

METHODS AND STANDARDS FOR PAYMENT OF INPATIENT MEDICAL HOSPITAL SERVICES

1. TYPE A AND TYPE B RURAL OREGON HOSPITALS

The definition of Type A and Type B hospitals is contained in ORS 442.470. The responsibility for designating Type A and Type B hospitals was assigned to the Office of Rural Health, Department of Higher Education. Type A and Type B hospitals receive retrospective cost-based reimbursement for all covered inpatient services effective with admissions occurring on or after July 1, 1991.

Costs are derived from the most recent audited Medicare Cost Report and are adjusted to reflect the Medicaid mix of services.

Payment for inpatient services provided to an individual age 21 and older is prorated to the number of hospital benefit days remaining at the time the claim is received. The claim is prorated to the number of hospital days remaining from the fiscal year in which the admission occurred at the time the claim is processed.

Type A and B hospitals are eligible for disproportionate share reimbursements, but do not receive cost outlier, capital, or medical education payments.

2. HOSPITALS PROVIDING SPECIALIZED INPATIENT SERVICES

Some hospitals provide specific highly specialized inpatient services by arrangement with OMAP. Reimbursement is made according to the terms of a contract between OMAP and the hospital. The rate is negotiated on a provider-by-provider basis and is a rate sufficient to secure necessary services. When the service is provided by an out-of-state hospital, the rate is generally the rate paid by the Medicaid program of the state in which the provider is located. In all instances, the negotiated rate is a discounted rate.

3. FREE-STANDING INPATIENT PSYCHIATRIC FACILITIES (IMDS)

Free-standing inpatient psychiatric facilities (Institutions for Mental Diseases), including Oregon's state-operated psychiatric and training facilities, are reimbursed according to the terms of an agreement between the Mental Health and Developmental Disabilities Services Division and the hospital.

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4. SPINAL CORD INJURED PROGRAM

Reimbursement under the Spinal Cord Injured program is made on a prospective payment basis for inpatient rehabilitative services provided by CARF or JCAHO-Rehab. certified facilities for treatment of severe disabling spinal cord injuries for persons who have exhausted their hospital benefit days. Services must be authorized by the Spinal Cord Injured Committee in order for payment to be made.

5. INPATIENT RATE CALCULATIONS FOR OTHER HOSPITALS: DRG METHODOLOGY

A. OREGON ACUTE CARE HOSPITALS

(1) DIAGNOSIS RELATED GROUPS

Diagnosis Related Groups (DRG) is a system of classification of diagnoses and procedures based on the International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM).

The DRG classification methodology assigns a DRG category to each inpatient service, based on the patient's diagnoses, age, procedures performed, length of stay, and discharge status.

(2) MEDICARE GROUPEUR

The Medicare Grouper is the software used to assign individual claims to a DRG category. Medicare revises the Grouper program each year in October.

OMAP uses the Medicare Grouper program in the assignment of inpatient hospital claims. The most recent version of the Medicare grouper will be installed each year within 90 days of the date it is implemented by Medicare. Where better assignment of claims is achieved through changes to the grouper logic, OMAP may modify the logic of the grouper program. OMAP will work with representatives of hospitals which may be affected by grouper logic changes in reaching a cooperative decision regarding changes.

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(3) DRG RELATIVE WEIGHTS

Relative weights are a measure of the relative resources required in the treatment of the average case falling within a specific DRG category.

For most DRGs, OMAP establishes a relative weight based on Federal Medicare DRG weights. For state-specific Rehabilitation, Neonate, and Adolescent Psychiatric, Oregon Title XIX fee-for-service claims history is used. OMAP employs the following methodology to determine whether enough claims exist to establish a reasonable weight for each state-specific Rehabilitation, Neonate, and Adolescent Psychiatric DRG.

Using the formula $N = ((Z * S)/R)^2$, where $Z = 1.15$ (a 75% confidence level), S is the Standard Deviation, and $R = 10\%$ of the mean, OMAP determines the minimum number of claims required to set a stable weight for each DRG (N must be at least 5).

For state-specific Rehabilitation, Neonate, and Adolescent Psychiatric DRGs lacking sufficient volume, OMAP sets a relative weight using:

OMAP non-Title XIX claims data, or

Data from other sources expected to reflect a population similar to the OMAP Title XIX caseload.

When a t-test shows at the 90% confidence level that an externally derived weight is not representative of the average cost of services provided to the OMAP Title XIX population in that DRG, the weight derived from OMAP Title XIX claims history is used instead of the externally-derived weight for that DRG.

“Pen and Ink” Change

Those relative weights, based on Federal Medicare DRG weights, will be established when changes are made to the DRG Grouper logic. State-specific relative weights shall be adjusted, as needed, as determined by OMAP. When relative weights are recalculated, the overall average CMI will be kept constant. Reweighting of the DRGs or the addition or modification of the group logic will not result in a reduction of overall payments or total relative weights.

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(4) CASE MIX INDEX

The hospital-specific case mix index is the total of all relative weights for all services provided by a hospital during a period, divided by the number of discharges.

