

Certificate and Order for Filing  
**TEMPORARY ADMINISTRATIVE RULES**  
A Statement of Need and Justification accompanies this form.

I certify that the attached copies\* are true, full and correct copies of the TEMPORARY Rule(s) adopted on \*date signed by the  
Date prior to or same as filing date.

Oregon Health Authority (Authority), Division of Medical Assistance Programs (Division) 410

Agency and Division Administrative Rules Chapter Number

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to become effective 10/20/11 through 3/25/2012  
Date upon filing or later    A maximum of 180 days including the effective date.

**RULEMAKING ACTION**

**Rule Filing Caption:** Non-Participating Provider retroactive reimbursement change

**AMEND:** OAR 410-120-1295

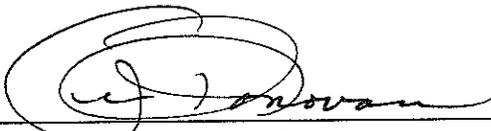
**Statutory Authority:** ORS 413.042

**Other Authority:** SB101, 2011 State of Oregon Legislative Assembly

**Statutes Implemented:** 414.025, 414.065, 414.705 & 414.743

**Subject Matter:**

The General Rules Program administrative rules govern the Division payments for services provided to clients. The Division temporarily amended OAR 410-120-1295 effective to October 1, 2011, to allow providers to be reimbursed at the correct rate for services rendered on or after Oct. 1. The formula established by the reimbursement methodology in ORS 414.743 gives correct and appropriate information to hospitals and managed care organizations when applying the formula to claims for reimbursement for services rendered to medical assistance clients. The statute is based on the budget period that coordinates with the managed care and Division contracts. The Division intends to permanently amend this rule.

Authorized Signers:  10-20-11  
Judy Mohr Peterson, Jean S. Donovan or Sandy Wood

Secretary of State  
**Statement of Need and Justification**

A Certificate and Order for Filing Temporary Administrative Rules accompanies this form.

Oregon Health Authority (OHA), Division of Medical Assistance Programs (Division) 410  
Agency and Division Administrative Rule Chapter Number

**In the Matter of:** The temporary amendment of an administrative rule that governs payment for the Division's General Rules Program. The Division temporarily amended OAR 410-120-1295.

**Rule Filing Caption:** Non-Participating Provider retroactive reimbursement change

**Statutory Authority:** 413.042

**Other Authority:** SB101, 2011 State of Oregon Legislative Assembly

**Statutes Implemented:** 414.025, 414.065, 414.705 & 414.743

**Need for Rule(s):** The General Rules Program administrative rules govern the Division payments for services provided to clients. The Division temporarily amended OAR 410-120-1295 effective to October 1, 2011, to allow providers to be reimbursed at the correct rate for services rendered on or after Oct. 1. The formula established by the reimbursement methodology in ORS 414.743 gives correct and appropriate information to hospitals and managed care organizations when applying the formula to claims for reimbursement for services rendered to medical assistance clients. The statute is based on the budget period that coordinates with the managed care and Division contracts. The Division intends to permanently amend this rule.

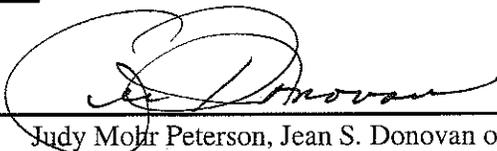
**Justification of Temporary Rule(s):** Following the permanent rulemaking process, rather than taking this temporary rulemaking action will result in serious prejudice to the public interest and to the interests of hospitals and managed care organizations that provide services to medical assistance clients. This rule revision is needed immediately to assist hospitals and managed care organizations that do not have a contract with each other in applying the reimbursement methodologies outlined in statute to address the current budget period. This rule revision does not make any change in the methodology addressed in statute, but updates the table of information that will permit hospitals and managed care organizations to apply the reimbursement formula. In order to implement the statute, the Division requested its actuary to perform certain calculations that form the basis for the tables being added in this temporary rule. The Division's efforts to confer with stakeholders, and the length of time required for the actuary to respond to requests for information, have resulted in an urgent need to proceed with a temporary rule at this time.

