

Direct Medical Education cost per discharge is calculated as follows:

The direct medical education cost 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 is the Title XIX

Direct Medical Education Cost per discharge.

The Title XIX Direct Medical Education cost per discharge for this period is inflated forward to January 1, 1992, using the compounded HCFA DRI market basket adjustment.

Direct Medical Education Payment Per Discharge

The number of Title XIX non-Medicare discharges from each hospital for the quarterly period is multiplied by the inflated Title XIX cost per discharge. This determines the current quarter's Direct Medical Education costs. This amount is then multiplied by 85%. Payment is made within thirty days of the end of the quarter.

The Direct Medical Education Payment Per Discharge will be adjusted using the same inflation factor described in subparagraph 5.A.(6)f.

(12) INDIRECT MEDICAL EDUCATION

The indirect medical education payment is a reimbursement made to in-state hospitals for indirect medical education costs associated with the delivery of services to Title XIX non-Medicare clients.

Indirect medical education costs are those indirect costs identified by Medicare as resulting from the effect of teaching activity on operating costs.

Indirect medical education payments are made to in-state hospitals determined by Medicare to be eligible for such payments. The indirect medical education factor in use by Medicare for each of these eligible hospitals at the beginning of the State's fiscal year is

**TN No. 96-10 Approval Date June 15, 1999 Effective Dates July 1, 1996
Supersedes October 1, 1996
TN No. 93-18**

the Office of Medical Assistance Program's indirect medical education factor. This factor is used for the entire Oregon fiscal year.

The calculation for the Indirect Medical Education Factor is as follows:

$$\begin{array}{r} \text{Total relative weights from claims paid during the quarter} \\ \text{X Indirect Medical Education Factor} \\ = \text{Indirect Medical Education Payment} \end{array}$$

This determines the current quarter's Indirect Medical Education payment. Indirect medical education payments are made quarterly to each eligible hospital. Payment for indirect medical education costs will be made within thirty days of the end of the quarter.

12(A) Graduate Medical Education Reimbursement for Public Teaching Hospitals

Graduate Medical Education (GME) payment is reimbursement made to an institution for the costs of an approved medical training program. The State makes GME payments to non-Type A and B inpatient acute hospitals based on the number of fee-for-service hospital inpatient discharges as provided in (11) Direct Medical Education and (12) Indirect Medical Education. Funding for GME is not included in the "capitation rates" paid to managed care plans under the Oregon Health Plan resulting in hospitals with medical teaching programs not being able to capture GME costs when contracting with managed care plans. Since a significant portion of Medicaid payments for acute inpatient hospital discharges are made through managed care plans, an additional payment for GME is necessary to ensure the integrity and quality of medical training programs.

The additional GME payment is a reimbursement to any in-state public acute care hospital providing a major teaching program, defined as a hospital with more than 200 residents or interns. This reimbursement is in addition to that provided under (11) Direct Medical Education or (12) Indirect Medical Education.

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DATE APPROVED July 21, 1999 EFFECTIVE DATE June 1, 1999

For each qualifying public hospital, the payment amount is initially determined based on its 1998 (base year) hospital specific costs for medical education as reported in the Medicare Cost Report. Total Direct Medical Education (DME) costs are derived from the HCFA Form 2552 Worksheet B Part I and consist of the costs "P & I" for medical residency and the paramedical education programs. Title XIX DME costs are determined based on the ratio of Title XIX days to total days applied to the total DME costs.

Indirect Medical Education (IME) costs are derived by first computing the percent of IME to total Medicare inpatient payments. This is performed by dividing the IME Adjustment reported in the Medicare Cost Report on the Form HCFA 2552 "P & I" "P & I"

Worksheet E Part A by the sum of this amount and Medicare payments for DRG "P & I" amount - other than outlier payments, inpatient program capital, and organ acquisition. The resulting percent is then applied to net allowable costs (total allowable costs from Worksheet B Part I less Total DME costs, computed as "P & I"

discussed in the previous paragraph). Title XIX IME costs are then determined based upon the ratio of Title XIX days to total days.

