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TEMPORARY ADMINISTRATIVE ORDER
INCLUDING STATEMENT OF NEED & JUSTIFICATION

DMAP 33-2024
CHAPTER 410
OREGON HEALTH AUTHORITY
HEALTH SYSTEMS DIVISION: MEDICAL ASSISTANCE PROGRAMS

FILED
01/12/2024 2:30 PM
ARCHIVES DIVISION
SECRETARY OF STATE
& LEGISLATIVE COUNSEL

FILING CAPTION: Amend Language to Comply with Federal Regulation Regarding Primary Payer of Oral Formula.

EFFECTIVE DATE: 01/12/2024 THROUGH 07/09/2024

AGENCY APPROVED DATE: 01/11/2024

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Filed By:
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NEED FOR THE RULE(S):

To amend this rule by clarifying the primary payer of oral formula covered by the Oregon Health Plan. This rule will specify that the Oregon Health Plan will be primary payer (not WIC) for all oral formula covered by the Oregon Health Plan for those infants and children who are enrolled in both OHP and participating in the WIC program.

JUSTIFICATION OF TEMPORARY FILING:

(1) The specific consequences that result from the failure to immediately amend this rule is direct harm and/or denial or delay in prior authorization and delivery of oral formula to infants and children enrolled in the Oregon Health Plan and who meet the OAR rules for oral formula covered by the Oregon Health Plan.

(2) Oregon Health Plan members who are participating in WIC and are trying to obtain coverage of oral formula that is covered by the Oregon Health Plan for whom the current rule is causing delay and/or denial of medically necessary oral formula.

(3) Failure to immediately take rulemaking action would cause harmful consequences to those infants and children enrolled in the Oregon Health Plan who qualify for medically necessary oral formula that is covered by the Oregon Health Plan and WIC program by continuing to increase WIC's formula supply shortages and continuing the rise in Medicaid prior authorization denial of oral formula for which result in continued delay of product delivery to the beneficiaries. CCO's and FFS programs are obligated to follow the existing Oregon Administrative Rule as written, which is no longer compliant with federal regulation.

(4) This temporary action will avoid and mitigate those consequences by clarifying Oregon Health Plan as the primary payer for all oral formula covered by the Oregon Health Plan to treat infants and children who are both enrolled in OHP and participating in the WIC program. Once amended, the rule will read:
(d) Oral formula not covered by the Oregon Health Plan (OHP) that is available through the Women's, Infant and Children (WIC) program. For covered formulas, OHP is the first payer before WIC

DOCUMENTS RELIED UPON, AND WHERE THEY ARE AVAILABLE:

CFR: 7CFR246.10(e)(3)(vi) available at:
https://www.ecfr.gov/current/title-7/subtitle-B/chapter-II/subchapter-A/part-246/subpart-D/section246.10#p-246.10(e)(3)(vi)

WIC Policy Memorandum FNS Document #2015-07, EO Guidance Document # FNS-GD-2015-0044 available at:
https://www.fns.usda.gov/wic/medicaid-primary-payer-exempt-infant-formulas-and-medicalfoods#:~:text=The%20Medicaid%20program%20is%20the,of%20mutual%20participants%20are%20met.

AMEND: 410-148-0100

RULE SUMMARY: Oregon Health Plan, Home Enteral/Parenteral Nutrition and IV Services Reimbursement Rule. This amendment is for adding language, per federal regulation requirements, to clarify the Oregon Health Plan is the primary payer (not WIC) for oral formula that is covered by the Oregon Health Plan.

CHANGES TO RULE:

410-148-0100
Reimbursement ¶

(1) Drug ingredients (medications) shall be reimbursed as defined in the Division of Medical Assistance Programs (Division) Pharmaceutical Services administrative rules (chapter 410, division 121).¶
(2) The following service/goods ~~wi~~shall be reimbursed on a fee-for-service basis according to the Division EPIV Fee Schedule found in the Home Enteral/Parenteral Nutrition and IV Services on the Division website:¶
(a) Enteral formula;¶
(b) Oral nutritional supplements which are medically appropriate and meet the criteria specified in 410-148-0260;¶
(c) Parenteral nutrition solutions;¶
(3) Reimbursement for services ~~wi~~shall be based on the lesser of the amount billed, or the Division maximum allowable rate. When the service is covered by Medicare, reimbursement ~~wi~~shall be based on the lesser of the amount billed, Medicare's allowed amount, or the Division maximum allowable rate.¶
(4) Reimbursement for supplies that require authorization or services/supplies that are listed as Not Otherwise Classified (NOC) or By Report (BR) must be billed to the Division at the providers' acquisition cost, and ~~wi~~shall be reimbursed at such rate.¶
(a) For purposes of this rule, Acquisition Cost is defined as the actual dollar amount paid by the provider to purchase the item directly from the manufacturer (or supplier) plus any shipping and/or postage for the item. Submit documentation identifying acquisition cost with your authorization request;¶
(b) Per diem, as it relates to reimbursement, represents each day that a given patient is provided access to a prescribed therapy. This definition is valid for per diem therapies of up to and including every 72 hours.¶
(c) Per diem reimbursement includes, but is not limited to:¶
(A) Professional pharmacy services:¶
(i) Initial and ongoing assessment/clinical monitoring;¶
(ii) Coordination with medical professionals, family and other caregivers;¶
(iii) Sterile procedures, including IV admixtures, clean room upkeep and all biomedical procedures necessary for a safe environment;¶
(iv) Compounding of medication/medication set-up.¶
(B) Infusion therapy related supplies:¶
(i) Durable, reusable or elastomeric disposable infusion pumps;¶
(ii) All infusion or other administration devices;¶
(iii) Short peripheral vascular access devices;¶
(iv) Needles, gauze, sterile tubing, catheters, dressing kits, and other supplies necessary for the safe and effective administration of infusion therapy.¶

(C) Comprehensive, 24-hour per day, seven (7) days per week delivery and pickup services (includes mileage).¶
(5) Reimbursement ~~wi~~shall not be made for the following:¶
(a) Central catheter insertion or transfusion of blood/blood products in the client's home;¶
(b) Central catheter insertion in the nursing facility;¶
(c) Intradialytic parenteral nutrition in the client's home or Nursing Facility;¶
(d) Oral ~~infant~~ formula that is not covered by the Oregon Health Plan (OHP) and available through the Women's, Infant and Children (WIC) program. For covered formulas, OHP is the first payer before WIC;¶
(e) Oral nutritional supplements that are in addition to consumption of food items or meals.¶
(f) Tocolytic pumps for pre-term labor management;¶
(g) Home enteral/parenteral nutrition or IV services outside of the client's place of residence (i.e. home, nursing facility or AIS).
Statutory/Other Authority: ORS 413.042
Statutes/Other Implemented: ORS 414.065