

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

SUBJECT: A description of the policy and the methods used in establishing payment rates for each type of care or service listed in Section 1905(a) of the Act.

Physician: Payment is based on a state-wide fee schedule based upon Medicare's Resource Based Relative Value Scale with Oregon specific conversion factors.

Dentist: A state-wide fee schedule was developed from a survey of other State Medicaid Programs and the major dental insurance carrier in Oregon.

Naturopath: Payment is on the same basis as Physician Services.

Direct Entry Midwives: Payment will be based on a state-wide fee schedule.

Acupuncturists: Payment will be based on a state-wide fee schedule.

Private Duty Nursing Services: Payment will be based on a state-wide fee schedule.

Nurse and Technician Anesthetists: Payment will be based on a state-wide fee schedule.

Chiropractor: Payment will be based on a state-wide fee schedule.

Podiatrists: Payment will be based on a state-wide fee schedule.

Physical Therapy: Payment will be based on a state-wide fee schedule.

Visual Care Services, examining and dispensing. Payment will be based on a state-wide fee schedule.

Hospitalization in an Institution for Mental Disease: These institutions are reimbursed for the cost of inpatient hospital services as prescribed in 42 CFR 447.253.

Home Health Services: Payment is based on a statewide fee schedule for each type of covered service. Medical supplies are covered at costs up to a specific dollar amount without prior authorization.

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Ophthalmic Materials. Payment will be based on a state-wide fee schedule.

Medical Transportation. Payment will be based on a state-wide fee schedule

Medical Supplies and Equipment.

Aged, blind and disable persons: Payment will be based on a state-wide fee schedule.

Families and children: Payment will be based on a state-wide fee schedule.

Personal Care Services. Payments are made to individual providers based on state-wide uniform hourly rates or individually negotiated rates. The state-wide uniform hourly rates are supported by a survey of Oregon wages in comparable work and payment history. Payments are also made to agencies under a contract obtained through negotiation.

Occupational Therapy.

Aged, blind and disabled persons: Payment will be based on a state-wide fee schedule.

Families and children: Payment will be based on a state-wide fee schedule.

Audiologist Services.

Aged, blind and disabled persons: Payment will be based on a state-wide fee schedule.

Families and children: Payment will be based on a state-wide fee schedule.

Clinical Laboratory and Pathology Procedures.

Payment will be based on the lesser of Medicare's fee schedule or the Division's state-wide fee schedule.

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Effective: 10/1/95

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Rehabilitative Mental Health Services

Payment will be based on a statewide fee schedule or prepaid capitation rates.

Rehabilitative Alcohol and Drug Services

Payment will be based on a statewide fee schedule or prepaid capitation rates.

Additional Services to Pregnant Women

Payment will be based on a statewide fee schedule.

EPSDT Services

The following describes the reimbursement methodologies for required EPSDT services not covered elsewhere in the plan:

Hospice payment and methodology is the same as used by Medicare's program.

Respiratory Care Services payment will be based upon Medicare principles of reimbursement.

Case Management Services reimbursement, for other than Targeted Case Management, will be based on a state-wide fee schedule with payment based on 15 minute time increments and billed on a monthly basis.

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Preventive Services for HIV Infected Individuals

Payment will be based on a statewide fee schedule.

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Reimbursement Methodology for Rehabilitation Services Provided in Psychiatric Day Treatment Centers

Payment will be made to private, non-profit treatment agencies using individually negotiated daily rates for each facility, negotiated by the appropriate Division.

Nurse Midwives

Payment for services by nurse midwives and other licensed nurse practitioners will be at the same level as for physicians and independent clinical labs.

Rehabilitative School-Based Health Services

Payment will be based on a statewide fee schedule to reimburse 15-minutes units of service. Rates were established by comparison of reported provider costs and prevailing community rates from billings to OMAP. Rates do not exceed the prevailing statewide average or the average reported costs.

Behavior Rehabilitation Services

Payment for Behavior Rehabilitation Services is on a fee-for-service basis, with one day being the unit of service. Rates are set using a prospective staffing based rate model that uses data gathered by the State Department of Employment reporting the prevailing wages in the State of Oregon. Specific position classifications were selected to reflect the comparable staffing requirements needed to provide quality rehabilitation services to the identified population. A factor is used to compensate for employee benefits and facility operating costs and supplies. Board and room are not included in the Behavior Rehabilitation Service rate paid to the provider. These rates are periodically adjusted based on appropriate cost-of-living adjustments and other market indicators and program standards.

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Prescribed Drugs

A. General

- (1) The Department of Human Resources (DHR) will pay the provider's usual charge to the general public for a drug or the estimated acquisition cost (EAC) plus a dispensing fee, whichever is the lower. The provider's usual charge to the general public for pharmaceutical products is the charge customarily made to the general public for the same product on the same date as the general public for the same product on the same date as that provided to DHR clients. DHR determines the EAC to be the lesser of: the manufacturer's direct price (for selected companies), Oregon maximum allowable cost (as defined in B.2.), the federally established maximum allowable cost or 89% of the average wholesale price.
- (2) The DHR requires prior authorization of payment for selected therapeutic classes of drugs. These drug classes are listed in the Oregon Administrative Rules in the Oregon Pharmaceutical Services Guide. Exception to the prior authorization requirement may be made in medical emergencies.
- (3) The DHR will reimburse providers only for drugs supplied from pharmaceutical manufacturers or labelers who have signed an agreement with HCFA or who have a HCFA approved agreement to provide drug price rebates to the Oregon Medicaid program.

B. Payment Limits for Multiple Source Drugs

- (1) The DHR has established the payment amount for multiple source (generic) drugs as the lesser of the direct price from the manufacturer (for selected companies), Oregon maximum allowable cost, HCFA upper limits for drug payment, 89% of average wholesale price, plus a dispensing fee or the usual charge to the general public.

