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NOTICE OF PROPOSED RULEMAKING
INCLUDING STATEMENT OF NEED & FISCAL IMPACT

CHAPTER 410
OREGON HEALTH AUTHORITY
HEALTH SYSTEMS DIVISION: MEDICAL ASSISTANCE PROGRAMS

FILED
05/09/2023 12:12 PM
ARCHIVES DIVISION
SECRETARY OF STATE

FILING CAPTION: Implement HB 2910

LAST DAY AND TIME TO OFFER COMMENT TO AGENCY: 06/21/2023 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.

A public rulemaking hearing may be requested in writing by 10 or more people, or by a group with 10 or more members, within 21 days following the publication of the Notice of Proposed Rulemaking in the Oregon Bulletin or 28 days from the date the Notice was sent to people on the agency mailing list, whichever is later. If sufficient hearing requests are received, the notice of the date and time of the rulemaking hearing must be published in the Oregon Bulletin at least 14 days before the hearing.

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NEED FOR THE RULE(S)

This is a brand new program that was created through the State Legislature via HB2910. The program mandates a quality assurance fee for qualifying private ambulance providers and issues a federal reimbursement match. The program has three main components, the quality assurance fee, Fee for Service (FFS) requirements, and Coordinated Care Organization (CCO) requirements.

DOCUMENTS RELIED UPON, AND WHERE THEY ARE AVAILABLE

HB 2910 https://olis.oregonlegislature.gov/liz/2021R1/Downloads/MeasureDocument/HB2910/Enrolled

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

None

FISCAL AND ECONOMIC IMPACT:

None

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).

(1) None

(2)

(a) None

(b) Requires reporting and administrative activities for compliance for the private ambulance providers and state employees running the program.
(c) None

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

None

WAS AN ADMINISTRATIVE RULE ADVISORY COMMITTEE CONSULTED? YES

RULES PROPOSED:
410-136-3372, 410-136-3373, 410-136-3374

ADOPT: 410-136-3372

RULE SUMMARY: This is general requirements and definitions for the Emergency Medical Service Transport (EMST) Private Provider Program. This rule lists the general requirements and definitions. The EMST private provider program is a program that initiates a quality assurance fee on private ambulance providers and is matched with federal funds for reimbursement.

CHANGES TO RULE:

410-136-3372
General Requirements for Emergency Medical Service Transport Private Provider Program
(1) The Emergency Medical Services Transport (EMST) Private Provider Program is a program that makes supplemental payments to eligible GEMT EMST private providers who furnish qualifying emergency ambulance services to Oregon Health Authority (Authority) Medicaid recipients:¶
(a) The supplemental payment covers an add-on reimbursement fee to the base rates for eligible emergency medical transportation services. The add-on reimbursement fee to the base rates for eligible emergency medical transportation services, excludes EMS air transports. The calculation is based on the gross receipts reported on the Centers for Medicare and Medicaid Services (CMS) approved data request template;¶
(b) The Authority makes add-on reimbursement payments only up to the amount calculated by the gross receipts. Total reimbursements from Medicaid including the supplemental payment may not exceed one hundred percent of actual costs;¶
(c) The reimbursement rate add-on shall cover EMST Private Provider Program and shall be applied in lump sum payment at least annually to eligible providers using the Healthcare Common Procedure Coding System (HCPCS) emergency transport codes;¶
(d) The supplemental payments shall be made at least annually on a lump-sum basis after the conclusion of each state fiscal year;¶
(e) The base rates for EMST shall not change with this amendment to Oregon's Medicaid's State Plan.¶
(2) Definitions:¶
(a) "Authority" means the Oregon Health Authority;¶
(b) "Advanced Life Support" means special services designed to provide definitive prehospital emergency medical care, including but not limited to, cardiopulmonary resuscitation, cardiac monitoring, cardiac defibrillation, advanced airway management, intravenous therapy, administration with drugs and other medicinal preparations, and other specified techniques and procedures;¶
(c) "Basic Life Support" means emergency first aid and cardiopulmonary resuscitation procedures to maintain life without invasive techniques;¶
(d) "Eligible Emergency Medical Services Transport Private Provider" means an EMS provider that meets all the eligibility requirements described in (Section 3) below. A nonfederal or nonpublic entity that: ¶
(A) Employs individuals who are licensed by the Authority under ORS chapter 682 to provide emergency medical services; and ¶
(B) Contracts with a local government pursuant to a plan described in ORS 682.062.¶
(e) "Emergency Medical Services" means the act of transporting an individual by ground from any point of origin to the nearest medical facility capable of meeting the emergency medical needs of the patient, as well as the advanced, limited-advanced, and basic life support services provided to an individual by Eligible Emergency Medical Services Provider before or during the act of transportation.¶

