PUBLIC HEALTH DIVISION
Office of Health Care Regulation and Quality Improvement
Tina Kotek, Governor

Oregon Health Authority

800 NE Oregon Street, Suite 465
Portland, OR 97232
Voice: (971) 673-0540
FAX: (971) 673-0556
TTY: 711

Hospital Housekeeping and Statutory Alignment
Rule Advisory Committee
October 11, 2023
10:00 a.m. – 12:00 p.m. via Zoom

RAC MEMBER ATTENDEES	
Alex Skog	Oregon Chapter of American College of Emergency Physicians
Annette Marcus	Alliance to Prevent Suicide Association of Oregon Community Mental Health
Chris Bouneff	National Alliance on Mental Illness - Oregon
Danielle Meyer	Hospital Association of Oregon
Jonathan Frochtzwajg	Cascade AIDS Project
Julie Magers	Family Advocate
Kristen Downey	Providence Health and Services
Mandi Dix	Salem Hospital
Stephanie Willard	Parent Advocate
Vanessa Timmons	Oregon Coalition Against Sexual and Domestic Violence
INTERESTED PARTIES	
Ruth Miles	Salem Health
Sasha Walia	Providence Health and Services
Troy Duker	Hospital Association of Oregon
Oregon Health Authority/Oregon Department of Human Services/	
Anna Davis	OHA-Public Health Division: Health Facility Licensing and Certification
Catherine Bennett	OHA-Public Health Division: Injury Violence and Prevention
Meghan Crane	OHD-Public Health Division: Suicide Prevention
Mellony Bernal	OHD-Public Health Division: Health Care Regulation & Quality Improvement
Rachel Ford	OHD-Public Health Division: EMS for Children
Zachary Thornhill	OHD-Health Systems Division: Civil Commitment Policy Analyst

Welcome, Housekeeping and Agenda Review

Mellony Bernal introduced self and welcomed attendees to this rule advisory committee to discuss amendments made to hospital administrative rules based on passage of several legislative measures, including two measures passed in 2021.

Housekeeping items for RAC participation reviewed:

- Attendees were asked to enter their name, title and organization into the Chat. Participants not considered a RAC member were asked to identify themselves in the Chat as a public participant.
- Attendees were asked to keep devices muted until called upon.

- RAC members were asked to type the word "Comment" to indicate they want to speak to a particular issue or ask questions. RAC members who do not want to talk but want the Health Care Regulation and Quality Improvement (HCRQI) section to consider information were asked to type into the Chat “For the Record” and include the information they wish to share. Persons will be called upon in the order appearing on the Chat.
- It was noted that pursuant to the OHA policy, members of the public may attend but may not participate or offer public comment during the meeting. Members of the public who wish provide comments or information should email those comments to mellony.c.bernal@oha.oregon.gov at the conclusion of the meeting.
- It was further noted that after the RAC process has concluded, there will be an opportunity to provide oral public comments at a public hearing or to send written public comments during the public comment period. Information about the notice of proposed rulemaking and public hearing will be shared by email using HCRQI's GovDelivery Listservs.
- It was noted that the RAC meeting will be recorded, and the recording and information shared in the Chat is a matter of public record and is subject to disclosure.
- Meeting notes will be drafted and shared with the RAC and posted on HCRQI's rulemaking activity webpage: http://www.healthoregon.org/hcrqirules.

Roll call was taken of the RAC members and RAC members introduced themselves as well as Oregon Health Authority staff.

The agenda was reviewed.

Rulemaking Advisory Committee Overview and Scope

Overview

M. Bernal noted the following:

- State agencies convene RACs for a variety of reasons including when the legislature passes laws that require rules be adopted, when the agency needs to clarify process or intent, and sometimes as a result of community partner feedback.
- RAC members include persons and communities that are most likely affected by the proposed rules including representation from licensed facilities, special interest groups, and associations.
- RAC members will consider the proposed text drafted by HCRQI and raise any concerns or issues or offer other suggested language. Additionally, the RAC will review the Statement of Need and Fiscal Impact (SNFI) which also includes a statement on how the proposed rules may affect racial equity in Oregon.
- Considering information provided by the RAC, HCRQI will finalize proposed rule text and submit notice of proposed rulemaking to the Secretary of State along with the SNFI.
- A public hearing will be scheduled where persons can present oral testimony or submit written comments. The public hearing's officer that presides over the public hearing will generate a report summarizing the comments.
- HCRQI will review and consider all testimony and comments received and determine whether additional changes to the rule are necessary based on those comments.
- HCRQI will provide a response to the hearing's officer report.