Failure to amend the rule and reference the current contract-year documents immediately to implement the new reimbursement document will result in serious prejudice to the needs of hospitals and managed care plans to apply the statutory reimbursement methodology. This temporary rule making action will avoid or mitigate these consequences immediately allowing the hospitals and managed care organizations to be able to apply the reimbursement methodology.

**Documents Relied Upon, and where these can be viewed or obtained:** SB 101, 2011 State of Oregon Legislative Assembly

**Other Agencies affected:** None

**Authorized Signers:**

  
Judy Mohr Peterson, Jean S. Donovan or Sandy Wood

10-20-11

Date

## 410-120-1295 Non-Participating Provider

(1) For purposes of this rule, a provider enrolled with the Division of Medical Assistance Programs (Division) that does not have a contract with a Division-contracted Prepaid Health Plan (PHP) is referred to as a non-participating provider.

(2) For covered services that are subject to reimbursement from the PHP, a non-participating provider, other than a hospital governed by (3) below, must accept from the Division-contracted PHP, as payment in full, the amount that the provider would be paid from the Division if the client was fee-for-service (FFS).

(3) For covered services provided on and after October 1, ~~2011~~2009, the Division-contracted Fully Capitated Health Plan (FCHP) that does not have a contract with a hospital, is required to reimburse, and hospitals are required to accept as payment in full, the following reimbursement:

(a) Non-participating Type A and Type B hospital: The FCHP will reimburse a non-participating Type A and Type B hospital fully for the cost of covered services based on the cost-to-charge ratio used for each hospital in setting the capitation rates paid to the FCHP for the contract period (ORS 414.727);

(b) All other non-participating hospitals (not designated as a rural access or Type A and Type B hospital): As specified in ORS 414.743, ~~the FCHP will shall reimburse inpatient and outpatient services uUsing a Medicare payment methodology the FCHP will reimburse inpatient and outpatient services in all other non-participating hospitals, not designated as a rural access or Type A and Type B hospital, at a rate designated percentage point less than the percentage of Medicare costs used by the Oregon Health Authority (Authority) inwhen calculating the base hospital capitation payment to FCHP's, excluding any supplemental payments: no less than a percentage of the Medicare reimbursement rate. The percentage of the Medicare reimbursement shall be equal to two percentage points less than the percentage of Medicare costs used by the Authority in calculating the base hospital capitation payment to FCHP's, excluding any supplemental payments.~~

(i) Effective for services on or after October 1, 2011, for a hospital providing 10 percent or more of the hospital admissions and outpatient hospital services to enrollees of the plan, the percentage of the Medicare reimbursement shall be equal to 64 percent;

(ii) Effective for services on or after October 1, 2011, for a hospital providing less than 10 percent of the hospital admissions and outpatient hospital services to enrollees of the plan, the percentage of the Medicare reimbursement shall be equal to 66 percent.

~~(4) The percentage of Medicare costs used by the Authority in calculating the base hospital capitation payment to the FCHP are calculated by the Authority's actuarial unit. The FCHP Non-Contracted DRG Hospital Reimbursement Rates dated October 1, 2009 are on the Authority's Web site at: [www.dhs.state.or.us/policy/healthplan/guides/ohp/main.html](http://www.dhs.state.or.us/policy/healthplan/guides/ohp/main.html), archived data is available on request from the Division.~~

(45) A non-participating hospital must notify the FCHP within 2 business days of an FCHP patient admission when the FCHP is the primary payer. Failure to notify does not, in and of itself, result in denial for payment. The FCHP is required to review the hospital claim for:

- (a) Medical appropriateness;
- (b) Compliance with emergency admission or prior authorization policies;
- (c) Member's benefit package;
- (d) The FCHP contract and the Division's administrative rules.

(56) After notification from the non-participating hospital, the FCHP may:

- (a) Arrange for a transfer to a contracted facility, if the patient is medically stable and the FCHP has secured another facility to accept the patient;
- (b) Perform concurrent review; and/or

(c) Perform case management activities.

(67) In the event of a disagreement between the FCHP and hospital, the provider may appeal the decision by asking for an administrative review as specified in OAR 410-120-1580.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.025, 414.065, 414.705 & 414.743

~~1-1-11~~  
~~3-1-11 (HK)~~ 10/20/11 (T)