" means July 1, 1981 through June 30, 1982.¶
(6) "Basic Health Program" means Section 1331 of the Affordable Care Act.¶
(7) "Disproportionate Share Adjusted Medicaid Rate" (DSR) means the weighted average Medicaid per diem rate (interim, year-end settlement or final settlement) for disproportionate share hospitals. This rate does not include the disproportionate share payment of uncompensated costs of participating hospital programs as provided in these rules.¶
(~~7~~8) "Disproportionate Share Costs" means costs that are reimbursable under federal disproportionate share statutes and regulations. These costs are limited to costs of participating hospital programs which have not already been reimbursed by Medicare, Medicaid, insurance, or the patient's own resources.¶
(~~8~~9) "Disproportionate Share Hospital" means a psychiatric hospital which has a low income utilization rate exceeding 25 percent as described in OAR 309-015-0035(5).¶
(~~9~~10) "Disproportionate Share Payment" means the payment made quarterly to reimburse participating hospital programs for disproportionate share costs. This payment is subject to recalculation at the time of each year-end or final settlement payment.¶
(1~~0~~1) "Distinct Program" means a specialized inpatient psychiatric treatment program with unique admission standards approved by the Division. If a participating psychiatric hospital has a specialized program based upon patient age or medical condition, contains 50 or more beds, has a nursing staff specifically assigned to the program which has experience or training in working with the specialized population, and has record keeping systems adequate to separately account for expenditures and revenue to that program relative to the entire hospital, the Division may approve it as a distinct program.¶
(1~~1~~2) "Division" means the Addictions and Mental Health Division of the Oregon Health Authority.¶
(1~~2~~3) "Fiscal Intermediary" means:¶
(a) Blue Cross of Oregon for Medicare, Parts A and B; and¶
(b) Division for Medicaid services provided under the provisions of this rule;¶
(c) The Division's Assistant Administrator for Administrative Services, is the designated Fiscal Intermediary.¶
(1~~3~~4) "Inpatient Psychiatric Services" means active treatment services provided under the direction of a licensed physician by a participating psychiatric hospital.¶
(1~~4~~5) "Interim Per Diem Rate" means the daily rate established with and paid to each provider for the agreement period during which reimbursable services are to be provided.¶
(1~~5~~6) "Low Income Utilization Rate" means the sum of the ratio of a hospital's Medicaid revenues (plus governmental subsidies) to total revenue added to the ratio of a hospital's proportion of charity care expenditures (less governmental subsidies) to total inpatient psychiatric services charges (as outlined in OAR 309-015-0035(5)).¶
(1~~6~~7) "Maximum Allowable Rate" means the statewide average per diem cost for services as derived in accordance with OAR 309-015-0020 and 309-015-0021.¶
(1~~7~~8) "Medicaid" means Title XIX of the Social Security Act.¶
(1~~8~~9) "Medicaid Allowable Costs" means that portion of total costs determined to be eligible for Medicaid

reimbursement. Medicaid allowable costs are determined based on the amount of allowable cost for inpatient services by making the following calculations:¶
(a) For all providers, determine the reasonable cost of covered services furnished by multiplying the ratio of Medicaid patient days to total patient days by total allowable inpatient costs;¶
(b) For proprietary providers, determine the allowable return on equity capital invested and used for the provision of patient care by following the general rule outlined in 42 CFR 413.157(b);¶
(c) Adding the results of the calculations in subsections (a) and (b) of this section to establish the full Medicaid allowable cost.¶
(~~19~~20) "Medicaid Intermediary" for the purpose of services provided under this rule, means the Assistant Administrator for Administrative Services, Addictions and Mental Health Division.¶
(2~~0~~1) "Medicaid Patient Days" means the accumulated total number of days, including therapeutic leave days, during which psychiatric inpatient services were provided to Medicaid eligible patients during a cost reporting period. The Fiscal Intermediary shall determine the total number of Medicaid patient days on the basis of dates of service per patient by provider and fiscal period.¶
(2~~1~~2) "Medicaid Inpatient Utilization Rate" means the following fraction (expressed as a percentage) for a hospital:¶
(a) "Numerator": The hospital's number of inpatient days attributable to patients who (for such days) were eligible for Title XIX medical assistance under the state Medicaid plan and for whom the Division of Medical Assistance Programs made payment during the fiscal period;¶
(b) "Denominator": The total number of the hospital's inpatient days for the same period.¶
(2~~2~~3) "Medicare Market Basket Percentage Increase" means the annual allowable increase factor for a standard array of hospital services nationwide as published annually by the Health Care Financing Administration. The percentage is a component of the "Target Rate Percentage Increase" as defined in section (29) of this rule.¶
(2~~3~~4) "Non-Allowable Costs" means any costs excluded under the provisions of state and federal statutes, regulations, and administrative rules.¶
(2~~4~~5) "Participating Psychiatric Hospital" means those portions of a licensed psychiatric hospital certified to provide services to Medicaid patients.¶
(2~~5~~6) "Patient Eligibility" means persons eligible for medical assistance under Medicaid who meet the criteria for admission to psychiatric hospital inpatient services as defined in these rules and OAR 309-031-0200 through 309-031-0255.¶
(2~~6~~7) "Resident in the Hospital" means a patient who is in the facility at least 12 hours of each day, including the hours of sleep. The day of admission is exempt from this 12 hour rule; however, to be counted for residence purposes, the day of admission must extend through midnight (2,400 hours). The day of discharge is not counted.¶
(2~~7~~8) "Sanction" means:¶
(a) Termination of contract with the Division to provide psychiatric hospital services for Medicaid eligible patients;¶
(b) Suspension of contract with the Division to provide psychiatric hospital services for Medicaid eligible patients; or¶
(c) Suspension or withholding of payments to a provider. (See OAR 309-015-0052 for further information.)¶
(2~~8~~9) "Separate Cost Entity" means an entity of a hospital for which Medicare has approved the submission of a separate cost report.¶
(~~29~~30) "Target Rate Percentage Increase" means the annual allowable increase factor applied to the previous year's maximum allowable rate for psychiatric hospitals and hospital units excluded from the prospective payment system. This percentage includes the Medicare market basket percentage increase as a component and is published annually by the Health Care Financing Administration.¶
(3~~0~~1) "Therapeutic Leave Days" means a planned and medically authorized period of absence from the hospital not exceeding 72 hours in seven consecutive days.¶
(3~~1~~2) "Total Patient Days" means the accumulated total number of days, excluding non-Medicaid therapeutic leave days, during which psychiatric inpatient services were provided to patients during a cost reporting period. The fiscal intermediary shall determine the total number of patient days on the basis of dates of service per patient by provider and fiscal period.
Statutory/Other Authority: ORS 413.042
Statutes/Other Implemented: ORS 414.025, 414.065