- HCRQI will finalize rule text and determine effective date and file permanent rulemaking notice with the Secretary of State's office.

Scope

- The purpose of this RAC is to consider amending and making permanent proposed amendments and adoption of rules that were drafted based on the following:
  - SB 556 (2021) – housekeeping bill relating to in-person inspections;
  - HB 3036 (2021) – bill relating to physician assistants;
  - SB 1043 (2023) – providing two doses of opioid reversal medication such as Narcan at time of release or discharge for patients treated for an opioid use disorder;
  - HB 2574 (2023) – providing a five-day supply of HIV post-exposure prophylactic following a possible occupational or non-occupational exposure;
  - Adding an equity impact analysis for hospitals seeking a waiver from current rule requirements;
  - Amending the type of providers who may provide caring contacts to persons being released from the emergency department who were seen for a behavioral health crisis; and
  - Changes to policy requirements including ID badges and transferring a patient from the emergency department to another hospital.
- Staff anticipate only one meeting will be necessary but based on discussion an additional meeting may be needed.
- Goal is to have final proposed rule text submitted to the Public Health Division's Rule's Coordinator by November 17th for posting in the December 1 Oregon Bulletin.

RAC member asked about possible public hearing date and written comment deadline. M. Bernal responded that if the deadline is met and the notice is posted in the December 1 Oregon Bulletin, HCRQI anticipates a public hearing being scheduled on or after December 15th and the written public comment period ending on or around December 22nd.

Administrative Rule Review
M. Bernal opened discussion on the proposed changes to the administrative rule and summarized requirements of the rule.
OAR 333-500-0034 – Application Review
Based on passage of SB 556 (2021), amendment was made to clarify that on-site means in-person for purposes of conducting a licensing survey. RAC members had no comment.
ACTION – None.
OAR 333-500-0055 – Discontinuance and Recommencement of Operation of Hospitals
Similar to OAR 333-500-0034, the term on-site was updated to in-person based on passage of SB 556 (2021). RAC members had no comment.

ACTION – None.

OAR 333-500-0065 – Waivers

The waiver rule allows hospitals that wish to stop providing a required service or other changes that do not align with administrative rule requirements to request a waiver from HCRQI. HB 3592 was a measure introduced in 2023 that did not pass, but it was an opportunity for the Agency to hear from the community about concerns raised about the closure of birthing services in the community, and how closure of services may impact equity. As such, HCRQI has amended this rule to require a hospital, as part of its request for a waiver, to include:
1) A description of possible impacts the proposed waiver would have on persons different backgrounds and cultures including individuals of color, individuals with disabilities, people or households with lower incomes, and the LGBTQIA2S+ communities;
2) Identify how the impact was determined; and
3) Proposed steps to mitigate the impact on disproportionately affected populations.

Discussion:

- RAC member asked since the bill did not pass, under what statutory authority are the rules being amended? Anna Davis responded that the HCRQI section has general rulemaking authority under ORS 441.025 for purposes of licensing hospitals and legislation is therefore not required. The legislation did provide an opportunity to consider what the Agency should consider when granting waivers. Generally, the HCRQI section has seen few waiver requests to stop providing a service. Waivers are more common for physical environment requirements and hospital nurse staffing.
- RAC member asked follow-up question on whether this rule may impact existing waivers that must be renewed or only affect new requests for waivers. It was requested that this rule only apply to new waivers and not renewals. A. Davis responded that generally for a renewal, there wouldn't be any new disproportionate impacts. The HCRQI section may need to discuss with DOJ.
- RAC member noted this is an important consideration and they were engaged in the legislative conversations, including how existing waivers may be impacted. It was stated that this is one reason why the measure did not move forward.
- RAC member via Chat indicated "this is a critically important intervention that affects patient care far beyond that specific hospital's patient population. Oregon Emergency Physicians strongly support this change."

ACTION – Consider whether the equity analysis will apply to hospitals seeking to renew an existing waiver and whether the equity analysis will apply to existing waivers.

OAR 333-501-0015 – Surveys

Similar to OAR 333-500-0034 and OAR 333-500-0055, the term on-site was updated to in-person based on passage of SB 556 (2021).

RAC members had no comment.

ACTION – None

OAR 333-505-0005 – Governing Body Responsibilities

Based on passage of HB 3036 (2021), a housekeeping bill relating to physician assistant practices, rule language was amended to align with the statutory language.

