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PERMANENT ADMINISTRATIVE ORDER

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DMAP 50-2017
CHAPTER 410
OREGON HEALTH AUTHORITY
HEALTH SYSTEMS DIVISION: MEDICAL ASSISTANCE PROGRAMS

FILING CAPTION: Comply with Amended CFRs for Dispensing Fees; Revise Reimbursement Methodology for Certain Practitioner Administered Drugs

EFFECTIVE DATE: 01/01/2018

AGENCY APPROVED DATE: 11/07/2017

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RULES:
410-120-1340, 410-121-0160

AMEND: 410-120-1340

RULE TITLE: Payment

NOTICE FILED DATE: 09/14/2017

RULE SUMMARY: The Division needs to amend these rules to stay in compliance with federal law by updating professional dispensing fee rates based on Oregon's most recent Professional Dispensing Fee Analysis. Amendment is also needed for federal compliance by more closely matching the ingredient cost for Practitioner Administered Drugs (PADs) when there is no published Medicare rate. The changes in this filing apply to fee-for-service coverage of pharmacy benefits.

RULE TEXT:
(1) The Health Systems Division (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 that is administering the program under which the billed services or items are provided sets fee-for-service (FFS) payment rates.
(4) The Division uses FFS payment rates in effect on the date of service that are the lesser of:
(a) The amount billed;
(b) The Division maximum allowable amount or;
(c) Reimbursement specified in the individual program provider rules.
(5) The amount billed may not exceed the provider's "usual charge" (see definitions).
(6) The Division's maximum allowable rate setting process uses the following methodology for:
(a) Relative Value Unit (RVU) weight-based rates: For all CPT/HCPCS codes assigned an RVU weight, the 2017 Total RVU weights published in the Federal Register, Vol. 81, November 15, 2016 to be effective for dates of services on or

after January 1, 2017:
(A) For professional services not typically performed in a facility, the Non-Facility Total RVU weight;
(B) For professional services typically performed in a facility, the Facility Total RVU weight;
(C) The Division applies the following conversion factors:
(i) $40.79 for labor and delivery codes (59400-59622);
(ii) $27.82 for Oregon primary care providers. A current list of primary care CPT, HCPCs, and provider specialty codes is available at http://www.oregon.gov/oha/healthplan/Pages/providers.aspx
(iii) $25.48 for all remaining RVU weight based CPT/HCPCS codes.
(D) Rate calculation: Effective January 1, 2017, the Division shall calculate rates for each RVU weight-based code using statewide Geographic Practice Cost Indices (GPCIs) as follows:
(i) Work RVU) X (Work GPCI of 1) + (Practice Expense RVU) X (Practice GPCI of 0.974) + (Malpractice RVU) X (Malpractice GPCI of 0.746);
(ii) Sum in paragraph (D)(i) multiplied by the applicable conversion factor in paragraph (C).
(b) Non RVU based rates:
(A) $20.78 is the base rate for anesthesia service codes 00100-01996. The rate is based on per unit of service;
(B) Clinical lab codes are priced at 70 percent of the 2017 Medicare clinical lab fee schedule;
(C) All approved Ambulatory Surgical Center (ASC) procedures are reimbursed at 80 percent of the 2017 Medicare fee schedule;
(D) Physician administered drugs billed under a HCPCS code are based on Medicare's published reimbursement rate (Average Sales Price (ASP) plus six percent). When no ASP rate is listed, the rate shall be based upon the Wholesale Acquisition Cost (WAC). If no WAC is available, then the rate shall be reimbursed at Acquisition Cost. Pricing information for WAC is provided by First Databank. These rates may change periodically based on drug costs;
(E) All procedures used for vision materials and supplies are based on contracted rates that include acquisition cost plus shipping and handling;
(F) Individual provider rules may specify reimbursement rates for particular services or items.
(7) The rates in section (6) are updated periodically and posted on the Authority web site at http://www.oregon.gov/oha/healthplan/pages/feeschedule.aspx.
(8) The Division reimburses inpatient hospital service 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.
(9) 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.
(10) 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.
(11) The Division sets payment rates for out-of-state institutions and similar facilities such as skilled nursing care facilities and psychiatric and rehabilitative care facilities at a rate that is:
(a) Consistent with similar services provided in the State of Oregon; and
(b) The lesser of the rate paid to the most similar facility licensed in the State of Oregon or the rate paid by the Medical Assistance Programs in that state for that service; or
(c) The rate established by APD for out-of-state nursing facilities.
(12) The Division may not make payment on claims that have been assigned, sold, or otherwise transferred or when the billing provider, billing agent, or billing service receives a percentage of the amount billed or collected or payment authorized. This includes, but is not limited to, transfer to a collection agency or individual who advances money to a provider for accounts receivable.
(13) The Division may not make a separate payment or copayment to a nursing facility or other provider for services

