Secretary of State

NOTICE OF PROPOSED RULEMAKING HEARING

A Statement of Need and Fiscal Impact accompanies this form.

Oregon Health Authority (OHA),	Health Systems Division (Division)	410
Agency and Division		Administrative Rules Chapter Number

Sandy Cafourek	500 Summer St NE, Salem, OR 97301	(503) 945-6430
Rules Coordinator	Address	Telephone

RULE CAPTION

Client Copayment

Not more than 15 words that reasonably identifies the subject matter of the agency's intended action.

December 20, 2016	10:30 a.m.	500 Summer St. NE, Salem, OR 97301	Room 160	Sandy Cafourek
Hearing Date	Time	Location		Hearings Officer

Auxiliary aids for persons with disabilities are available upon advance request.

RULEMAKING ACTION

Secure approval of new rule numbers (Adopted or Renumbered rules) with the Administrative Rules Unit prior to filing.

ADOPT:

AMEND: OAR 410-120-1230, 1230-1 Table

REPEAL:

RENUMBER:

AMEND & RENUMBER:

Stat. Auth.: ORS 413.042

Other Auth.:

Stats. Implemented: ORS 414.025, 414.065

RULE SUMMARY

The Oregon Health Authority needs to revise OAR 410-120-1230 Client Copayment in order to reflect that effective with dates of service on or after January 1, 2017, copayments will not be assessed for Medicaid services. Under the ACA, states are required to meet some federal Marketplace requirements for recipients receiving benefits as a part of the expansion population. One of these requirements is to cover and to waive all cost sharing for certain preventive services. The OHA determined that it will waive cost sharing for all services not just preventive.

The agency requests public comment on whether other options should be considered for achieving the rule's substantive goals while reducing the negative economic impact of the rule on business.

December 22, 2016 by 5 p.m.	Send written comments to: hsd.rules@state.or.us

Last Day for Public Comment (Last day to submit written comments to the Rules Coordinator)

Karen Wheeler	Karen Wheeler	10/25/16
Signature	Printed name	Date

Note: Hearing Notices must be submitted by the 15th day of the month to be published in the next month's *Oregon Bulletin.*

Secretary of State

STATEMENT OF NEED AND FISCAL IMPACT

A Notice of Proposed Rulemaking Hearing or a Notice of Proposed Rulemaking accompanies this form.

Oregon Health Authority (Authority), Health Systems Division (Division) 410

Agency and Division — Administrative Rules Chapter Number

Client Copayment

Rule Caption (Not more than 15 words that reasonably identifies the subject matter of the agency's intended action.)

In the Matter of: The amendment of OAR 410-120-1230, 1230-1 Table

Statutory Authority: ORS 413.042
Other Authority:
Stats. Implemented: ORS 414.025, 414.065

Need for the Rule(s): The Oregon Health Authority needs to revise OAR 410-120-1230 Client Copayment in order to reflect that effective with dates of service on or after January 1, 2017, copayments will not be assessed for Medicaid services. Under the ACA, states are required to meet some federal Marketplace requirements for recipients receiving benefits as a part of the expansion population. One of these requirements is to cover and to waive all cost sharing for certain preventive services. The OHA determined that it will waive cost sharing for all services not just preventive.

Documents Relied Upon, and where they are available:

- Federal Register, Vol 179, No. 166, published August 27, 2014. https://www.federalregister.gov/documents/2014/08/27/2014-20252/coverage-of-certain-preventive-services-under-the-affordable-care-act
- Center for Medicare and Medicaid Services Affordable Care Act Implementation FAQs - Set 12 https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs12.html

Fiscal and Economic Impact: See detail below.

Statement of Cost of Compliance:

1. Impact on state agencies, units of local government and the public (ORS 183.335(2)(b)(E)): Amending this rule will have a fiscal impact on the Authority, clients, or businesses, including small businesses. Provider payments will increase by the amount of the copayment assessed for a specific service. The aggregate Total Fund amount for the period January 1, 2017, to September 30, 2017, is $1,172,011. The Medicaid agency will have an overall savings due to an additional 1% of Federal Medical Assistance Percentages. Clients will not be responsible to pay a copayment to receive services.

