

Secretary of State
NOTICE OF PROPOSED RULEMAKING HEARING*
 A Statement of Need and Fiscal Impact accompanies this form

<u>Oregon Health Authority, Division of Medical Assistance Programs</u>	410
Agency and Division	Administrative Rules Chapter Number
Darlene Nelson	(503) 945-6927
Rules Coordinator	Telephone
Oregon Health Authority, Division of Medical Assistance Programs, 500 Summer St. NE, Salem, OR 97301	
Address	

RULE CAPTION

FCHP Non-contracted Hospital reimbursement rate methodology change

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

Hearing Date	Time	Location	Hearings Officer
3-19-12	10:30 AM	DHS Building-500 Summer St NE, Salem, Or HR 137C	Darlene Nelson

Auxiliary aids for persons with disabilities are available upon request.

RULEMAKING ACTION

Secure approval of rule numbers with the Administrative Rules Unit prior to filing

ADOPT:

AMEND:

410-120-1295

REPEAL:

RENUMBER: Secure approval of new rule numbers with the Administrative Rules Unit prior to filing.

AMEND AND RENUMBER: Secure approval of new rule numbers with the Administrative Rules Unit prior to filing.

Statutory Authority:

ORS 413.042

Other Authority:

SB101, 2011 State of Oregon Legislative Assembly

Statutes Implemented:

ORS 414.025, 414.065, 414.705 & 414.743

RULE SUMMARY

Having Temporarily amended 410-120-1295 effective October 1, 2011, DMAP will permanently amend this rule, 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 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.

<u>03-20-2012 Close of Business</u>	<u>Darlene Nelson</u>	<u>dar.l.nelson@state.or.us</u>	1-3-12 3:37p.m.
Last Day (m/d/yyyy) and Time for public comment	Printed Name	Email Address	Date Filed

*The Oregon Bulletin is published on the 1st of each month and updates the rule text found in the Oregon Administrative Rules Compilation. Notice forms must be submitted to the Administrative Rules Unit, Oregon State Archives, 800 Summer Street NE, Salem, Oregon 97310 by 5:00 pm on the 15th day of the preceding month unless this deadline falls on a Saturday, Sunday or legal holiday when Notice forms are accepted until 5:00 pm on the preceding workday.

ARC 923-2003

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), Division of Medical Assistance Programs (Division)	410
Agency and Division	Administrative Rules Chapter Number

FCHP Non-contracted Hospital reimbursement rate methodology change

Rule Caption

In the Matter of: The permanent amendment of a temporary administrative rule that governs payment for the General Rules Program. DMAP will permanently amend 410-120-1295 and repeal 410-120-1295 (T)

Proposed rules are available on the Division Website:
<http://www.dhs.state.or.us/policy/healthplan/rules/notices.html>
 For hardcopy requests, call: (503) 947-5081

Statutory Authority: ORS 413.042

Other Authority: SB101, 2011 State of Oregon Legislative Assembly

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

Need for the Rule(s): The General Rules Program administrative rules govern the Division payments for services provided to clients. Having Temporarily amended 410-120-1295 effective October 1, 2011, DMAP will permanently amend this rule, 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.

Documents Relied Upon, and where they are available: SB 101, 2011 State of Oregon Legislative Assembly available at http://www.leg.state.or.us/bills_laws/

Fiscal and Economic Impact:

Statement of Cost of Compliance:

1. Impact on state agencies, units of local government and the public (ORS 183.335(2)(b)(E)): None
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: There will be no impact on small businesses; this rule effects payments to Hospitals by managed care organizations.
 - b. Projected reporting, recordkeeping and other administrative activities required for compliance, including costs of professional services: The proposed revisions impose no new record keeping, reporting or administrative requirements on small businesses.
 - c. Equipment, supplies, labor and increased administration required for compliance: The proposed revisions impose no new equipment, supplies, labor or increased administration requirements on small businesses.

How were small businesses involved in the development of this rule? Hospitals and Managed care plans are not considered small businesses therefore small businesses were not involved. However, Stakeholders were involved in drafting the legislation for SB 101 and included in meetings after passage of the bill.

Administrative Rule Advisory Committee consulted? No

If not, why? This rule implements a change to Oregon statute based on Legislative action; the Division determined a RAC is not necessary.

Signature  _____
 Judy Mohr Peterson, Jean S. Donovan or Sandy Wood

12-21-11

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, 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 shall 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 shall reimburse inpatient and outpatient services using a Medicare payment methodology at a specified percentage point less than the percentage of Medicare costs used by the Oregon Health Authority (Authority) when 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) 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.

(5) 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.

(6) 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

10-20-12 (T) 3-25-12 (P)