

Secretary of State
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 [upon filing] by the
Date prior to or same as filing date

Oregon Health Authority, Division of Medical Assistance Programs **410**
Agency and Division Administrative Rules Chapter Number

Dar Nelson **500 Summer St. NE Salem, Oregon 97301** **503-945-6527**
Rules Coordinator Address Telephone

to become effective [1/31/12] through [7/28/12].
Date upon filing or later A maximum of 180 days including the effective date.

RULE CAPTION

Adoption of rules governing the Rural Medical Practitioners Insurance Subsidy Program

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

RULEMAKING ACTION

List each rule number separately, 000-000-0000.

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

ADOPT: OAR 410-500-0000, 410-500-0010, 410-500-0020, 410-500-0030, 410-500-0040, 410-500-0050, 410-500-0060

Stat. Auth.: ORS 413.022 and 2011 Or Law chapter 560

Other Auth.:

Stats. Implemented: ORS 413.022

RULE SUMMARY

The Rural Medical Practitioners Insurance Subsidy Program administrative rules govern Division payments to medical professional liability insurance carriers from the Rural Medical Liability Subsidy Fund. Payments from the fund will subsidize the cost of premiums charged by carriers to qualified practitioners for policies issued, in force or renewed on or after January 1, 2012. The rules identify medical practitioner criteria for participation in the program, as well as insurance carrier requirements for submitting requests for subsidy payments.


Authorized Signer

Judy Mohr Peterson, Jean Donovan or Sandy Wood

1-31-12

Date

*With this original and Statement of Need, file one photocopy of certificate, one paper copy of rules listed in Rulemaking Actions, and electronic copy of rules. ARC 940-2005

Secretary of State
Statement of Need and Justification

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

Oregon Health Authority, Division of Medical Assistance Programs
Agency and Division

410
Administrative Rule Chapter Number

In the Matter of: The temporary adoption of administrative rules that govern payment for the Division's Rural Medical Practitioners Insurance Subsidy Program. The Division is temporarily adopting OAR 410-500-0000, 410-500-0010, 410-500-0020, 410-500-0030, 410-500-0040, 410-500-0050, 410-500-0060.

Rule Filing Caption: Adoption of rules governing the Rural Medical Practitioners Insurance Subsidy Program

Statutory Authority: ORS 413.022 and 2011 Or Law chapter 560

Other Authority:

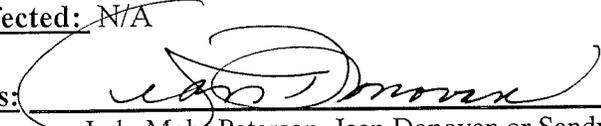
Statutes Implemented: ORS 413.022

Need for Rule(s): The Rural Medical Practitioners Insurance Subsidy Program administrative rules govern Division payments to medical professional liability insurance carriers from the Rural Medical Liability Subsidy Fund. Payments from the fund will subsidize the cost of premiums charged by carriers to qualified practitioners for policies issued, in force or renewed on or after January 1, 2012. The rules identify medical practitioner criteria for participation in the program, as well as insurance carrier requirements for submitting requests for subsidy payments.

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 interest of medical professional liability insurance carriers and medical practitioners who provide services to patients in rural areas in Oregon. These rules need to be adopted promptly to allow the Division to make subsidy payments from the Rural Medical Liability Subsidy Fund to authorized medical professional liability insurance carriers. The administration of the Rural Medical Liability Subsidy Fund by the Authority became effective January 1, 2012. The fact that the Division is already responsible for program administration creates an urgent need to proceed with temporary rules at this time. These temporary rules explain the qualifying criteria and payment methodology and other information necessary for the Division to appropriately process payments from the Rural Medical Liability Subsidy Fund.

Documents Relied Upon, and where these can be viewed or obtained: A copy of the Department's temporary rules are found at the CAF Self-Sufficiency Programs website:
http://www.dhs.state.or.us/policy/selfsufficiency/ar_search.htm

Other Agencies affected: N/A

Authorized Signers: 
Judy Mohr Peterson, Jean Donovan or Sandy Wood

1-31-12
Date

OREGON HEALTH AUTHORITY

Division 500

RURAL MEDICAL PRACTITIONERS INSURANCE SUBSIDY PROGRAM

410-500-0000

Purpose

(1) Effective retroactive to January 1, 2012, the Rural Medical Practitioners Insurance Subsidy Program (Program) has been established in the Oregon Health Authority (Authority).