(A) This includes to assess, treat, and stabilize the individual's medical condition; or¶
(B) Prepare and transport the individual to a medical facility.¶
(f) "Emergency Medical Services Transport" means an emergency medical services provider's evaluation of an individual experiencing a medical emergency and the transportation of the individual to the nearest medical facility capable of meeting the needs of the individual. For the purposes of this state plan, EMS air transports are excluded;¶
(g) "Emergency Medical Services Fund" is a fund established in the state treasury, separate and distinct from the General Fund. The Emergency Medical Services Fund consist of moneys collected by the Authority as a quality assurance fee;¶
(h) "Federal Financial Participation (FFP)" means the portion of medical assistance expenditures for emergency medical services that are paid or reimbursed by the Centers for Medicare and Medicaid Services in accordance with the State Plan for medical assistance. Clients under Title XIX are eligible for FFP;¶
(i) "Gross Receipts" means gross payments received as patient care revenue for emergency medical services transports, determined on a cash basis of accounting. Gross receipts do not include Medicaid Supplemental Reimbursement pursuant to Attachment 4.19-B, pages 31-39 of Oregon's Medicaid's State Plan;¶
(j) "Local Government" means all cities, counties and local service districts located in this state, and all administrative subdivisions of those cities, counties and local service districts as defined in ORS 174.116;¶
(k) "Limited Advanced Life Support" means special services to provide prehospital emergency medical care limited to techniques and procedures that exceed basic life support but are less than advanced life support services;¶
(l) "Treatment in Place" means EMT services (basic, limited-advanced, and advanced life support services) provided by a Medicaid-enrolled EMS professional to an individual who is released on the scene without transportation by ambulance to a medical facility;¶
(m) "Usual Charge" means the lesser of the following unless prohibited by federal statute or regulation:¶
(A) The providers charge per unit of service for the majority of non-medical assistance users of the same service based on the preceding months charges;¶
(B) The providers lowest charge per unit of service on the same date that is advertised, quoted, or posted. The lesser of these applies regardless of the payment source or means of payment;¶
(C) Where the provider has established a written sliding fee scale based upon income for individuals and families with income equal to or less than 200 percent of the federal poverty level, the fees paid by these individuals and families are not considered in determining the usual charge. Any amounts charged to third party resources are to be considered.¶
(3) EMST Private Provider Eligibility Requirements:¶
(a) To be eligible for enhanced reimbursement, EMST private providers must meet all the following requirements:¶
(A) Be enrolled as an Oregon Health Plan Medicaid provider; ¶
(B) Provide ground emergency medical transport services to Medicaid recipients; ¶
(C) The organization is not a publicly owned or operated, and/or not participating in the GEMT supplemental program.¶
(4) Enhanced Reimbursement Methodology:¶
(a) A uniform add-on rate per emergency transport shall be determined at least annually and shall not exceed one hundred percent (100%) of the difference between Medicaid payments otherwise made to each EMST private provider for EMS services (base rates) and the usual charge for the service; ¶
(b) Medicaid base rate to the EMST private providers for providing EMS services are derived from the ambulance FFS fee schedule established for reimbursements payable by the Medicaid program by procedure code:¶
(A) The primary source of paid claims data, managed care encounter data, and other Medicaid reimbursements is the Oregon Medicaid Management Information System (MMIS);¶
(B) The number of paid Medicaid EMS transports is derived from and supported by the MMIS reports and the data from the Data Request Report for services during the applicable service period. ¶
(c) The least annual ambulance add-on payments shall not exceed the funding in the Emergency Medical Services Fund established in ORS 413.234 reimbursement may not exceed the costs for the emergency medical service transport, less the amount of reimbursement that the emergency medical services provider is eligible to receive from all public and private sources;¶
(d) Add-on payments for each EMST private provider shall be calculated for each at least annually:¶
(A) By multiplying the uniform add-on rate by the provider's volume of Medicaid transports billed with HCPCS codes A0429 BLS Emergency, A0427 ALS Emergency (Level 1); and ¶
(B) A0998 Ambulance Response/Treatment and paid at least annually as determined through the Medicaid Management Information System. ¶
(e) EMST private providers not subject to licensure within the State of Oregon shall not receive the enhanced add-on rate payment. ¶