Discussion:

- RAC member inquired about cleaning up both existing and amended language. Privileges are what the hospital offers and may not be granted. It was suggested that language be revised to "Privileges may be granted on the same general basis that privileges are granted for other members of the hospital medical staff." It was further stated that a hospital doesn't refuse privileges, it just doesn't grant privileges. A. Davis suggested that HCRQI consider language that allows a hospital to conduct privileging for specified providers in the same manner that they do for other providers.
- RAC member via Chat suggested changing refuse to 'decline to grant privileges.'

ACTION – Consider updating language regarding granting privileges and removing references to refusal.

OAR 333-505-0030 – Organization, Hospital Policies

ORS 441.096 requires health care facilities to develop policies that specify use, size and content of identification (ID) badges. In response to a survey conducted by HCRQI staff, it was requested that policy language be added to rule.

Discussion:

- RAC member noted that there may be practitioners including nurses that are uncomfortable having their full name displayed on their badge and consideration should be given to what "name" might mean including allowing persons to use a name they are comfortable with.
- RAC member concurred with comment above and in reviewing policy, it allowed caregivers the option to choose. A hospital policy should be amenable to this, and the caregiver allowed to have some say in name used.
- RAC member stated via Chat noted that name choice can have a significant impact on domestic violence survivors.
- RAC member indicated that use of name must also consider the needs of patients, patient representatives, guardians, or caregivers. It is important for these individuals to be able to gather information and know who is treating a loved one (or self). Given the existing climate the need to respect a person's choice to use full name is understood but would like to consider further.
- RAC member via Chat indicated support of the language regarding ID badges as drafted.
- Staff noted that both the rule and statute does not specify what "name" includes. It is understood that a hospital has the discretion to set requirements in its policy, including for safety and security purposes.

ACTION – None. It is understood that the hospital has the discretion to set requirements in policy in terms of name use on badges.

OAR 333-505-0055 – Discharge Planning Requirements

Subsection (2)(a) of this rule was amended based on discussions with the EMS for Children's Program that has had conversations with the Hospital Association of Oregon. The proposed language would require that a hospital adopt a policy that includes a plan to transfer a patient's personal belongings and to provide directions and referral institution information to the patient and the patient's family when a patient is being transferred from one hospital to another. In considering language, staff reviewed current federal requirements under EMTALA and other federal regulations.

Discussion:

- RAC member questioned whether the proposed rule is duplicative considering what hospitals are already doing and is potentially unnecessary. In particular, it was noted that hospitals don't necessarily "give" directions, rather provide the address of the other hospital. Wording could be changed to clarify intent, but the rule is not really necessary. In follow-up to comments, this RAC member stated via Chat: "Remove entirely or revise the text to read: 'Upon transfer from the emergency department to another hospital, a plan to provide the address of the referral institution to the patient and the patient's family, caregiver, legal representative, or health care representative.'
- RAC member indicated via Chat support of the recommendation noted above.

Paragraph (2)(c)(E) relating to the policy for patients hospitalized for mental health treatment was amended to clarify that a follow-up appointment must be scheduled no later than seven *calendar* days after discharge.

Discussion: RAC members had no comments.

Subsection (2)(d) is a new rule based on passage of SB 1043 (2023) and requires a hospital to have a policy on providing at least two doses of an opioid overdose reversal medication, such as Narcan, to a patient who was actively treated for an opioid use disorder and who is being discharged or released to a private residence or an unlicensed setting. The rule further states that a hospital is not required to provide the medication if the patient leaves the hospital against medical advice prior to discharge. Rule text is based on the legislative language.

Discussion:

- RAC member stated that Emergency Medical Physicians strongly supported this legislation and continue to support it. It was requested that wording be reconsidered in terms of a hospital not being required to dispense medication. RAC member stated it is assumed the intent is a hospital is not penalized when a patient leaves the hospital against medical advice so quickly or elopes before medication can be given. There should be no reason that a hospital could not provide a patient with medication when signing out against medical advice. Language should be amended to consider that a hospital will not be penalized if a patient elopes or leaves against medical advice before there is an opportunity to dispense the medication. A. Davis questioned whether the language as written does not make it clear that the hospital could dispense. RAC member replied that the hospital could and should try to dispense the medication but should not be penalized if someone has left and they are unable to give the medication.
- RAC member stated there is nothing in the rule that allows the patient to refuse the medication. It was also noted that there are cases where the same individual presents to the hospital multiple times per week or month, and the rule essentially requires the hospital to

force the individual to take two doses every time. It doesn't allow patient autonomy or a patient to refuse because they had received doses previously. RAC member further noted that there are challenges particularly around the 'two naloxone kits' for patients discharged from inpatient unit. Information was shared about Washington issuing a standing order from their Health Authority that helps alleviate strict dispensing rules. Washington considers Naloxone or other opioid reversal medications as over the counter to relieve pressures of tracking, dispensing, etc. from acute care facilities. There needs to be a parallel path to alleviate the administrative burden associated with the rule as written.