(2) The purpose of the Program is to provide payments from the Rural Medical Liability Subsidy Fund to authorized medical professional liability insurance carriers to subsidize the cost of premiums charged by carriers to qualified practitioners for policies issued, in force or renewed on or after January 1, 2012, in the manner provided in these rules.

(3) Payment of premium subsidies in accordance with these rules is the sole purpose of the Authority's responsibility under this Program. The Authority does not accept or assume any liability for claims involving a carrier or a practitioner, or disputes between them.

Stat. Auth.: ORS 413.022 and 2011 Or Laws chapter 560

Stat. Imp.: 413.022

410-500-0010

Definitions

For the purposes of OAR 410-500-0000 through 410-500-0060, the following definitions shall apply:

(1) Carrier means a medical professional liability insurer holding a valid certificate of authority from the Director of the Department of Consumer and Business Services (DCBS) that authorizes the transaction of insurance as defined in ORS 731.066(1) and 731.072(1), and does not include DCBS listed insurers pursuant to ORS 735.300 to 735.365 and ORS 735.400 to 735.495.

(2) Medical assistance has the same meaning given that term in ORS 414.025.

(3) Medicare means medical coverage provided under Title XVIII of the Social Security Act.

(4) Office of Rural Health (Office) has the meaning established in ORS 442.475.

(5) Practitioner means a physician licensed under ORS chapter 677 or a nurse practitioner certified under ORS 678.375 who has a rural practice that meets criteria established by the Office of Rural Health that applied as of January 1, 2004, for the purposes of ORS 315.613. Practitioner does not include a physician or nurse practitioner who is located in an urbanized area of Jackson County, as defined by the United States Census Bureau according to the most recent federal decennial census taken pursuant to the authority of the United States Department of Commerce under 13 U.S.C. 141(a), unless the practitioner is:

(a) A physician who specializes in obstetrics or who specializes in family or general practice and provides obstetrical services; or

(b) A nurse practitioner who is certified for obstetric care.

(6) Rural Medical Liability Subsidy Fund means a fund established in Section 3 of 2011 Oregon Laws chapter 560 to provide payments to medical professional liability insurance carriers to subsidize the cost of premiums charged by the carriers to qualifying practitioners.

(7) Rural Medical Practitioner Insurance Fund Program (Program) is the program established by the Authority to provide payments to authorized medical professional liability insurance carriers to subsidize the cost of premiums charged by the carriers to qualified practitioners from the Rural Medical Liability Subsidy Fund established in Section 3 of 2011 Oregon Laws chapter 560.