The additional GME payment is calculated as follows:

Total Title XIX GME is the sum of Title XIX IME and DME costs. Payments for Title XIX fee-for-service IME and DME are then subtracted from the Total Title XIX GME leaving the net unreimbursed Title XIX GME costs for 1998 (the base year). The net unreimbursed Title XIX GME costs for the base year is divided by the base year total Title XIX inpatient hospital days to determine the amount of unreimbursed GME per total Title XIX inpatient hospital days. This factor is multiplied by the payment year total Title XIX inpatient hospital days and then multiplied by HCFA PPS Hospital Index.

For example in SFY '99, the base year net unreimbursed Title XIX GME costs is divided by the base year Title XIX inpatient hospital days and then multiplied by the SFY '99 Title XIX inpatient hospital day which is then multiplied by the HCFA PPS Hospital Index. The base year is updated each subsequent year. For example in SFY '00, the SFY '99 net unreimbursed Title XIX GME costs is divided by SFY '99 Title XIX inpatient hospital days and then multiplied by the SFY '00 Title XIX inpatient hospital days which is then multiplied by the HCFA PPS Hospital Index.

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DATE APPROVED July 21, 1999 EFFECTIVE DATE June 1, 1999

The additional GME reimbursement is made annually within 90 days of the end of the SFY for that portion of the costs attributable to the Title XIX patient population only. Reimbursement is limited to the availability of public funds, specifically, the amount of public funds available for GME attributable to the Title XIX patient population.

Total payments including the additional GME payments will not exceed that determined by using Medicare reimbursement principles for the portion of costs attributable to the Title XIX population. The Medicare upper limit will be determined from the most recent ~~HCFA Form 2552~~ Medicare Cost Report and
"P & I" "P & I"

will be performed for all inpatient acute hospitals and separately for State operated inpatient acute hospitals in accordance with 42 CFR 447.272(a) and (b). The upper limit review will be performed before the additional GME payment is made.

(13) DISPROPORTIONATE SHARE

The disproportionate share hospital (DSH) payment is an additional reimbursement made to hospitals which serve a disproportionate number of low-income patients with special needs.

A hospital's eligibility for DSH payments is determined at the beginning of each State fiscal year. Hospitals which are not eligible under Criteria 1 may apply for eligibility at any time during the year under Criteria 2. A hospital may be determined eligible under Criteria 2 only after being determined ineligible under Criteria 1. Eligibility under Criteria 2 is effective from the beginning of the quarter in which eligibility is approved. Out-of-state hospitals are eligible for DSH payments if they have been designated by their state Title XIX Medicaid program as eligible for DSH payments within that state.

- a. **Criteria 1: The ratio of total paid Medicaid inpatient (Title XIX, non-Medicare) days to total inpatient days is one or more standard deviations above the mean for all Oregon hospitals.**

Information on total inpatient days is taken from the most recent Medicare Cost Report.

TN # 99-06 DATE APPROVED July 21, 1999 EFFECTIVE DATE June 1, 1999
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Information on total paid Medicaid days is taken from Office of Medical Assistance Programs (OMAP) reports of paid claims for the same fiscal period as the Medicare Cost Report.

b. **Criteria 2: A Low Income Utilization Rate exceeding 25%.**

The low income utilization rate is the sum of percentages (1) and (2) below:

- (1) **The Medicaid Percentage:** The total of Medicaid inpatient and outpatient revenues paid to the hospital plus any cash subsidies received directly from State and local governments in a cost reporting period. This amount is divided by the total amount of inpatient and outpatient revenues and cash subsidies of the hospital for patient services in the most recent Medicare cost reporting period. The result is expressed as a percentage.
- (2) **The Charity Care Percentage:** The total hospital charges for inpatient hospital services for charity care in the most recent Medicare cost reporting period, minus any cash subsidies received directly from State and local government in the same period, is divided by the total amount of the hospital's charges for inpatient services in the same period. The result is expressed as a percentage.