2. Cost of compliance effect on small business (ORS 183.336):
   a. Estimate the number of small businesses and types of business and industries with small businesses subject to the rule: The Authority has approximately 63,000 enrolled Medicaid providers. These enrolled providers range from large hospital affiliates, national Durable Medical Equipment or Pharmacy chains to individually owned physician offices. The Division's fee-for-services providers serve approximately 10% of the total OHP population. The Division does not have available information to estimate the percentage of these medical practices that are small businesses.
   b. Projected reporting, recordkeeping and other administrative activities required for compliance, including costs of professional services: Amending this rule will not add additional reporting, record keeping, or other administrative activities.
   c. Equipment, supplies, labor and increased administration required for compliance: Amending this rule will not impose any new equipment, supplies, labor, and increased administration requirements on small or large businesses.

How were small businesses involved in the development of this rule? Because this proposed rule implements an Affordable Care Act requirement, small business providers did not participate in the development of these rules.

Administrative Rule Advisory Committee consulted?: No, because the proposed rule implements a federal requirement, a formal rule advisory committee was not used. Agency staff and key stakeholders were consulted in the development of this proposed rule change.

Karen Wheeler — Karen Wheeler — 10/25/16

Signature — Printed Name — Date

Administrative Rules Unit, Archives Division, Secretary of State, 800 Summer Street NE, Salem, Oregon 97310.

410-120-1230

Client Co-payment

(1) Effective January 1, 2017, Oregon Health Plan (OHP) Plus clients are not responsible for paying a co-payment.

(2) For dates of service prior to January 1, 2017, ~~Oregon Health Plan (~~OHP~~)~~ Plus clients ~~shall be~~are responsible for paying a co-payment for some services. This co-payment shall be paid directly to the provider. A co-payment applies regardless of location of services rendered, i.e., provider's office or client's residence.

(3~~2~~) The following services are exempt from co-payment:

(a) Emergency medical services as defined in OAR 410-120-0000;

(b) Family planning services and supplies;

(c) Prescription drug products for nicotine replacement therapy (NRT);

(d) Prescription drugs ordered through the Division's ~~of Medical Assistance Programs' (Division's)~~ Mail Order (a.k.a., Home-Delivery) Pharmacy program;

(e) Services to treat "health care-acquired conditions" (HCAC) and "other provider preventable conditions" (OPPC) services as defined in OAR 410-125-0450.

(4~~3~~) The following clients are exempt from co-payments:

(a) Pregnant women;

(b) Children under age 19;

(c) Young adults in substitute care and in the former Foster Care Youth Medical program;

(d) Clients receiving services under the Medicaid-funded home and community-based services program;

(e) Inpatients in a hospital, nursing facility, or Intermediate Care Facility for Intellectually or Developmentally Disabled (ICF/IDD);

(f) American Indian/Alaska Native (AI/AN) clients who are members of a federally recognized Indian tribe or receive services through Indian Health Services (IHS), a tribal organization, or services provided at an Urban Tribal Health Clinic as provided under Public Law 93-638;

(g) Individuals receiving hospice care;

(h) Individuals eligible for the Breast and Cervical Cancer program.

(54) For services provided prior to January 1, 2017:

(a) Co-payment for services is due and payable at the time the service is provided unless exempted in sections (2) and (3) above. Services to a client may not be denied solely because of an inability to pay an applicable co-payment. This does not relieve the client of the responsibility to pay the applicable co-payment, nor does it prevent the provider from attempting to collect any applicable co-payments from the client. The co-payment is a legal debt and is due and payable to the provider of service;~~.~~

(6b5) Except for prescription drugs, one co-payment is assessed per provider/per visit/per day unless otherwise specified in other Division's program administrative rules;~~.~~

(c6) Fee-for-service co-payment requirements:

(aA) The provider may not deduct the co-payment amount from the usual and customary billed amount submitted on the claim. Except as provided in section (23) and (34) of this rule, the Division shall deduct the co-payment from the amount the Division pays to the provider (whether or not the provider collects the co-payment from the client);

(bB) If the Division's payment is less than the required co-payment, then the co-payment amount is equal to the Division's lesser required payment, unless the client or services are exempt according to exclusions listed in section (23) and (34) above. The client's co-payment shall constitute payment-in-full;

(cC) Unless specified otherwise in individual program rules and to the extent permitted under 42 CFR 1001.951–1001.952, the Division does not require providers to bill or collect a co-payment from the Medicaid client. The provider may choose not to bill or collect a co-payment from a Medicaid client; however, the Division shall still deduct the co-payment amount from the Medicaid reimbursement made to the provider.