Stat. Auth.: ORS 413.022 and 2011 Or Laws chapter 560

Stat. Imp.: 413.022

410-500-0020

Eligibility Criteria for Rural Practitioners

- (1) A practitioner who has a rural practice that meets the criteria established by the Office for the purposes of ORS 315.613 is eligible for a subsidy under this program if the practitioner:
- (a) Holds an active, unrestricted license or certification;
 - (b) Is covered by a medical professional liability insurance policy issued by an authorized carrier with minimum limits of coverage of \$1 million per occurrence and \$1 million annual aggregate; and
 - (c) Is willing to serve patients with Medicare coverage and patients receiving medical assistance in at least the same proportion to the practitioner's total number of patients as the Medicare and medical assistance populations represent of the total number of individuals determined by the Office to be in need of care in the areas served by the practice.
- (2) A nurse practitioner who is employed by a licensed physician is eligible for a subsidy if they are covered by a medical professional liability insurance policy that names the nurse practitioner and separately calculates the premium for the nurse practitioner.
- (3) A practitioner whose medical professional liability insurance coverage is provided through a health care facility, as defined in ORS 442.400, and who otherwise meets the requirements of section (4) of this section is eligible for a premium subsidy if the Office determines that practitioner:
- (a) Is not an employee of the health care facility;
 - (b) Is covered by a medical professional liability insurance policy that names the practitioner and separately calculates the premium for the practitioner; and
 - (c) Fully reimburses the health care facility for the premium calculated for the practitioner.
- (4) Eligibility by individual practitioners to participate in the Program must be requested each year using an annual attestation administered by the Office. Consistent with the requirements of this rule, the Office shall establish criteria and procedures for making the eligibility determinations and for an annual attestation procedure that must be used by practitioners.
- (5) The Office shall determine the eligibility of practitioners to participate in the Program in accordance with this rule, and shall provide its eligibility determination to the Authority and the practitioner.
- (a) If a practitioner disagrees with a determination about whether a particular practitioner qualifies for the Program, the Office shall conduct an informal review and issue its recommendation to the Authority.
 - (b) The Authority shall make the final determination of eligibility to participate in the Program. Appeals shall be handled in accordance with the procedure for administrative review described in OAR 410-500-0060.
- (6) The Authority shall forward to each of the authorized carriers participating in this Program, the list of eligible practitioners that it receives from the Office. The list shall include the practitioner's name, mailing address, specialty, and applicable professional license or certification number issued by either the Board of Medical Examiners or the Board of Nursing.
- Stat. Auth.: ORS 413.022 and 2011 Or Laws chapter 560
Stat. Imp.: 413.022

410-500-0030

Determination of Subsidy Amount

- (1) Beginning with the first calendar quarter in 2012, premium subsidy payments may be made to authorized carriers to subsidize the cost of premiums charged by the carrier to eligible practitioners, in accordance with these rules.
- (a) Premium subsidies are paid as a percentage of the actual premium charged for medical professional liability insurance with limits of coverage of \$1 million per occurrence and up to \$3 million annual aggregate.
 - (b) Notwithstanding section (1) (a) of this rule, the premium subsidy for a practitioner referred to in 410-500-0030(3)(c) or (d) shall be the lesser of the percentage of the premium due or paid for the current calendar year and the premium paid in the previous calendar year. When determining the lesser amount, any step increases in the premium owing to the claims-made nature of the policy may not be considered.

(2) Within 30 days after the end of each billing period (monthly or quarterly), each authorized carrier must electronically submit a report to the Authority showing the following information for each eligible practitioner who has been determined eligible for a premium subsidy by the Office in accordance with OAR 410-500-0020, as of the end of the billing quarter under this Program.

(a) The information required to be submitted electronically (using Microsoft Excel or similar spreadsheet application) must include the following:

(A) Carrier's name;

(B) Practitioner's name and, for each practitioner:

(i) Oregon Board of Medical Examiners license number or Oregon State Board of Nursing certification number;

(ii) Practitioner's specialty and specialty class;

(iii) ISO code;

(iv) Policy number;

(v) Policy effective date;

(vi) Billing period coverage start date;

(vii) Billing period coverage end date;

(viii) Billing frequency (annually, quarterly, monthly);

(ix) Current in-force annual premium for limits of coverage of \$1 million per occurrence and up to \$3 million annual aggregate;

(x) Premium subsidy percentage, calculated in accordance with section (3) of this rules;

(xi) Dollar amount of premium subsidy, calculated in accordance with these rules;

(xii) Explanation of any adjustments under this Program from previous reports;

(xiii) Policy coverage limits;

(xiv) Identification of practitioners who were not on the eligible list at the beginning of the quarter, including all of the foregoing information for eligible practitioners;

(xv) Claims-made step of practitioner, if applicable.

(b) In January of each calendar year, each authorized carrier must provide the Authority with a copy of its base rates and increased limits factors table; and the authorized carrier must inform the Authority of the base rates and increased limits factors table from their current rate filing for Oregon within 30 days of any change to those rates and table.

(c) When a carrier submits its report or rates, the submission is deemed to be a certification that the information included in the report is true, accurate and complete.

(d) Failure to make a timely submission may result in delay in processing the payment request. The payment of premium subsidies from the Rural Medical Liability Subsidy Fund is calculated by the Authority based on the funds available for the applicable billing period. In the event of insufficient funds, the risk of carrier delay in submission of a request for subsidy payment is on the carrier, because payments shall be based on the subsidy requests timely received for each applicable billing period.