Charity care is care provided to individuals who have no source of payment, including third party and personal resources.

Charity care shall not include deductions from revenues or the amount by which inpatient charges are reduced due to contractual allowances and discounts to other health insurance or third party payers, such as HMO's, Medicare, Medicaid, etc.

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SUPERSEDES
TN# 94-14

DATE APPROVED MAY 4, 1998
EFFECTIVE DATE FEBRUARY 15, 1998

The information used to calculate the Low Income Utilization rate is taken from the following sources:

- The most recent Medicare Cost Reports.
- OMAP records of payments made during the same reporting period.
- Hospital provided financial statements, prepared and certified for accuracy by a licensed public accounting firm for the same reporting period.
- Hospital provided official records from state and county agencies of any cash subsidies paid to the hospital during the same reporting period.
- Any other information which OMAP, working in conjunction with representatives of Oregon hospitals, determines is necessary to establish eligibility.

OMAP determines within 30 days of receipt of all required information if a hospital is eligible under the Low Income Utilization rate criteria.

c. Other Disproportionate Share Eligibility Requirements

To receive DSH payments under Criteria 1 and Criteria 2, a hospital must have at least two obstetricians with staff privileges at the hospital who have agreed to provide non-emergency obstetrical services to Medicaid patients. For hospitals in a rural area (outside of a Metropolitan Statistical Area, as defined by the Executive Office of Management and Budget), the term "obstetrician" includes any physician with staff privileges at the hospital who performs non-emergency obstetric procedures. This requirement does not apply to a hospital in which a majority of inpatients are under 18 years of age, or a hospital which had discontinued or did not offer non-emergency obstetric services as of December 21, 1987. No hospital may qualify for DSH payments, unless the hospital has, at a minimum, a Medicaid utilization rate of one percent. The Medicaid utilization rate is the ratio of total paid Medicaid (Title XIX, non-Medicare) days to total inpatient days. Newborn days, days in specialized wards, and administratively necessary days are included. Days attributable to individuals eligible for Medicaid in another state are also accounted for.

Information on total inpatient days is taken from the most recent Medicare Cost Report.

Information on total paid Medicaid days is taken from OMAP reports of paid claims for the same fiscal period as the Medicare Cost Report.

d. Disproportionate Share Payment Calculations

Eligibility Under Criteria 1

The quarterly DSH payments to hospitals eligible under Criteria 1 is the sum of DRG weights for paid Title XIX non-Medicare claims for the quarter multiplied by a percentage of the hospital-specific Unit Value. This determines the hospital's DSH payment for the current quarter. The Unit Value used for eligible Type A and Type B hospitals is the Unit Value set at the 50th percentile. The calculation is as follows:

- (1) For eligible hospitals more than one standard deviation and less than two standard deviations above the mean, the disproportionate share percentage is 5%. The total of all relative weights is multiplied by the hospital's unit value. This amount is multiplied by 5% to determine the DSH payment.
- (2) For eligible hospitals more than two and less than three standard deviations above the mean, the percentage is 10%. The total of all relative weights is multiplied by the hospital's unit value. This amount is multiplied by 10% to determine the DSH payment.
- (3) For eligible hospitals more than three standard deviations above the mean, the percentage is 25%. The total of all relative weights is multiplied by the hospital's unit value. This amount is multiplied by 25% to determine the DSH payment.

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EFFECTIVE DATE FEBRUARY 15, 1998

Eligibility under Criteria 2

For hospitals eligible under Criteria 2 (Low Income Utilization Rate), the quarterly DSH payment is the sum of DRG weights for claims paid by OMAP in the quarter, multiplied by the hospital's disproportionate share adjustment percentage established under Section 1886(d)(5)(F)(iv) of the Social Security Act multiplied by the hospital's unit value.