- RAC member suggested revising the language to align with statute and state, 'For a patient *that the hospital* is actively treating…' In agreement with the previous comment, this RAC member asked what the next steps are to ensure that these two paths are going along at same time as we consider implementation dates of these rules.
- RAC member stated via Chat that the wording of "two" doses is because naloxone only comes commercially in a 2-dose package and there are not "two kits" being distributed.

ACTION – 1) Consider removing the rule reference relating to transferring a patient's belongings and providing directions or consider amending to clarify intent. 2) Consider updating the language in terms of providing opioid reversal medication to make it clear that a hospital may dispense medication even if a person chooses to leave against medical advice. 3) Consider adding language that allows for patient refusal of medication. 4) Update language to state, 'For a patient that the hospital is actively treating…' 5) Provide information on next steps relating to opioid reversal medication and provisions of the rules and legislation.

OAR 333-505-0075 – HIV Post-Exposure Prophylaxis

This is a new rule that has been adopted based on passage of HB 2574. The HCRQI section discussed elements of the rule with the Oregon Health Authority's – HIV, STD and TB section. The rules specifies that a hospital must have a policy in place by January 1, 2024 for the dispensing of HIV prophylaxis to a patient for occupational or nonoccupational exposure to HIV. As stated in the legislation, the policy must conform to guidelines issued by the CDC and the HCRQI section has identified specified, dated CDC guidance in subsections (2)(a) and (b). The rule outlines that an evaluation must occur within 72 hours after possible exposure and that the hospital shall ensure that informed consent is obtained, that there are no medical contraindications, and that information on the importance of starting and completing the medication regimen is shared along with information on resources to obtain the full medication regimen. Lastly, documentation of informed consent and the date the prophylaxis was started is necessary.

Discussion:

- RAC member requested that 1) under section (3) nonoccupation 'postexposure' be changed to 'exposure;' 2) Under subsection (3)(c), it was recommended that instead of stating 'first dose' it be changed to reflect the first 5 days of the medication regimen; 3) sections (3) and (4) refer to informed consent and medication contraindications and are duplicative based on other state and federal regulations around informed consent; and 4) information was requested on how Type A and Type B hospitals will be obtaining the medication. A. Davis noted that while a person being released from the emergency department would receive their 5-day regimen all at once, an inpatient would receive the prophylaxis on each day while admitted.

- RAC member agreed that references to 'postexposure' need to be updated. Additionally, concern was expressed that the CDC guidelines will likely be updated at some point and then the rules will be outdated. It was suggested that the rule just refer to CDC guidelines as stated in the statute to allow for the flexibility of future updates. Staff responded that the Department of Justice requires that guidance be dated in its rules and that the program works to monitor guidance so that when updates occur, the rules can be re-opened, and new guidelines added.
- RAC member shared concerns from Emergency Medical Physicians that giving out a 5-day supply of HIV postexposure prophylactics (PEP) will actually decrease compliance with the full 28-day medication regimen. The rule language specifically calls out a policy in accordance with CDC guidelines, but those guidelines don't suggest a 5-day course of HIV PEP. It was noted that the data cited in the CDC guidelines suggests that any course given that is less than 28-days, actually decreases compliance with the 28-day course. This allows hospitals to develop policies to only supply 5-day course that is not supported by the guidance. While the statute specifies the 5-day course, the focus must be on how to connect patients to the resources to get the full 28-day course and this rule and legislation may inadvertently cause more infections by focusing on the 5-day course.
- RAC member concurred with comments above and noted discussions with emergency room and pharmacy teams and the dangers of opening the packaging and splitting it up. RAC expressed thanks to the HCRQI section for ensuring language states 'at least' representing what the legislation allows and hospitals should still be giving out the full medication regimen. This RAC member also concurred with earlier comments that the informed consent is duplicative. While the bills expressly provide for informed consent, hospitals are working to make sure that HIV care is part of everyday care and doesn't require anything extra and has a standard course of treatment. As such, hospitals have general informed consent documents and process that is a part of standard care. The rule language implies that additional informed consent and additional documentation is necessary. RAC member asked whether persons who worked on the measure could speak to whether the preference is to keep it as part of the normal practice and providing services or whether the intent is that additional documentation and records are necessary. The preference is that it is part of the standard general informed consent form.
- RAC member responded that the intent of the bill was not to require informed consent above and beyond standard practice. As advocates for legislation, the Cascade AIDS Project heard concerns about the requirement that medication be dispensed, and that people be allowed to decline if they did not agree to receive. The process should not be more burdensome than standard care.
- RAC member concurred with the issue of the 5-day regimen versus full medication regimen. Hospitals are not prevented from providing the full 28-day course. This RAC member further noted that the language states that the hospital must conform to CDC guidance, and 5-days is not supported by the guidance.
- RAC member remarked that the rule, in accordance with statute, specifies that hospitals must conform with CDC guidance with the exception of the medication course.
- RAC members were encouraged to consider language selections and submit to staff.