(3) Subject to section (4) of this rule, the amount of the premium subsidy paid under this Program shall be calculated for eligible practitioners, as follows:

(a) Eighty percent of the actual premium charged for physicians specializing in obstetrics and nurse practitioners certified for obstetric care;

(b) Sixty percent of the actual premium charged for physicians specializing in family or general practice who provide obstetrical services;

(c) Forty percent of the actual premium charged for physicians and nurse practitioners engaging in one or more of the following practices:

(A) Family practice without obstetrical services;

(B) General practice without obstetrical services;

(C) Internal medicine;

(D) Geriatrics;

(E) Pulmonary medicine;

(F) Pediatrics;

(G) General surgery; or

(H) Anesthesiology;

(d) Fifteen percent of the actual premium charged for physicians and nurse practitioners other than those included in sections (3)(a) through (c).

(e) Using the information timely provided by carriers provided pursuant to section (2) of this rule, the information provided by the Office about eligible practitioners, and the provisions of this rule describing the calculation of the premium subsidy amounts, the Authority shall review the report for accuracy, and make the appropriate premium subsidy payments to the authorized carriers under this Program for undisputed items to the authorized carrier within 30 days of receipt.

(4) All payments authorized to be made by the Authority under this Program must be made from the Rural Medical Liability Subsidy Fund. No other funds have been established by the Legislative Assembly to make any premium subsidy payments under this Program.

(a) If the funds available for the Program in the Rural Medical Liability Subsidy Fund are insufficient to provide the maximum premium subsidy for all practitioners who qualify for the Program, the Authority shall reduce or eliminate subsidies for practitioners described in section (3)(d).

(b) If, after eliminating subsidies for practitioners described in section (3)(d), the funds in the Rural Medical Liability Subsidy Fund are insufficient to provide the maximum premium subsidies for the remaining practitioners, the Authority shall also reduce or eliminate the subsidies for practitioners described in section (3)(c).

(c) If the funds available for the Program in the Rural Medical Liability Subsidy Fund are insufficient to provide the subsidies for the remaining practitioners, the Program may not make payments that exceed the amounts remaining in the Fund.

(d) If the Authority is required to take any of the actions described in this rule due to insufficient funds to pay a premium subsidy, the Authority shall inform the affected participants and carriers about the action.

(5) An authorized carrier shall reduce the premium charged to a practitioner by the amount of any premium subsidy paid or to be paid under this Program. Each authorized carrier must provide its participating practitioners with the following information each quarter this Program is in effect:

(a) The quarterly premium due before the premium subsidy is applied;

(b) The amount of the premium subsidy; and

(c) The premium after the premium subsidy is applied.

(6) The authorized carrier shall display these three figures on each billing statement of a participating practitioner.

Stat. Auth.: ORS 413.022 and 2011 Or Laws chapter 560

Stat. Imp.: 413.022

410-500-0040

Authorized Carriers

(1) Carriers seeking to participate in the Program must provide written notice and certification to the Authority in writing not less than 30 days prior to the beginning date of a calendar quarter. However, for the first quarter of 2012, that notification may occur up to and including, but not later than January 31, 2012, for subsidy payments applicable to the first calendar quarter of 2012. The initial carrier written notification and certification required in this rule must be signed by an individual authorized to represent the carrier and delivered to the Authority at the following address: Oregon Health Authority, 500 Summer St NE, E-44, Salem, OR 97301, Attention: Rural Medical Practitioners Insurance Subsidy Program.

(a) The written notification must certify to the Administrator of the Program the following:

(A) That the carrier is a medical professional liability insurer holding a valid certificate of authority from the Director of DCBS that authorizes the transaction of insurance as defined in ORS 731.066(1) and 731.072(1), and does not include DCBS listed insurers pursuant to ORS 735.300 to 735.365 and ORS 735.400 to 735.495;

(B) That the carrier understands that the Authority may confirm the representations in paragraph (A) with DCBS, and that DCBS' determination about whether the carrier holds a valid certificate of authority to engage in professional liability insurance in the state of Oregon and the other criteria in paragraph (A) shall be relied upon by the Authority in determining whether an insurer is an authorized carrier under this Program; and

(C) That the carrier agrees to comply with the terms and conditions of the rules applicable to this Program in effect at the time of initial certification and those rules in effect when any request for subsidy payment is submitted to the Authority for payment.