(5) Eligible EMST Private Provider Reporting Requirements:¶
(a) Submit CMS approved data request template to the Authority; ¶
(b) Provide any supporting documentation to serve as evidence supporting information on the data request template, if specifically requested by the Authority;¶
(c) Keep, maintain, and have readily retrievable such records to fully disclose reimbursements amounts that the eligible EMST private provider is entitled to, and any other records required by CMS.¶
(6) Agency Responsibilities:¶
(a) The Authority shall submit any necessary materials to the federal government to provide assurances that all gross receipts are allowable under federal law;¶
(b) The Authority shall complete an annual audit and reconciliation process.
Statutory/Other Authority: ORS 413.234
Statutes/Other Implemented:

ADOPT: 410-136-3373

RULE SUMMARY: This is the rule for the quality assurance fee (QAF) portion of the EMST private provider program. It describes how the QAF will be assessed and enforced.

CHANGES TO RULE:

410-136-3373
Quality Assurance Fee for Emergency Medical Service Transport Private Provider Program
(1) Quality Assurance Fee (QAF) assessment for the GEMT EMS provider program:¶
(a) The amount of the QAF is assessed at least annually; ¶
(b) The amount of the QAF is five percent of the projected gross receipts for the following 12-month period. The projections must be based on the data reported in the data request template;¶
(c) The GEMT EMS provider shall file the data request template form approved by the Authority on or before the 45th day following the term in which the assessment is due.¶
(A)The payment is due and shall be paid at the same time required for filing the data request template form. ¶
(B) The GEMT EMS provider shall provide all information required on the data request template form when due. ¶
(C) Failure to file or pay when due shall be a delinquency;¶
(d) An EMS provider shall report the data in the data request template form within five days after the date upon which the report is due. After sending written notice to an EMS provider, the Authority may impose a penalty of $100 per day against an EMS provider for every day that the report is overdue. Any funds resulting from the penalty imposed under this section shall be deposited in the General Fund to be available for general governmental purposes;¶
(e) All QAFs and interest collected in section (2) of this rule shall be deposited into the EMS Fund.¶
(2) QAF Penalties, Interest, and Fees:¶
(a) The Authority has the right to assess interest on QAF's not paid by the due date at ten percent, beginning on the day after the date the payment was due;¶
(b) The Authority has the right to assess a penalty equal to the interest charged under paragraph (a) of this subsection for each month for which the payment is more than sixty days overdue;¶
(c) The Authority shall deduct the amount of any unpaid fee, interest or penalty assessed under this section from any Fee For Service medical assistance reimbursement owed to the EMS provider until the full amount of the fee, interest or penalty is recovered.¶
(A) The Authority may not make a deduction pursuant to this paragraph until after the Authority gives the EMS service provider written notification;¶
(B) The Authority may permit the amount owed to be deducted over a period of time that takes into account the financial condition of the EMS provider.¶
(d) The Authority may waive a portion or all of the interest or penalties, or both, assessed under this section if the Authority determines that the imposition of the full amount of the QAF in accordance with the due dates established under this section will impose an undue financial hardship on the EMS provider. The waiver must be conditioned on the EMS provider's agreement to pay the QAF on an alternative schedule developed by the Authority;¶
(e) In the event of a merger, acquisition or similar transaction involving an EMS provider that has outstanding QAFs, interest or penalties due, the successor EMS provider is responsible for paying to the Authority the full amount of outstanding QAFs, interest and penalties that are due on the effective date of the merger, acquisition or transaction.¶
(3) Data Request Template Form:¶
(a) The Authority shall approve the data request template form for an EMS provider to report the data necessary to administer the QAF, including information about the portion of funds that the EMS provider used to increase wages and benefits for employees, and may require a certification by each EMS provider under penalty of perjury of the truth of the data reported under this section;¶
(b) The Authority requires an EMS provider to report the number of emergency medical services transports it provided in each 12-month period, by payer type;¶
(c) Requires an EMS provider to report to the Authority its gross receipts for each 12-month period;¶
(d) Requires an EMS provider to report to the Authority the provider's costs for EMS transports.
Statutory/Other Authority: ORS 413.234
Statutes/Other Implemented: ORS 413.234