(d7) CCO or ~~,~~ PHP~~, or PCO~~ co-payment requirements:

(aA) Unless specified otherwise in individual program rules and to the extent permitted under 42 CFR 447.58 and 447.60, the Division does not require CCOs or ~~,~~ PHPs~~, or PCOs~~ to bill or collect a co-payment from the Medicaid client. The CCO or ~~,~~ PHP~~, or PCO~~ may choose not to bill or collect a co-payment from a Medicaid client; however, the Division shall still deduct the co-payment amount from the Medicaid reimbursement made to the CCO or~~,~~ PHP~~, or PCO~~;

(bB) When a CCO or ~~,~~ PHP~~, or PCO~~ is operating within the scope of the safe harbor regulation outlined in 42 CFR 1001.952(l), a CCO or~~,~~ PHP~~, or PCO~~ may elect to assess

a co-payment on some of the services outlined in Table 120-1230-1 but not all. The CCO or~~,~~ PHP~~, or PCO~~ must assure they are working within the provisions of 42 CFR 1003.102(b) (13). [Table not included. See ED. NOTE.]

(9~~6~~8) Services that require co-payments are listed in Table 120-1230-1. [Table not included. See ED. NOTE.]

(1~~0~~79) Table 120-1230-1. [Table not included. See ED. NOTE.]

[ED. NOTE: Tables referenced are not included in rule text. The table is available by clicking here.]

Stat. Auth.: ORS 413.042

Stat. Implemented: ORS 414.025, 414.065

Table 120-1230-1

OHP ~~Benefit Package~~ Plus Client Co-payment Requirements (Benefit Identifier BMH, BMD, BMM)	**~~OHP Plus (BMH, BMD, BMM)~~Effective 1/1/03-12/30/16**	**Effective 1/1/17**
Acupuncture services	$3	$0
Ambulance services (emergency)	$0	$0
Ambulatory Surgical Center	$3	$0
Audiology services • Hearing Aids	$3 $0	$0
Chemical Dependency services • Outpatient services • Medication dosing/dispensing, case management • Inpatient hospital detoxification	 $3 $0 $0	 $0 $0 $0
Chiropractic services	$3	$0
Dental services • Diagnostic – (D0100-D0999) oral examinations used to determine changes in the patient's health or dental status, including x-rays, laboratory services and tests associated with making a diagnosis and/or treatment. • Preventive services (D1000-D1999) routine cleanings fluoride, sealants • Restorative treatment or other dental services (D2000-D9999)	 $0 $0 $3	 $0 $0 $0
DME and supplies	$0	$0
Home visits for • Home health • Private duty nursing • Enteral/Parenteral	 $3 $3 $3	 $0 $0 $0
Hospital • Inpatient care • Outpatient surgery • Emergency room services • Outpatient, other • Non-emergent visit performed in the ER	 $0 $3 $0 $3 $3	 $0 $0 $0 $0 $0
Laboratory test	$0	$0
Mental Health services • Initial assessment/evaluation by psychiatrist or psychiatric mental health nurse practitioners (90791, 90792); • Outpatient hospital- Electroconvulsive (ECT) treatment (Revenue code 901) including facility, professional fees (90870-90871) and anesthesiology fees (00104);	 $3 $3 $0	 $0 $0 $0

OHP ~~Benefit Package~~ Plus Client Co-payment Requirements (Benefit Identifier BMH, BMD, BMM)	~~OHP Plus (BMH, BMD, BMM)~~Effective 1/1/03-12/30/16	Effective 1/1/17
• Consultation between psychiatrist/psychiatric mental health nurse practitioner and primary care physician (90887)		
Naturopathic services	$3	$0
Podiatry services	$3	$0
Prescription drugs		
• Non-preferred PDL generic or generics in non-PDL classes costing >$10	$1	$0
• Preferred PDL generic or generics in non-PDL classes costing <$10	$0	$0
• Preferred PDL brand	$0	$0
• All other brands	$3	$0
Refer to OAR 410-121-0030 for PDL list PDL list is not applicable to those enrolled in MCO, contact the MCO for details.		
Professional visits for		
• Primary care, including urgent care by a Physician, Physician Assistant, Certified Nurse Practitioner	$3	$0
• Specialty care	$3	$0
• Office medical procedures	$0	$0
• Surgical procedures	$0	$0
• PT/OT/Speech	$3	$0
Radiology		
• Diagnostic procedures	$0	$0
• Treatments	$0	$0
Vision services		
• Exams- for medical purposes or solely for glasses	$3	$0
• Frames, contracts, corrective devices	$0	$0