(D) The Authority shall confirm in writing that the carrier meets the criteria as an authorized carrier for purposes of this Program. If the Authority determines that an entity is not eligible to participate as a carrier in this Program, the Authority shall provide notice to the entity of its determination and shall deny participation in the Program. A request to appeal that determination shall be handled by the Authority in accordance with the procedure for administrative review described in OAR 410-500-0060.

(b) An insurer's failure to provide the notice and certification to the Authority within the time established in this rule means that the insurer is not authorized to submit a request for premium subsidy payment for the next calendar quarter and also means that the insurer's otherwise eligible practitioners shall be ineligible to receive a premium subsidy for that quarter.

(c) An authorized carrier must provide, and continue to provide, to the Authority accurate, complete and truthful information concerning their qualification for participation in the Program. A carrier must notify the Authority in writing of a material change in any status or condition that relates to their eligibility to participate in the Program.

(2) An authorized carrier choosing not to continue to participate in the Program shall notify the Authority at least 90 days prior to the beginning date of the next calendar quarter. The carrier shall notify its insured practitioners participating in the Program of its intent to not participate at least 60 days prior to the date of the next calendar quarter.

(3) Authorized carriers understand and agree that the Authority may determine that funds available for the Program are insufficient to provide maximum premium subsidy for all qualified practitioners, and that the Authority may reduce or eliminate subsidies. There is no guarantee of any amount of premium subsidy that may be provided to any carrier.

Stat. Auth.: ORS 413.022 and 2011 Or Laws chapter 560

Stat. Imp.: 413.022

410-500-0050

Program Integrity

(1) The Authority shall analyze and monitor the operation of the Program and audit and verify the accuracy and appropriateness of subsidy payments, or other program integrity actions. To promote the integrity of the administration of the program, the carrier shall:

(a) Develop and maintain adequate financial and other documentation which supports the actual premium payments and coverage records for which payment has been requested. Payment shall be made only for services that are adequately documented. Documentation must be completed before the service is billed to the Authority. The records must be accurate and in sufficient detail to substantiate the data reported in relation to a request for premium subsidy payment;

(b) Have policies and procedures to ensure the maintenance of the applicable records;

(c) Upon written request from the Authority, the Oregon Secretary of State (Secretary), other federal or state oversight agency or their authorized representatives, furnish requested documentation immediately or within the time-frame specified in the written request. Copies of the documents may be furnished unless the originals are requested. At their discretion, official representatives of the Authority or Secretary or other oversight agency, may review and copy the original documentation in the carrier's place of business. Upon the written request of the carrier, the Program or the Secretary or other oversight agency may, at their sole discretion, modify or extend the time for provision of such records if, in the opinion of the Program or the Secretary or other oversight agency good cause for such extension is shown;