Out-of-state hospitals

For out-of-state hospitals, the quarterly DSH payment is 5% of the out-of-state unit value multiplied by the sum of the Oregon Medicaid DRG weights for the quarter. Out-of-state hospitals which have entered into agreements with OMAP for payment are reimbursed according to the terms of the agreement or contract. The rate is negotiated on a provider-by-provider basis and is a rate sufficient to secure necessary services. In general, the rate paid by State of Oregon is 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.

e. Additional disproportionate share adjustments

Public academic medical centers that meet the following eligibility standards shall be deemed eligible for additional DSH payments up to 100% of their uncompensated care costs for serving Medicaid fee for service clients and indigent and uninsured patients:

- (1) The hospital must have at least two obstetricians with staff privileges at the hospital who have agreed to provide obstetric services to individuals who are entitled to medical assistance for such services; and
- (2) The hospital must be located within the State of Oregon (border hospitals are excluded); and
- (3) The hospital provides a major medical teaching program, defined as a hospital with more than 200 residents or interns.

100% of the costs for hospitals qualifying for this DSH payment will be determined from the following sources:

The most recent Medicare Cost Reports.

OMAP's record of payments made during the same reporting period.

Hospital provided financial statements prepared and certified for accuracy by a licensed public accounting firm.

Hospital provided official records from state and county agencies of any cash subsidies paid to the hospital during the same reporting period.

Any other information which OMAP, working in conjunction with representatives of Oregon hospitals, determines necessary to establish cost.

f. Disproportionate Share Payment Schedule

Hospitals qualifying for DSH payments under section (13d) will receive quarterly payments based on claims paid during the preceding quarter. Payments are made within 30 days of the end of the quarter. Hospitals which were eligible during one fiscal year but are not eligible for disproportionate share status during the next fiscal year will receive DSH payments based on claims paid in the quarter in which they were eligible. Hospitals qualifying for DSH payments under section (13)e will receive quarterly payments of 1/4 of the amount determined under this section.

Effective October 1, 1994, and in accordance with the Omnibus Budget Reconciliation Act of 1993, DSH payments to hospitals will not exceed 100 percent of the "basic limit", which is:

- (1) The inpatient and outpatient costs for services to Medicaid patients, less the amounts paid by the State under the non-DSH payment provisions of the State Plan, plus:

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- (2) The inpatient and outpatient costs for services to uninsured indigent patients, less any payments for such services. An uninsured indigent patient is defined as an individual who has no other resources to cover the costs of services delivered. The costs attributable to uninsured patients are determined through disclosures in the Medicare (HCFA-2552) cost report and state records on indigent care.

The state has a contingency plan to ensure that DSH payments will not exceed the "State Disproportionate Share Hospital Allotment." A reduction in payments in proportion to payments received will be effected to meet the requirements of section 1923(f) of the Social Security Act. DSH payments are made quarterly. Before payments are made for the last quarter of the Federal fiscal year, payments for the first three quarters and the anticipated payment for the last quarter are cumulatively compared to the "State Disproportionate Share Hospital Allotment." If the allotment will be exceeded, the DSH payments for the last quarter will be adjusted proportionately for each hospital qualifying for payments under section (13)e, first. If the Allotment will still be exceeded after this adjustment, DSH payments to out-of-state hospitals will be adjusted in proportion to DSH payments received during the previous three quarters. If this second adjustment still results in the Allotment being exceeded, hospitals qualifying for payments under section (13)d (Criteria 1 and 2) will be adjusted by applying each hospital's proportional share of payments during the previous three quarters to total DSH payments to all hospitals for that period. Similar monitoring, using a predetermined limit based on the most recent audited costs, and including the execution of appropriate adjustments to DSH payments are in effect to meet the hospital specific limit provisions detailed in section 1923(g) of the Social Security Act.

TN# 98-01
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DATE APPROVED MAY 4, 1998
EFFECTIVE DATE FEBRUARY 15, 1998