(5) OPERATING COSTS

For the purposes of determining costs for all non-Type A and Type B hospitals, costs are defined as costs derived from the Medicare costs reports for the hospital FY ending during the State FY 87 (July 1, 1986 through June 30, 1987) adjusted to the Medicaid mix of services and traded forward using DRI inflation

For the purposes of determining each hospital's unit value for services beginning July 1, 1991, the following procedure was used:

- a. The Medicaid cost per discharge was derived from each hospital's Medicare cost report as described above, and adjusted to the Medicaid mix of services. The costs of capital and direct and indirect medical education were deducted from this amount (capital and education costs were taken from the Medicare cost report for the hospital's fiscal year ending during the State 1987 Fiscal Year). The resultant amount is referred to as the "operating cost" per discharge.
- b. The operating cost per discharge as described in a. above (Operating Costs) for each hospital was adjusted in order to bring all hospitals to the same 1987 mid-point, using HCFA-DRI inflation adjustments. The operating cost was then inflated forward to the mid-point of Oregon Fiscal Year 1992 (January, 1992) using the compounded HCFA-DRI inflation factor.

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(6) UNIT VALUE

The Unit Value for each hospital effective for services beginning on or after July 1, 1991, was established as follows:

- a. The Oregon Fiscal Year 1992 operating cost per discharge from b. above (Operating Costs) was multiplied by the ratio of the projected 1992 CMI to the 1987 CMI to adjust for changes in the CMI between 1987 and the CMI for 1992.
- b. The CMI-trend adjusted cost per discharge from a. immediately above (Unit Value) is divided by the hospital's projected 1992 CMI in order to compare all hospitals as though they had a CMI of 1.0.
- c. All hospitals, including Type A and B hospitals, are ranked by their Case Mix Index adjusted cost per discharge.
- d. Each hospital below the 70th percentile is assigned a Preliminary FY 1992 Unit Value equal to its CMI adjusted operating costs described in b. above (Unit Value). This Preliminary Unit Value is reduced by the cost outlier payments which had been projected for FY 1992 (the projections which were the basis for the FY 1992 prospective rates). This shall be the hospital's Unit Value for the period beginning December 1, 1993.

The Unit Value multiplied by the relative weight for the DRG into which a claim falls is the hospital's Operational Payment.

For services beginning on or after July 1, 1992, the same process is followed in calculating the Unit Value as described above, except that the compounded HCFA-DRI for FY 92 and FY 93 is used in determining the Intermediate Unit Value.

- e. Each hospital at or above the 70th percentile is assigned a Preliminary FY 1992 Unit Value equal to the Preliminary Unit Value of the hospital at the 70th percentile. This Preliminary FY 1992 Unit Value is adjusted downwards as required in order that the cost outlier payments which had been projected for FY 1992 combined with the Operational Payment will not exceed the hospital's FY 1992 Operating Cost per Discharge (as described in (5), above). This preliminary unit value is further reduced by 2.45% to get the Final Unit Value for FY 1992. This shall also be the hospital's Unit Value for the period beginning December 1, 1993.

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- f. Effective October 1 of each year commencing on October 1, 1996, the unit values will be adjusted by first reviewing the operating margin for each DRG hospital (i.e., non-Type A and non-Type B hospitals). The operating margin (Operating Income/Total Operating Revenue) is an indicator of the fiscal integrity (or health) of a hospital. Using the most recent operating margins compiled by the Office For Oregon Health Plan Policy and Research, an average operating margin (A.O.M.) for the DRG hospitals is determined for the most recent preceding fiscal year ending September 30 in which all DRG hospitals have reported their operating margins to the Office of Oregon Health Plan Policy and Research.

The second component in determining the adjustment factor is the Hospital Market Basket (Market Basket) for acute-care hospitals published by HCFA in the Federal Register on or around September 1 of each year and effective on October 1. The Market Basket is a projection of the growth in the prices of goods and services purchased by hospitals.

The adjustment factor is then determined as follows:

1. If the Average Operating Margin is -0-% or less, unit values will be adjusted by the Market Basket.
2. If the Average Operating Margin is greater than -0-% and does not exceed 5% (the Upper Limit of Operating Margin Range (ULOMR)), the adjustment factor will be based on the inverse relationship that the Average Operating Margin bears to the Upper Limit of the Operating Margin Range or (5%).

As the Average Operating Margin approaches the Upper Limit of the Operating Margin Range (5%), the adjustment factor will be proportionately less than that determined when the Average Operating Margin approaches -0-%.

$[100\% - (A.O.M./ULOMR) \times HCFA \text{ Market Basket}] = \text{Adjustment Factor}$

For example, if the Average Operating Margin is 4% and the Market Basket is 10%, the adjustment factor is $[(100\% \text{ minus } \{4\% \text{ divided by } 5\%\}) \times 10\%]$ or 2%.

3. If the Average Operating Margin exceeds 5% (ULOMR), the adjustment factor will be 0%.

(7) DRG PAYMENT

The DRG payment to each hospital is calculated by multiplying the Relative Weight for the DRG by the Hospital-Specific Unit Value. This is referred to as the Operational Payment.