- (d) Failure to comply with requests for documents and within the specified time-frames means that the records subject to the request may be deemed by the Authority not to exist for purposes of verifying appropriateness of payment, and accordingly subjects the carrier to possible denial or recovery of payments made by the Authority or to other actions;
- (e) The Authority may communicate with and coordinate any program integrity actions with the federal and state oversight authorities, including but not limited to DCBS if documentation is missing or is inconsistent with claims made for payment of subsidies.
- (2) When the Authority determines that an overpayment has been made to a carrier, the amount of overpayment is subject to recovery. The Authority may take appropriate action to redress payment errors or false claims for payment under the Program.
- (a) If an authorized carrier determines that a subsidy payment request is incorrect, the carrier shall submit a correction within 30 calendar days of the discovery of the error and refund the amount of any overpayment at that time.
- (b) If the Authority determines that an authorized carrier received a premium subsidy for an insured eligible practitioner that exceeded the amount that should have been paid, the Authority shall notify the authorized carrier and require the carrier to remit the overpayment to the Authority within 30 days of the date of the notification. Overpayment collection repayment from a carrier does not prevent the authorized carrier from collecting the appropriate premium from the insured; however, the Authority's ability to recover an overpayment from a carrier is not limited by whether the carrier recovers any amount from its insured.
- (c) The Authority may recover overpayments made to a carrier by direct reimbursement, offset, civil action, or other actions authorized by law:
- (A) The carrier must make a direct reimbursement to the Authority within 30 calendar days from the date of the notice of the overpayment;
- (B) The Authority may grant the carrier an additional period of time to reimburse the Authority upon written request made within 30 calendar days from the date of the notice of overpayment if the carrier provides a statement of facts and reasons sufficient to show that repayment of the overpayment amount should be delayed pending appeal because there is a reason to believe that the overpayment is not correct or is less than the amount in the notice, and the carrier has timely filed a request for administrative review of the overpayment determination, or that carrier accepts the amount of the overpayment but is authorized in writing by the Authority to make repayment over a period of time;
- (3) Appeals of overpayment determinations are handled by the Authority in accordance with the procedure for administrative review described in OAR 410-500-0060.
- (4) If the carrier does not timely request an administrative review, the overpayment is final and the amount of the overpayment shall be due and payable to the Authority.
- (5) The Authority may withhold payment on pending premium subsidy payment requests and on subsequently received premium subsidy payment requests for the amount of the overpayment when overpayments are not paid in accordance with the requirements of this rule;
- (6) The Authority may file a civil action in the appropriate court and exercise all other civil remedies available to the Authority in order to recover the amount of an overpayment.
- (7) A noncompliant carrier may be terminated from participation in the Program.
- (8) An authorized carrier's failure to reduce the premium charged to a qualified practitioner by the amount of the premium subsidy paid under this Program or other noncompliance with Program requirements may result in termination of the carrier from the Program and recovery of any premium payments made to the carrier that were not expended in accordance with the requirements of this Program, if the authorized carrier fails to cure the deficiency within the time and in the manner prescribed by the Authority.

Stat. Auth.: ORS 413.022 and 2011 Or Laws chapter 560

Stat. Imp.: 413.022

410-500-0060

Appeals: Administrative Review

(1) Administrative review, for purposes of these rules, shall be the process for any appeals made to the Authority under this Program. An administrative review is an appeal process that allows an opportunity for the Administrator of the Program or designee to review a decision. Administrative review is not a contested case.

(2) A request for administrative review must be received by the Authority not later than 30 calendar days after the date of the Authority's notice.

(3) If administrative review is timely requested, the practitioner or the carrier must provide the Authority with a copy of all relevant records and other materials relevant to the appeal, not later than 10 days before the review is scheduled.

(4) If the Administrator or designee decides that a preliminary meeting between the practitioner or carrier and Authority staff may assist the review, the Administrator or designee shall notify the individual requesting the review of the date, time, and place the meeting is scheduled.

(5) The administrative review meeting shall be conducted as follows:

(a) It will be conducted by the Administrator, or designee;

(b) No minutes or transcript of the review shall be made;

(c) The individual requesting the review does not have to be represented by counsel during an administrative review meeting and shall be given ample opportunity to present relevant information;

(d) Authority staff shall not be available for cross-examination, but Authority staff may attend and participate in the review meeting;

(e) Failure to appear without good cause constitutes acceptance of the Authority's determination;

(f) The Administrator may combine similar administrative review proceedings involving the same individual or similar facts, including the meeting, if the Administrator determines that joint proceedings may facilitate the review;

(g) The Administrator or designee may request the practitioner or carrier making the appeal to submit, in writing, new information that has been presented orally. In such an instance, a specific date for receiving such information shall be established.

(5) The results of the administrative review shall be sent to the participants involved in the review, within 30 calendar days of the conclusion of the administrative review meeting, or such time as may be agreed to by the participants or designated by the Authority.

(6) The Authority's final decision on administrative review is the final decision on appeal and binding on the parties. Under ORS 183.484, this decision is an order in other than a contested case. ORS 183.484 and the procedures in OAR 137-004-0080 to 137-004-0092 apply to the Authority's final decision on administrative review.

(7) These rules shall be construed in accordance with the laws of the State of Oregon without regard to principles of conflicts of law. The courts of the State of Oregon are empowered to resolve any disputes, with venue in Marion County.

Stat. Auth.: ORS 413.022 and 2011 Or Laws chapter 560

Stat. Imp.: 413.022