ADOPT: 410-136-3374

RULE SUMMARY: This is a rule for the CCO preprint. OHA has to send the federal match portion of funds to the CCOs and they reimburse the private ambulance providers. This rule describes the process of the CCO preprint and requirements.

CHANGES TO RULE:

410-136-3374
CCO Provider Requirements and Payment Processing for the Emergency Medical Service Transport Private Provider Program
(1) Definitions:¶
(a) "Coordinated Care Organization" has the meaning defined in OAR 410-141-3500;¶
(b) "Eligible Emergency Medical Services Provider" means an EMS provider that meets all the eligibility requirements described in (section B) below. A nonfederal or nonpublic entity that: ¶
(A) Employs individuals who are licensed by the Oregon Health Authority under ORS chapter 682 to provide emergency medical services; and ¶
(B) Contracts with a local government pursuant to a plan described in ORS 682.062.¶
(c) "Emergency Medical Services" means the act of transporting an individual by ground from any point of origin to the nearest medical facility capable of meeting the emergency medical needs of the individual, as well as provide advanced, limited-advanced, and basic life support services provided by Eligible Emergency Medical Services Provider before or during the act of transportation. This includes to assess, treat, and stabilize the individual's medical condition; or prepare and transport the individual to a medical facility;¶
(d) "Emergency Medical Services Transport" means an emergency medical services provider's evaluation of an individual experiencing a medical emergency and the transportation of the individual to the nearest medical facility capable of meeting the needs of the individual. For the purposes of this state plan, EMS air transports are excluded;¶
(e) "Managed Care Entity" has the meaning defined in OAR 410-141-3500;¶
(f) "Participating Provider" has the meaning defined in OAR 410-141-3500;¶
(g) "Qualified Directed Payment" means a supplemental payment made by the Authority to Community Care Organization (CCO) for EMST private providers' qualifying services when rendered by provider classes as defined in 42 CFR §438.6(c) Preprint forms approved by Centers for Medicare and Medicaid Services (CMS);¶
(h) "Supplemental Payment" means a payment amount set by the Authority for each approved procedure code to supplement allowable costs for EMST services;¶
(i) "§438.6(c) Preprint" means a 42 CFR §438.6(c) Preprint approved by U.S. Department of Health and Human Services CMS for Qualified Directed Payments to GEMT Providers for GEMT Services rendered during the applicable CCO contract rating period.¶
(2) EMST Private Provider Eligibility Requirements. To be eligible for supplemental payments, EMST private providers shall meet the following requirements:¶
(a) Be enrolled as an Oregon Health Plan Medicaid provider; ¶
(b) Provide ground emergency medical transport services to Medicaid recipients; ¶
(c) The organization is not a publicly owned or operated, and/or not participating in the GEMT supplemental program;¶
(d) Be a participating provider having a contractual agreement with a CCO on the date of EMST services; and¶
(e) Have an agreement in place with the Oregon Health Authority (Authority) for the approved service period to allow for transfer of funds between participating EMST private provider and the Authority to supplement the allowable costs of providing qualifying emergency medical services to CCO members.¶
(3) Supplemental Qualified Directed Payment Process:¶
(a) An EMST private provider may participate in the EMST private provider program described in this rule if the EMST provider is a participating provider in accordance with OAR 410-141-3500 on the date of service during the approved service period;¶
(b) The EMST Private Provider Program is for supplemental payments made by the Authority to CCOs for EMST private providers' qualifying services when rendered by EMST private providers for the approved service period;¶
(c) In accordance with 42 CFR §438.6(c)(2)(i)(A), the supplemental payments are based on paid CCO member encounters in the Medicaid Management Information System (MMIS) for approved qualifying EMST services' procedure codes;¶
(d) The Authority shall pay any federal financial participation received from CMS, for qualifying EMST services, to the CCO;¶
(e) The CCO shall increase, by the same amount, the amount of reimbursement paid to the appropriate EMST

