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NOTICE OF PROPOSED RULEMAKING
INCLUDING STATEMENT OF NEED & FISCAL IMPACT

FILED
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ARCHIVES DIVISION
SECRETARY OF STATE

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

FILING CAPTION: Aligning With Legislatively Approved Rate Adjustment For Neonatal, Pediatric Intensive Care Services

LAST DAY AND TIME TO OFFER COMMENT TO AGENCY: 01/21/2022 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)

Oregon's 81st Legislative Assembly passed House Bill 5024. As part of the budget package 801, legislators authorized additional funding for the Oregon Health Authority (Authority) for reimbursement adjustment to increase rates for specific professional services provided to Oregon Health Plan beneficiaries in neonatal and pediatric intensive care units. Upon approval of State Plan Amendment from Centers for Medicare and Medicaid Services (CMS), the amendment to this payment gives the Authority the ability to adjust the rate methodology calculation using a specific conversion factor for procedure codes 99468-99480.

DOCUMENTS RELIED UPON, AND WHERE THEY ARE AVAILABLE

https://www.oregonlegislature.gov/bills_laws/lawsstatutes/2021orlaw0668.pdf
https://olis.oregonlegislature.gov/liz/2021R1/Downloads/MeasureAnalysisDocument/62990

FISCAL AND ECONOMIC IMPACT:

This change will have a positive impact on medical providers who provide professional services to Oregon Medicaid beneficiaries who are hospitalized in neonatal or pediatric intensive care units by increasing the reimbursement rate paid to these providers. The legislature authorized $750,000 General Fund and $1,174,000 Federal Fund expenditure for these procedure codes. There are no additional administrative requirements for providers and no expense to providers.

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) Funding authorized by HB 5024A is $750,000 in state general funds for biennium 2021-2023. No other impact on state, local government or the public.

(2)

(a) Estimate of the number provider groups who serve this population to be less than 10 (ten).

(b) None.

(c) None

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

None.

WAS AN ADMINISTRATIVE RULE ADVISORY COMMITTEE CONSULTED? NO IF NOT, WHY NOT?

This is a legislatively mandated change to reimbursement for specific professional services. Neonatology practice groups have been identified to inform them of this upon approval of State Plan Amendment (SPA) approval from Centers for Medicare and Medicaid Services (CMS).

AMEND: 410-120-1340

RULE SUMMARY: Amended rule language incorporates new conversion factor applied to specific procedure codes for professional services provided for neonatal and pediatric intensive care Medicaid beneficiaries. Resulting rates for Relative Value Unit (RVU) weight-based codes aligns with reimbursement increase authorized by Oregon's 81st Legislative Assembly under the budget package 801 in HB 5024. A distinct conversion factor is applied to Current Procedural Codes (CPTs) 99468-99480.

CHANGES TO RULE:

410-120-1340
Payment ¶

(1) The 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 sets fee-for-service (FFS) payment rates for the billed services or items. The FFS payment rates are the Division's maximum allowable rates for billed services or items.¶
(4) The Division reimburses providers for billed services or items at the lesser of:¶
(a) The amount billed;¶
(b) The Division's FFS payment rate in effect on the date of service~~;~~; or~~;~~¶
(c) The rate 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~~:~~. The Division updates all CPT/HCPCS codes assigned an RVU weight effective January 1 of each year, based on the annual RVU updates published in the Federal Register~~;~~;¶
(A) The Division applies RVU weights as follows:¶
(i) The Non-Facility Total RVU weight, to professional services not typically performed in a facility;¶
(ii) The Facility Total RVU weight, to professional services typically performed in a facility~~;~~;¶
(B) The Division applies the following conversion factors:¶
(i) $40.79 for labor and delivery codes (59400-59622);¶
(ii) $38.76 for neonatal intensive care and pediatric intensive care professional service codes (99468-99480);¶
(iii) $27.82 for Oregon primary care providers. A current list of primary care CPT, HCPCs, and provider types and specialties ("Oregon Primary Care Providers and Procedure Codes") is available at http://www.oregon.gov/OHA/HSD/OHP/Pages/Providers.aspx;¶
(i~~i~~iv) $25.48 for all remaining RVU weight-based CPT/HCPCS codes~~;~~.¶

(C) The Division calculates rates using statewide Geographic Practice Cost Indices (GPCIs) as follows:¶
(i) (Work RVU) X (Work GPCI) + (Practice Expense RVU) X (Practice GPCI) + (Malpractice RVU) X (Malpractice GPCI). The formula used to create the statewide GPCI is (3*(Portland GPCI) + 33* (Rest of State GPCI))/36 = GPCI.¶
(ii) The sum in paragraph (C)(i) is multiplied by the applicable conversion factor in section (B) to calculate the rate;¶
(b) Non-RVU-weight-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 70 percent of the Medicare clinical lab fee schedule effective on the date of service;¶
(C) All approved Ambulatory Surgical Center procedures are 80 percent of the Medicare fee schedule effective on the date of service;¶
(D) Physician-administered drugs billed under a HCPCS code are 100 percent of the Medicare rate. The Medicare rate is equal to Average Sales Price (ASP) plus six percent;¶
(c) When no ASP rate is available, the rate is based upon the Wholesale Acquisition Cost (WAC) provided by First Data Bank;¶
(d) If no WAC is available, then the rate is the Acquisition Cost. These rates may change periodically based on drug costs;¶
(e) All procedures used for vision materials and supplies are contracted rates that include acquisition cost plus shipping and handling;¶
(f) Individual provider rules may specify rates for particular services or items.¶
(7) The Division reimburses inpatient hospital services 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.¶
(8) 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.¶
(9) 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.¶
(10) For services provided by out-of-state institutions and facilities such as skilled nursing care facilities, psychiatric facilities and rehabilitative care facilities, the Division sets rates that are:¶
(a) Consistent with the rate for similar services provided in Oregon; and¶
(b) The lesser of the rate paid to the most similar licensed Oregon facility or the rate paid by the other state's Medicaid program; or¶
(c) Consistent with the rate established by APD for out-of-state nursing facilities.¶
(11) The Division may not make payment on the following claims:¶
(a) Assigned, sold or otherwise transferred claims; or¶
(b) Claims where the billing provider, billing agent, or billing service receives a percentage of the amount billed, amount collected or payment authorized. This includes, but is not limited to, claims transferred to a collection agency or individual who advances money to a provider for accounts receivable.¶
(12) Nursing facility payments:¶
(a) The Division may not make a separate payment to a nursing facility or other provider for services included in the nursing facility's all-inclusive rate (OAR 411-070-0085).-¶
(b) The following services are not in the all-inclusive rate and may be reimbursed separately:¶
(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).¶
(13) 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.¶
(14) 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.¶
(15) For clients with third-party resources (TPR), the Division pays the allowed rate less the TPR payment but not to exceed the billed amount.¶
(16) The Division payments including contracted Managed Care Entity (MCE) payments, unless in error, constitute payment in full, except in limited instances involving allowable spend-down. 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.¶
(17) 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