included in the nursing facility's all-inclusive rate. The following services are not included in the all-inclusive rate (OAR 411-070-0085) and may be separately reimbursed:
(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).
(14) The Division reimburses hospice services based on CMS Core-Based Statistical Areas (CBSA's). A separate payment may not be made for services included in the core package of services as outlined in chapter 410, division 142.
(15) 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.
(16) For clients with third-party resources (TPR), the Division pays the allowed rate less the TPR payment but not to exceed the billed amount.
(17) The Division payments including contracted PHP or CCO payments, unless in error, constitute payment in full, except in limited instances involving allowable spend-down or copayments. 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.
(18) 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.

STATUTORY/OTHER AUTHORITY: ORS 413.042

STATUTES/OTHER IMPLEMENTED: ORS 414.025, 414.033, 414.065, 414.095, 414.727, 414.728, 414.742, 414.743

AMEND: 410-121-0160

RULE TITLE: Dispensing Fees

NOTICE FILED DATE: 09/14/2017

RULE SUMMARY: The Division needs to amend these rules to stay in compliance with federal law by updating professional dispensing fee rates based on Oregon's most recent Professional Dispensing Fee Analysis. Amendment is also needed for federal compliance by more closely matching the ingredient cost for Practitioner Administered Drugs (PADs) when there is no published Medicare rate. The changes in this filing apply to fee-for-service coverage of pharmacy benefits.

RULE TEXT:

(1) Effective January 1, 2018, professional dispensing fees allowable for services shall be reimbursed as follows:

(a) All enrolled chain affiliated pharmacies with ten or more pharmacies under common ownership shall be reimbursed at a rate of $9.80 per claim. A "chain affiliated pharmacy" shall be defined as a pharmacy that is part of a group of pharmacies under common ownership and does not include fully independent pharmacies or franchise pharmacies;

(b) Independently owned pharmacies in communities that are the only enrolled pharmacy within a fifteen (15) mile radius from another pharmacy shall be reimbursed at a dispensing fee of $14.30 per claim;

(c) All 340B pharmacies operated by a 340B covered entity shall be reimbursed at a rate of $14.30 per claim;

(d) All other enrolled independently owned pharmacies excluding those in 410-121-0160(b) and (c) shall be reimbursed based on an individual pharmacy's annual claims volume as follows:

(A) Less than 30,000 claims a year = $14.30;

(B) Between 30,000 and 69,999 claims per year = $11.91;

(C) 70,000 or more claims per year = $9.80.

(2) All Division enrolled independent pharmacies shall be required to complete an annual survey that collects claim volumes from enrolled pharmacies and other information from the previous 12-month period to determine the appropriate dispensing fee reimbursement:

(a) Claims volume shall be stated by total OHP covered prescriptions and claims from all payer types;

(b) Survey activities shall be conducted by either the Division or its contractor and must be completed and returned by pharmacies within 14 days of receipt;

(c) Completed surveys must be signed with a letter of attestation by the store owner or majority owner;

(d) Pharmacies that fail to respond to the survey or do not include the letter of attestation shall default to the lowest dispensing tier;

(e) Once a tier is established for a calendar year, the pharmacy's dispensing fee shall remain in that tier until the next annual claims volume survey is conducted;

(f) Newly enrolled 340B pharmacies shall be reimbursed at a rate of $14.30 per claim. All other independent pharmacies shall be defaulted to the lowest dispensing tier until the next claims volume survey is conducted.

(3) All chain affiliated pharmacies shall be exempt from completing the annual claims volume survey.

[Publications referenced are available from the agency.]

STATUTORY/OTHER AUTHORITY: ORS 413.042, 414.065

STATUTES/OTHER IMPLEMENTED: ORS 414.065