

Enclosure 3

Transmittal #98-01

Attachment 4.19 A

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- The State has in place a public process which complies with the requirements of Section 1902(a)(13)(A) of the Social Security Act.

TN# 98-01
SUPERSEDES
TN# NA

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

B. NON-CONTIGUOUS AREA OUT-OF-STATE HOSPITALS

Non-contiguous area hospitals are out-of-state hospitals located more than 75 miles outside the Oregon border. Unless such hospitals have an agreement or contract with OMAP for specialized services, non-contiguous area out-of-state hospitals will receive DRG reimbursement. The Unit Value for non-contiguous out-of-state hospitals will be set at the Final Unit Value for the 50th percentile of Oregon hospitals (see DRG Rate Methodology for the methodology used to calculate the Final Unit Value at the 50th percentile). No cost outlier, capital or medical education payments will be made. The hospital will receive a Disproportionate Share reimbursement if eligible.

C. CONTIGUOUS AREA OUT-OF-STATE HOSPITALS

Contiguous Area Hospitals are out-of-state hospitals located less than 75 miles outside the border of Oregon. Unless such hospitals have an agreement or contract with OMAP for specialized services, contiguous area out-of-state hospitals will receive DRG reimbursement. The Unit Value for contiguous out-of-state hospitals will be set at the Final Unit Value for the 50th percentile of Oregon hospitals (see DRG Rate Methodology, for the methodology used to calculate the Unit Value at the 50th percentile.) Contiguous area out-of-state hospitals are also eligible for cost outlier payments. No capital or medical education payments will be made. The hospital will receive a Disproportionate Share reimbursement if eligible.

D. DEATH OCCURRING ON DAY OF ADMISSION

A hospital receiving DRG reimbursements will receive the DRG reimbursement for the inpatient stay when death occurs on the day of admission as long as at least one hospital benefit day is available from the fiscal year in which the admission occurred at the time the claim is processed.

E. TRANSFERS AND REIMBURSEMENT

When a patient is transferred between hospitals the transferring hospital is paid on the basis of the number of inpatient days spent at the transferring hospital multiplied by the Per Diem Inter-Hospital Transfer Payment rate.

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COMMENTS	

The Per Diem Inter-Hospital Transfer Payment rate = the DRG payment divided by the geometric mean length of stay for the DRG.

The final discharging hospital receives the full DRG payment. Hospitals receiving cost-based reimbursement receive the cost-based reimbursement prorated to the remaining hospital benefit days.

Transfers from acute care to a distinct part rehabilitation unit within the same hospital shall be considered a discharge and readmission, with both admissions eligible for a separate DRG payment.

6. HOSPITAL BENEFIT DAYS AND REIMBURSEMENT

Individuals under the age of 21 have no hospital benefit day limits. Qualified Medicare Beneficiaries and Qualified Medicare-Medicaid Beneficiaries have no hospital benefit day limits. All other individuals are limited to 18 hospital benefit days per fiscal year.

A. TYPE A AND TYPE B HOSPITALS AND OTHER HOSPITALS RECEIVING RETROSPECTIVE COST-BASED REIMBURSEMENT.

Payment for inpatient services provided to an individual subject to hospital benefit day limits is prorated to the number of hospital benefit days remaining at the time the claim is processed. The claim is prorated to the number of hospital days remaining from the fiscal year in which the admission occurred.

Payments for inpatient services provided to an individual who is not subject to hospital benefit day limits admission are not prorated.

B. HOSPITALS RECEIVING DRG PAYMENTS

Full payment will be made if at least one hospital benefit day remains from the fiscal year in which the admission occurred at the time the claim is processed.

No payments will be made to any receiving hospital if a transfer to that hospital occurs after the benefit days have been used.

Inpatient days covered by other insurance are counted as hospital benefit days used when OMAP processes the claim.

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7. **THIRD PARTY RESOURCES AND REIMBURSEMENT**

- A. The Office of Medical Assistance Programs establishes maximum allowable reimbursements for all services. When clients have other third party payers, the payment made by that payer is deducted from the OMAP maximum allowable payment.

OMAP will not make any additional reimbursement when a third party pays an amount equal to or greater than the OMAP reimbursement. OMAP will not make any additional reimbursement when a third party pays 100 percent of the billed charges, except when Medicare Part A is the primary payer.

- B. When Medicare is Primary

OMAP calculates the reimbursement for these claims in the same manner as described in the Inpatient Rates Calculations sections above.

Payment is the OMAP allowable payment, less the Medicare payment, up to the amount of the deductible due. For clients who are Qualified Medicare beneficiaries OMAP does not make any reimbursement for a service which is not covered by Medicare. For clients who are Qualified Medicare/Medicaid beneficiaries OMAP payment is the allowable payment, less the Medicare payment, up to the amount of the deductible due for services covered by either Medicare or Medicaid.

- C. When Medicare is Secondary

Payment is the OMAP allowable payment, less the Medicare Part B payment.

- D. Clients with PCO or HMO Coverage

OMAP payment is limited to those services which are not the responsibility of the PCO or HMO. Payment is made at OMAP rates.

- E. Other Insurance

OMAP pays the maximum allowable payment, less any third party payments.

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OMAP will not make any additional reimbursements when a third party payor (other than Medicare) pays an amount equal to or greater than the OMAP reimbursement, or 100 percent of billed charges.

F. Medically Needy

Reimbursement is the OMAP maximum allowable payment for covered services, less the amount of the spend-down due.

8. UPPER LIMITS ON PAYMENT OF HOSPITAL CLAIMS

A. PAYMENTS WILL NOT EXCEED TOTAL OF BILLED CHARGES

Excepting for Type A hospitals which are reimbursed 100% of costs by Oregon statute, the total reimbursement during each hospital's fiscal year for inpatient services, including the sum of DRG payments, cost-outlier, capital, direct medical education, and indirect medical education payments shall not exceed the individual hospital's total billed charges for the period for these services.

If the total billed charges for all inpatient claims during the hospital's fiscal year is less than the total OMAP payment for those services, the overpayment shall be recovered.

B. PAYMENTS WILL NOT EXCEED FINALLY APPROVED PLAN

Total reimbursements to a State operated facility made during OMAP's fiscal year (July 1 through June 30) may not exceed any limit imposed under Federal law in a finally approved plan.

Total aggregate inpatient reimbursements to all hospitals made during OMAP's fiscal year (July 1 through June 30) may not exceed any limit imposed under Federal law in a finally approved plan.

9. DISALLOWED PAYMENTS

Payment will not be made to hospitals for non-emergency admissions if the appropriate prior authorization has not been obtained. Payment will not be made to hospitals for admissions determined not to be medically necessary. OMAP will not reimburse for non-covered services. OMAP may disallow payment for physicians' services provided during patient hospitalizations for which prior approval was required but not obtained.

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REMARKS	

10. APPEALS

Providers may request an appeal or exception to any State decision affecting payment rates. Providers may submit additional evidence and receive prompt administrative review as referenced in OAR 410-120-780 through 410-120-1060 and OAR 410-125-2040 and 2060.

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