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- (2) The Oregon Maximum Allowable Cost (OMAC) is determined on selected multiple-source drugs designated as bioequivalent by the Food and Drug Administration. The upper limit of payment for a selected multiple source drug is set at a level where one bioequivalent drug product is available from at least two wholesalers serving the State of Oregon. When the OMAC is based upon AWP it will be set at 89% of that AWP. The upper limit of payment established by the OMAC listing does not apply if a prescriber certifies that a single-source (brand) drug is medically necessary.
- (3) The direct price from the manufacturer and the average wholesale price is determined using information furnished by the DHR's drug price data base contractor.
- (4) Payment for multiple-source drugs for which HCFA has established upper limits will not exceed, in the aggregate, the set upper limits plus a dispensing fee.
- (5) No payment shall be made for an innovator multiple source drug having a federal upper limit for payment if under applicable Oregon State law a less expensive noninnovator multiple source drug could have been dispensed.

C. Payment Limits for Single-Source Drugs

- (1) The DHR will pay the EAC plus a dispensing fee or the usual charge to the general public, whichever is lower, for single-source drugs. The DHR defines EAC for single-source drugs as the lesser of the direct price from selected manufacturers or 89% of average wholesale price.
- (2) The usual charge to the general public is established as indicated in A.(1).
- (3) The direct price is determined for selected drugs from price information furnished by the DHR's drug price data base contractor.
- (4) The average wholesale price is determined from price information furnished by the DHR's drug price data base contractor.
- (5) Payments for single-source drugs shall not exceed, in the aggregate, the lesser of the estimated acquisition cost plus a reasonable dispensing fee or the provider's usual charge to the general public.

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D. Dispensing or Professional Fees

- (1) The DHR establishes pharmacy dispensing fee payments based on the results of surveys of pharmacies and other Medicaid programs, and by approval of the State Legislature.
- (2) The present dispensing fee payment mechanism is four-tiered. The fee amount is based on yearly prescription sales volume, the percentage of dispensing sales volume that is Medicaid dispensings and the type of unit dose dispensing system used. The pharmacy must provide documentation substantiating annual prescription sales volume, Medicaid dispensing volume and unit dose dispensing system employed.
- (3) Pharmacies dispensing through a unit dose or 30-day card system must bill the DHR only one dispensing fee per medication dispensed in a 30-day period.
- (4) Fee allowances are made for preparation time and dispensing of compounded prescriptions.

91-8

6/3/91
4/1/91

Payment Methodology for Targeted Case Management
for Persons with Developmental Disabilities

The Mental Health and Developmental Disability Services Division (the Division) established an initial monthly statewide rate for regular case management services for persons with developmental disabilities in 1989. The rate was based on the total average monthly cost per client served by each case manager and included all direct service and administrative costs associated with case management service delivery under ideal caseloads. The Division has adjusted the rate annually for cost of living changes. The Division has the option to adjust for expenditure changes, as needed, through use of the following targeted case management contract language: "If asked to assist DIVISION with rate computations, COUNTY agrees to submit detailed information on expenditures as specified by the DIVISION."

Providers of regular case management bill the Division at the prevailing monthly rate. Beginning in 1994, providers of the new intensive case management may bill the Division at a higher monthly rate. Billings for both types of providers flow through the Division's Client Process Monitoring System (CPMS). CPMS provides all required information, including:

- Date of Service;
- Name of Recipient;
- Name of Provider Agency and Person Providing the Service;
- Nature, Extent, or Units of Service; and
- Place of Service.

The Division advances State General Funds to each community mental health program on a monthly basis. This monthly advance equals 1/12 of their annual allocation. Case Managers document the provision of case management services to clients enrolled in CPMS. The Division then compares CPMS information to the state Medicaid eligibility tape to identify Medicaid eligible clients and bills Medicaid for regular or intensive case management services. The Division monitors General Fund advances and Medicaid billings and makes adjustments as necessary.

The community mental health programs submit cost statements to the Division as requested. Rate recomputations (separate from normal cost-of-living adjustments) are conducted as described below:

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Rate Computation Methodology

The rate for reimbursement of the case management services is computed as follows:

<u>Compute the</u>	Annual Case Manager salary and fringe benefits
<u>Plus</u>	Other operating cost including travel, supplies, telephone, and occupancy cost
<u>Plus</u>	Direct supervisory cost
<u>Plus</u>	Average indirect administrative cost of provider organization
<u>Equals</u>	TOTAL ANNUAL COST PER CASE MANAGER
<u>Divided by</u>	12
<u>Equals</u>	MONTHLY COST PER CASE MANAGER
<u>Divided by</u>	Number of clients to be served during month
<u>Equals</u>	TOTAL MONTHLY COST PER CLIENT

The total cost per case manager is the sum of the case manager's salary, direct supervisory costs, indirect administrative costs of the provider organization and other operating costs such as travel, supplies, occupancy, and telephone. Dividing the statewide average cost per case manager by twelve (12) months yields the average monthly cost per case manager. Dividing the monthly cost per case manager by the number of clients to be served during the month results in the total monthly costs per client for regular and for intensive case management. These two figures are the monthly statewide reimbursement rates.

In setting the regular and intensive case management rates, the Division uses ideal caseloads to estimate the number to be served relative to the need. For intensive case management, the Division uses a lower ideal caseload ratio to reflect higher service need (severity). This makes possible the provision of case management services such as: 1) transition planning and coordination of services for clients moving from school to employment (the employer provides natural supports); and 2) coordination of services to clients in their family home to avoid institutionalization. When clients with developmental disabilities no longer need intensive case management, the Division serves them through regular case management.

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