ACTION – 1) Change references to "postexposure" to "exposure" where needed based on discussion; 2) consider removing references to informed consent and documentation

requirements which are required under other federal and state rules and is duplicative based on standard of care.

OAR 333-520-0070 – Emergency Department and Emergency Services

This rule has been amended to change the definition for the types of providers that can provide caring contacts to successfully transition a patient to outpatient services as a result of a recommendation from the follow-up HB 3090 legislative report, "Emergency Department Discharge Practices for Behavioral Health Crisis Care: A Statewide Survey of Hospitals." This report can be found at: https://sharedsystems.dhsoha.state.or.us/DHSForms/Served/le4272.pdf

The rule has been amended by adding the following new provider types to the rule:

- Crisis counselor operating under the direction of a behavioral health clinician (this was added as suggested by advice from our legal counsel);
- Qualified mental health associate as defined in OAR 309-039-0510;
- A registered nurse whose training, experience and competence demonstrates ability to conduct a suicidal risk assessment, provide lethal means counseling and safety planning for suicide prevention.

The rule further specifies that for a registered nurse, the hospital must ensure that policies and personnel records document the required training, experience and competence necessary.

Discussion:

- RAC member stated via Chat that the "experience and competency" that is listed under the Registered Nurse should apply to all provider types. This RAC member further stated that 'caring contacts' are a type of specific intervention, and everyone listed as a provider needs to have the competency to conduct those contacts. It was further noted that not all of the providers called out in the definition have those competencies.
- RAC member stated that in setting up systems and structures, the peer support and peer wellness specialists, family support specialist, and youth support specialist are an important part of the care team and at time of hire may not have achieved final certification but are in the process. To continue to propel people into the work, HCRQI was asked to allow some grace for persons newly certified or in process of certification. This RAC member further noted that this work is still not being paid for despite passage of HB 3091.
- To comment above, RAC member indicated that the supervision of these individuals who are newly certified or working towards certification is really important. For example, a Qualified Mental Health Associate (QMHA) is an individual working under the direction of a Qualified Mental Health Professional (QMHP) who must meet minimum qualifications. As proposed, a crisis counselor must work under direction of a behavioral health clinician. To do this work effectively, all of the roles need to be under the proper licensing, certification, and supervision. It may be that language 'under the supervision of' would help to create a workforce pathway for persons in some roles that may not be fully certified or licensed. While not under the scope of this RAC, this RAC member also reiterated the purpose of HB 3091 which was to pay for the services being described and must be considered.
- RAC member remarked that paragraph (4)(g)(A) is duplicative and addressed by other rules and regulations and doesn't need to be called out, and also noted it would cover all of the provider types not just RNs. This RAC member further concurred with comments around payment and HB 3091.

