

Public notice

Notice of intent – OHA will amend the Medicaid State Plan to change the methods used to pay out-of-state hospitals.

Date: Jan. 3, 2025

Contact: Jesse Anderson, State Plan manager

Comments due: 5 p.m. Friday, Jan. 31, 2025

Oregon Health Authority (OHA) intends to submit a State Plan Amendment (SPA) to the Centers for Medicare & Medicaid Services. The SPA will change how OHA pays out-of-state hospitals for outpatient services.

- Out-of-state hospitals currently receive payment based upon their billed charges.
- OHA proposes using the same Ambulatory Payment Classification methodology used for in-state DRG hospitals.

The estimated annual savings for fee-for-service reimbursement is \$120,000.

Obtaining SPA language

The next page shows the new State Plan language in the proposed SPA. You can also view the full State Plan, approved SPAs and proposed SPAs on [the OHA website](#).

How to comment:

OHA welcomes public review and input. Please send written comments by 5 p.m. Friday, Jan. 31, 2025, to jesse.anderson@oha.oregon.gov.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State/Territory: OREGON

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

2.a. OUTPATIENT HOSPITAL SERVICES (Cont)

For non-state government owned hospitals, payments will be limited to the total available non-state government owned hospital upper payment limit gap calculated in the following section. The distribution of payments will be determined by first calculating a percentage as follows: one quarter of the upper payment limit gap divided by the total non-state government owned DRG hospital outpatient Medicaid fee-for-service payments from the quarter preceding the month of payment. This percentage will then be applied to each non-state government owned DRG hospital's outpatient Medicaid fee-for-service payments from the quarter preceding the month of payment to determine the individual non-state government owned DRG hospital outpatient supplemental payments. This process will be repeated and payments will be made quarterly.

3. Out-of-state contiguous and non-contiguous hospitals are reimbursed at an APC methodology as outlined in 2.a.(2), 50% of billed charges for all for outpatient services except for clinical laboratory which are reimbursed at the lesser of billed charges or the DMAP fee schedule. There is no cost settlement.

The reimbursement for out-of-state contiguous and non-contiguous hospital's will be 80% of Medicare. The Agency will grandfather a reimbursement rate of 50% of the 2024 hospital specific charge master if requested by the hospital. Supporting documentation will be required for this process.

4. Highly specialized out-of-state outpatient services are provided by written agreement or contract between DMAP and the provider. The rate is negotiated on a provider-by-provider basis and is a discounted rate.

Outpatient reimbursement does not exceed applicable Federal upper payment limits.