private provider;¶
(f) The non-federal share portion of the supplemental qualified directed payment is contributed by EMST private providers only;¶
(g) The EMST private provider shall agree to pay a fee to reimburse the Authority for the costs of administering the program;¶
(h) The Authority may adjust the amount of supplemental payments based on actual utilization and available EMST funds for the period receiving supplemental payment. Qualified services rendered must be in accordance with OAR 410-120-1280 through 410-120-1340 for submission of claims and adhere to the record keeping and documentation requirements for services as described.¶
(4) Reporting and Billing Processes:¶
(a) The Authority shall combine the qualified encounters into a report to assist CCOs in distributing the program's supplemental funds to the appropriate EMST private provider in the manner agreed to by CCO and EMST private provider.¶
(A) In 2021 the report shall be distributed at least once to each CCO and each EMST private provider;¶
(B) In each subsequent program year that is approved by CMS, the report shall be distributed monthly to each CCO and each EMST private provider.¶
(b) After receipt of the report, CCOs shall submit a qualified directed payment for the amount indicated on the report to an account established by the appropriate EMST private provider;¶
(A) Adjustments shall be processed through the MMIS and included in the subsequent monthly report;¶
(B) If an error is identified in the monthly report, the CCO shall make the payment based on the original amount provided in the report. The Authority shall identify separately the correction in the following month's report and adjust the total payment amount to account for the error.¶
(c) Payment by the CCO as a MCE to participating providers for qualifying EMST services shall be in accordance with OAR 410-141-3565 Managed Care Entity Billing;¶
(d) Consistent with OAR 410-141-3610, GEMT supplemental payments are considered premium equivalents and subject to the MCE assessment under OAR 410-141-3601.¶
(5) Quality Measurement:¶
(a) In accordance with 42 CFR §438.6(c)(2)(i)(C), this payment arrangement must advance at least one of the goals and objectives in Oregon's Medicaid quality strategy required per 42 CFR §438.340; and the Authority shall review progress on the advancement of the state's goal(s) and objective(s) in the quality strategy identified in this section;¶
(b) EMST private providers shall submit the quality measurement data specified in the §438.6(c) Preprint.¶
(6) Authority Responsibilities:¶
(a) The Authority shall apply for program authorization through a §438.6(c) Preprint for each calendar year;¶
(b) The Authority shall make a supplemental payment only if the EMST private provider meets criteria established by the Authority for the EMST CCO Supplemental payment program in accordance with applicable federal requirements approved by CMS for the applicable program year;¶
(c) The Authority shall make a supplemental payment consistent with §438.6(c) Preprint approved with CMS for qualified paid encounters as described in Section 3 of this rule, with an approved procedure code that meets criteria for payment established by the Authority, up to one encounter, per CCO member, per day;¶
(d) Upon receipt of an acceptable funds transfer from EMST private provider consistent with Section 3 of this rule, the Authority shall verify data received and draw the federal funds in an amount consistent with the applicable Oregon Federal Medical Assistance Percentage (FMAP).
Statutory/Other Authority: ORS 413.234
Statutes/Other Implemented: ORS 413.234