- RAC member inquired via Chat whether peer support included domestic violence advocates working in community-based organizations. RAC member responded that ORS 414.025 and OAR chapter 410, division 180 are the regulations pertaining to mental health peers.
- RAC member asked about whether there will be additional time to comment on proposed changes. Staff noted that the goal is to have final draft language ready to submit to the Public Health Division's Rule's Coordinator by November 17th. In follow-up to comment about calling out RNs specifically, this RAC member agreed and noted that even a QMHP may not have all of the necessary competencies. It was suggested that an overarching statement be developed that ensures that all individuals have the training, experience and competence to conduct suicide risk assessment, provide lethal means counseling, and safety planning for suicide prevention.
- RAC member agreed with comment about calling RNs out for specific documentation requirements and any duplicative requirements should be removed. It was further noted that caring contacts is specific type of intervention and provider types need to clearly understand what it means. Definition was noted during the RAC and can be found in subsection (1)(d).
- RAC member agreed with comment above.
- RAC member noted via Chat that HB 3090 doesn't require caring contacts. Neither does HB 3091. Caring contacts was added in the rulemaking process, so it will be difficult to provide reimbursement as this isn't a mandate in statute. It is a specific service for which we need to address the pathway to payment. Otherwise, caring contacts won't be universally available as intended under this rule.
- RAC members via Chat agreed with comment above. One RAC member via Chat noted that reimbursement and availability of caring contacts is a very important issue. RAC member stated that during initial drafting of HB 3090 and HB 3091 there were many components in the bill language that were removed, and the agreement was more specificity would be spelled out in the administrative rules. There needs to be a follow-up process and discussion around the link between HB 3090 and 3091 and what is in statute and rule. They were never meant to be separated and intended to work together. They are no longer effectively linked. M. Bernal acknowledged frustration and noted that this issue was highlighted in the Emergency Department Discharge Practices for Behavioral Health Crisis Care report and the recommendations included convene partners to address HB 3091 barriers and identify solutions to current reimbursement issues and called out that the Department of Consumer and Business Services (DCBS), hospitals, and Medicaid fee-for-service partners be involved. Rules around reimbursement for services do not fall under the HCRQI's scope and work. Meghan Crane further noted that programs continue to work to try and find pathways to address this need including raising awareness to leadership.
- Staff were asked via Chat what is the path forward on this specific issue? M. Bernal noted that she will try and find out which program would be on point to spearhead efforts on the reimbursement discussion. RAC member stated that at one point a representative from DCBS was invited to speak on this issue has since retired. A workgroup should be convened to discuss the challenges around reimbursement for these services.
- RAC member stated via Chat that the issue to be addressed is what suite of services falls under the general mandate created in HB 3091. To date, there isn't even universal reimbursements for the assessments that are mandated in HB 3090 and 3091. This RAC member further noted that the original drafted legislation and the intent of these two bills needs to be discussed and what is required at the hospital level is synced with the regulatory

agencies overseeing the CCOs and insurance plans regulated by the state. There needs to be a clear mandate for services and what those services look like needs to be worked on again.
- RAC members concurred with statement above and noted interest in participating in any conversations moving forward.

ACTION – 1) Consider revising rules to ensure that the training, experience and competence must apply to all provider types not just nurses. 2) Consider whether language can be crafted that allows Peer Wellness, Peer Support, Family Support and Youth Support Specialists working under direction of an individual can provide services while in process of seeking certification. 3) Consider removing paragraph (4)(g)(A) relating to policy and personnel record requirements for RNs. 4) Identify which program is taking lead on the recommendation in the Emergency Department Discharge Practices for Behavioral Health Crisis report specific to reimbursement and HB 3091.

Statement of Need and Fiscal Impact

M. Bernal reviewed the Statement of Need and Fiscal Impact including the need for the rule and the documents relating to changes. It was noted that an equity impact statement has been drafted by rule number and RAC members were encouraged to carefully review and provide any suggested edits or additional information by email. Proposed language on how these rules may financially impact hospitals, patients, or others was reviewed including the number of hospitals that currently have waivers in place. It was noted that the equity analysis review, providing patients with opioid reversal medication and HIV PEP will likely result in costs to the hospital and possibly to the patient. M. Bernal asked whether hospitals plan to bill insurance for these medications and whether there were other costs that should be identified.

- RAC member noted that the bill for HIV PEP will allow hospitals to bill insurance and insurance is required to cover. For Naloxone, insurance could be billed but regardless of someone's coverage, the hospital would need to provide the medication. It was noted that Naloxone often has cost-sharing in some plans, and this may need to be addressed in future legislation to make sure that health plans are not requiring cost-sharing for opioid reversal medication.
- RAC member indicated that the State should be providing the Naloxone to the hospitals and specific funds were supposed to be allocated to ensure that patients did not have to bear any costs, nor that insurance would be billed. RAC members asked for additional clarification on this including possible DOJ opinion on the state paying for distribution.
- RAC member noted that an insurance coverage mandate was included for purposes of HIV PEP and would be worthing mentioning in the fiscal and economic impact. It was also noted that PEP is already covered under OHP.

Next Steps

RAC members were asked to submit any proposed rule text recommendations and suggested revisions to the Statement of Need and Fiscal Impact to M. Bernal by October 20th (**follow-up – deadline for comments has been updated to October 23rd**.)

Meeting adjourned at 12:01 p.m.