(8) COST OUTLIER PAYMENT'S

Cost outlier payments are an additional payment made at the time a claim is processed for exceptionally costly services provided to Title XIX clients.

Effective for services beginning on or after July 1, 1991, the calculation to determine the cost outlier payment for all hospitals is as follows:

- Non-covered services (such as ambulance charges) are deducted from billed charges.
- The remaining billed charges are converted to hospital-specific costs using the hospital's cost-to-charge ratio derived from the most recent audited Medicare cost report and adjusted to the Medicaid case load.
- If the hospital's net costs as determined above are greater than 300 percent of the DRG payment for the admission and are greater than \$25,000, an additional cost outlier payment is made.
- Costs which exceed the threshold (\$25,000 or 300% of the DRG payment, whichever is greater) are reimbursed at a percentage. The percentage of net costs (costs above the threshold) to be paid is established by OMAP and may be

adjusted monthly as needed to maintain total cost outlier expenditures for the 1993-95 biennium at \$9.0 million in Total Funds, excluding cost outlier payments made to Oregon Health Sciences University Medical Center.

- Third party reimbursements are deducted from the OMAP calculation of payable amount.

Formula for Cost Outlier Calculation:

$$\begin{aligned} & \text{Billed charges less non-covered charges} \\ \text{X} & \text{ Hospital-specific cost-to-charge ratio} \\ = & \text{ Net Costs} \\ - & \text{ 300\% of the DRG or \$25,000 (whichever is greater)} \\ = & \text{ Outlier Costs} \\ \text{X} & \text{ Cost Outlier Percentage} \\ = & \text{ Cost Outlier Payment} \end{aligned}$$

The cost outlier percentage necessary to fully expend the cost outlier pool is estimated to be 30% for the biennium. OMAP will reimburse cost outlier claims at 50% of costs above the threshold and will monitor payments to determine the relationship between projected and actual outlier payments. An adjustment to the 50%

reimbursement rate will be made as needed to fully expend the cost outlier pool. The amount of the cost outlier pool will not be exceeded. Cost outlier payments made to Oregon Health Sciences University Medical Center will not be deducted from this pooled amount.

When hospital cost reports are audited, an adjustment will be made to cost outlier payments to reflect the actual Medicaid hospital-specific cost-to-charge ratio during the time cost outlier claims were incurred.

The cost-to-charge ratio in effect for that period of time will be determined from the audited Medicare Cost Report and OMAP 42, adjusted to reflect the Medicaid mix of services.

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| (9) DAY OUTLIERS

Effective for services beginning on or after July 1, 1991, a payment adjustment will be made to Oregon disproportionate share hospitals for services provided to Title XIX children under the age of six who have exceptionally long lengths of stay. The threshold for day outlier claims is the Oregon Medicaid Geometric Average Length of Stay for the DRG plus 1.5 standard deviations or 30 days, whichever is the greater.

Calculations to determine day outlier reimbursement for a claim are as follows:

If the claim exceeds the day outlier threshold, the Oregon DRG payment is divided by the Average Length of Stay (ALOS), yielding a per diem payment. The hospital receives the DRG payment, plus the per diem payment multiplied by the number of days above the threshold, less third party reimbursements.

Hospitals must apply for a day outlier payment.

Claims reimbursed under the cost outlier methodology will not be considered for day outlier status.

| (10) CAPITAL

The capital payment is a reimbursement to in-state hospitals for capital costs associated with the delivery of services to Title XIX, non-Medicare persons. The Office of Medical Assistance Programs uses the Medicare definition and calculation of capital costs. These costs are taken from the Hospital Statement of Reimbursable Cost (Medicare Report).

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Capital cost per discharge is calculated as follows:

- a. The capital costs proportional to the number of Title XIX non-Medicare discharges during the period from July 1, 1986 through June 30, 1987 is divided by the number of Title XIX non-Medicare discharges. This results in the Title XIX Capital Cost per discharge. The Title XIX Capital Cost per discharge for each hospital above the 50th percentile will be set at the 50th percentile for Oregon hospitals receiving DRG Reimbursement.
- b. The Title XIX Capital Cost per discharge for this period is inflated forward to Oregon FY 1992, using the compounded HCFA DRI market basket adjustment.

Capital Payment Per Discharge

The number of Title XIX discharges paid during the quarter for each hospital is multiplied by the Title XIX cost per discharge from 1987 trended forward as described above. This determines the current quarter's capital costs. Reimbursement is made at 85% of this amount. Payment is made within thirty days of the end of the quarter.

The capital payment per discharge will be adjusted using the same inflation factor described in subparagraph 5.A.(6)f.

(11) DIRECT MEDICAL EDUCATION

The direct medical education payment is a reimbursement to in-state hospitals for direct medical education costs associated with the delivery of services to Title XIX eligible persons. The Office of Medical Assistance Programs uses the Medicare definition and calculation of direct medical education costs. These costs are taken from the Hospital Statement of Reimbursable Cost (Medicare Report).

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