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TEMPORARY ADMINISTRATIVE ORDER

INCLUDING STATEMENT OF NEED & JUSTIFICATION

DMAP 31-2026

CHAPTER 410
OREGON HEALTH AUTHORITY
HEALTH SYSTEMS DIVISION: MEDICAL ASSISTANCE PROGRAMS

FILED: 07/21/2026 1:52 PM
ARCHIVES DIVISION SECRETARY OF STATE & LEGISLATIVE COUNSEL

FILING CAPTION: Technical correction relocating inpatient psychiatric rates paragraph to appropriate section for clarity and compliance.

EFFECTIVE DATE: 07/21/2026 THROUGH 01/16/2027

AGENCY APPROVED DATE: 07/21/2026

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NEED FOR THE RULE(S):

Technical correction relocating inpatient psychiatric rates paragraph to appropriate section for clarity and compliance.

JUSTIFICATION OF TEMPORARY FILING:

(1) Describe the specific consequences that result from the failure to immediately adopt, amend or suspend the rule(s):

The current placement of the subsection may lead to inconsistent implementation of the rule, resulting in confusion regarding the agency's intended requirements. Immediate amendment is necessary to ensure the rule accurately reflects its intended meaning and promotes uniform application.

(2) Who would suffer these consequences:

CCO's and hospitals.

(3) Why or how failure to immediately take rulemaking action would cause these consequences:

Rule could be misinterpreted

(4) How the temporary action will avoid or mitigate those consequences:

It will clarify the intent of the rule

DOCUMENTS RELIED UPON, AND WHERE THEY ARE AVAILABLE:

None

AMEND: 410-120-1295

RULE SUMMARY: Technical correction relocating inpatient psychiatric rates paragraph to appropriate section for clarity and compliance.

CHANGES TO RULE:

410-120-1295
Non-Participating Provider ¶

(1) For purposes of this rule, a provider enrolled with the Health Systems Division (Division) that does not have a contract with a Division-contracted Managed Care Entity (MCE) is referred to as a non-participating provider. ¶
(2) For services covered by the CCO or PHP, a non-participating provider, other than a hospital governed by (3) and (4) of this rule, must accept from the Division-contracted MCE, 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 MCE 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 MCE 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 global payments to the MCE for the contract period; ¶
(b) Hospitals (not designated as a rural access or Type A and Type B hospital) including Child/Adolescent Psychiatric units in a hospital: As specified in ORS 414.743, the MCE 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 the MCE excluding any supplemental payments~~;~~ ¶
~~(c) Effective for services on or after January 1, 2025, inpatient psychiatric adult and pediatric services shall be reimbursed using the DRG and outlier methodology outlined in OAR 410-125-0141 (10) and (11).~~ ; ¶
(A) 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; ¶
(B) 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~~.~~ ; ¶
(C) Effective for services on or after January 1, 2020 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 76 percent~~.~~ ; ¶
(D) Effective for services on or after January 1, 2020 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 78 percent~~.~~ ; ¶
(E) Effective for services on or after January 1, 2023 but before January 1, 2024. ¶
(i) 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 81 percent; and ¶
(ii) 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 83 percent. ¶

(c) Effective for services on or after January 1, 2025, inpatient psychiatric adult and pediatric services shall be reimbursed using the DRG and outlier methodology outlined in OAR 410-125-0141 (10) and (11); ¶
(d) For Maternity Services effective on or after January 1, 2026 but before January 1, 2027;; ¶
(A) For 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 100 percent; and ¶
(B) 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 102 percent. ¶
(4) A non-participating hospital must notify the MCE within two (2) business days of an MCE patient admission when the MCE is the primary payer. Failure to notify does not, in and of itself, result in denial for payment. The CCO or 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 MCE contract and the Division's administrative rules. ¶
(5) After notification from the non-participating hospital, the MCE may: ¶
(a) Arrange for a transfer to a contracted facility, if the patient is medically stable and the MCE 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 MCE and hospital, the provider may appeal the decision by asking for an administrative review as specified in OAR 410-120-1580.
Statutory/Other Authority: ORS 413.042
Statutes/Other Implemented: ORS 414.065, 414.025, 414.743