

Payment Methodology for Targeted Case Management

Rate Determination: The monthly rate for case management services for parents is based on the total average monthly cost per client served by the provider. The monthly rate will be limited to the provider's direct service and administrative costs associated with case management service delivery.

The rate is computed by taking the provider's monthly case management cost divided by the monthly number of clients that are provided case management services.

The rate is established on a prospective basis. In the first year, the rate will be based on estimates of cost and the number of clients to be served. For subsequent years, the rate will be based on actual case management costs for previous years. A cost statement will be completed at the end of each state fiscal year once the actual costs incurred have been determined.

Payment Methodology: Payment will be made through MMIS. The provider will bill at the full monthly rate for each client provided case management services during that month. The client is considered to have been provided some case management services if there has been an encounter between a case manager and the client during that month. Each encounter will be documented to support the billing.

Approved: NOV - 5 1999

Effective:

Transmittal: #91-15  
Attachment: 4.19 B  
Page: 4-c

**Payment methodology for targeted case management for children in substitute care financially supported by Children's Services Division:**

Targeted case management services will be billed at a monthly rate which is based on one or more documented targeted case management services provided to each client during that month. The rate will be based on the actual cost of providing the monthly service.

91-15  
91-23

1/10/92  
7/1/91

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Payment Methodology for Targeted Case Management for Medicaid High Risk  
Infants and Children

Payments for targeted case management services for Medicaid high risk infants and children (0 - 3 years of age) are made on a fee-for-service basis. Rates are based on a statewide fee schedule.

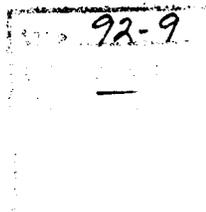
91-23

10/30/91  
7/1/91

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Attachment: 4.19 B  
Page: 4-e

Payment Methodology for Targeted Case Management  
for Persons with HIV Disease

Targeted case management services will be billed at a monthly rate which is based on one or more documented targeted case management services provided to each client during that month. The rate will be based on the actual cost of providing the monthly service.



4/28/92  
11/1/92

**Payment Methodology for Targeted Case Management for Medicaid Eligible Substance Abusing Pregnant Women and Women with Young Children**

Payments for targeted case management services for Medicaid eligible women in the target group are made on a fee-for-service basis. Rates are based on a statewide fee schedule.

93-8

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## OUTPATIENT HOSPITAL SERVICES

Oregon Type A and Type B hospitals are reimbursed for outpatient hospital services under a cost-based methodology. Interim payment is made by applying the cost-to-charge ratio, derived from the Medicare cost report, to billed charges for outpatient hospital services, except for laboratory, pathology, nuclear medicine, radiology and other imaging services, and maternity case management services. The interim payment for laboratory, pathology, nuclear medicine, radiology and other imaging services, and maternity case management is the lesser of billed charges or the OMAP fee schedule. A cost settlement based on the most recent finalized Medicare cost report is then applied to Medicaid covered charges billed and paid for the cost reporting year. The final reimbursement for Type A and Type B hospitals is at 100% of costs.

Oregon non-Type A and non-Type B hospitals (also referred to as DRG hospitals) are reimbursed for outpatient hospital services under a cost-based methodology. Interim payment is made by applying the cost-to-charge ratio, derived from the Medicare cost report, to billed charges for outpatient hospital services, except for laboratory, pathology, nuclear medicine, radiology and other imaging services, and maternity case management services. The interim reimbursement for laboratory, pathology, nuclear medicine, radiology and other imaging services, and maternity case management is the lesser of billed charges or the OMAP fee schedule. A cost settlement based on the most recent finalized Medicare cost report is then applied to Medicaid covered charges billed and paid for the cost reporting year. The final reimbursement for each DRG hospital is then calculated by applying an administratively established percentage to the costs. This calculation results in these hospitals receiving less than 100% of costs.

Out-of-state hospitals are reimbursed at 50% of billed charges for all outpatient services except for laboratory, pathology, nuclear medicine, radiology and other imaging services, and maternity case management. Laboratory, pathology, nuclear medicine, radiology and other imaging services, and maternity case management are reimbursed at the lesser of billed charges or the OMAP fee schedule. There is no cost settlement.

Highly specialized out-of-state outpatient services provided by arrangement with OMAP is made by written agreement or contract between OMAP and the provider. The rate is negotiated on a provider-by-provider basis and is a discounted rate.

Outpatient reimbursement does not exceed applicable Federal upper payment limits.

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SUPERSEDES	EFFECTIVE DATE <u>10/1/99</u>
TN # <u>97-8</u>	DATE TO GO _____
COMMENTS	

Federally Qualified Health Centers (FQHC) services and other ambulatory services designated by the Secretary will be paid at 100% of reasonable costs. Reasonable cost will be determined by financial data provided to the Office of Medical Assistance Programs by FQHCs using a modified HCFA 222 Form. Reasonable cost determination will not exceed that which would have been determined by Medicare cost reimbursement principles. Payments will be based upon, and will cover, the reasonable costs of providing covered services to Medicaid beneficiaries. Interim payment rates will be established for each FQHC subject to reconciliation at the end of the cost reporting period.

90-13

7/19/90  
4/1/90

STATE OF OREGON

Certified Psychiatric Facility Services (Non-Hospital)

This section applies to non-hospital child/adolescent residential psychiatric facilities providing inpatient psychiatric treatment services for individuals under age 21. The facilities are accredited by one of the following:

- the Joint Commission on Accreditation of Healthcare Organizations;
- the Council on Accreditation of Services for Families and Children;
- the Commission on Accreditation of Rehabilitation Facilities; or
- any other accrediting organization, with comparable standards, that is recognized by the State.

The facilities provide services under the terms of a written agreement with the Mental Health and Developmental Disability Services Division (the Division). The Division pays for such services on the basis of a prospective daily rate schedule determined by the State to represent 100% of the reasonable costs of economically and efficiently operated facilities, consistent with quality of care. Providers must submit billings that are based upon allowable costs as set forth in Office of Management and Budget Circular A-122, "Cost Principles for Non-Profit Organizations". In no case may billings exceed the prevailing charges in the locality for comparable services under comparable circumstances.

**RATE SETTING**

To establish maximum billing rates, the Division periodically renews a per diem rate schedule that represents 100% of the reasonable costs of economically and efficiently operated facilities providing services in conformity with applicable state and federal laws, regulations, and quality and safety standards. The rates are adequate to assure reasonable access to necessary psychiatric treatment services, taking into account geographic location, type of child/adolescent served and reasonable travel time.

**AUDITING**

The Division will periodically review the financial records of each participating child/adolescent residential psychiatric facility, allowing reasonable notification time to the facility.

The Division will subject patient utilization of child/adolescent residential psychiatric facilities to periodic professional review to determine appropriateness. If review of a Medicaid patient's records reveals that a patient has received an inappropriate level of care, i.e., less than active treatment, the Division will not allow payment.

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TN # 00-03

Supersedes TN # 96-15

Effective Date July 1, 2000

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STATE OF OREGON

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Attachment 4.19B  
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Nurse Practitioner Services

Payment will be based upon a state-wide fee schedule.

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7/1/90