

OFFICIAL

**TRANSMITTAL AND NOTICE OF APPROVAL OF
STATE PLAN MATERIAL**

1. TRANSMITTAL NUMBER:
00-05

2. STATE
Oregon

FOR: HEALTH CARE FINANCING ADMINISTRATION

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE
SOCIAL SECURITY ACT (MEDICAID) Medical Assistance

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
July 1, 2000

5. TYPE OF PLAN MATERIAL (Check One):

- NEW STATE PLAN
- AMENDMENT TO BE CONSIDERED AS NEW PLAN
- AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)

6. FEDERAL STATUTE/REGULATION CITATION:
~~1997 Balanced Budget Reconciliation Act~~ 1902(a)(13)(A), 1902(a)(30), &
23 of the Social Security Act, & 42 CFR 447.251, .252, .257, .271, .272, & .296-.299 "P & I"

7. FEDERAL BUDGET IMPACT:
a. FFY \$ -0-
b. FFY \$ -0-

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Attachment 4.19A, Pages 20, 21, 21A and 21A-1

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION
OR ATTACHMENT (If Applicable):

Attachment 4.19A, Pages 20, 21 and 21A

10. SUBJECT OF AMENDMENT:
This transmittal is submitted to include reimbursement for uncompensated care costs for hospital services at OHSU in Oregon's additional DSH payment program.

11. GOVERNOR'S REVIEW (Check One):
- GOVERNOR'S OFFICE REPORTED NO COMMENT
 - COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
 - NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL

OTHER, AS SPECIFIED:
Per Attachment 7.3A

12. SIGNATURE OF STATE AGENCY OFFICIAL:
Hersh Crawford *Gary Weeks*
17. TYPED NAME: Hersh Crawford Gary Weeks

16. RETURN TO:

Office of Medical Assistance Programs
Department of Human Services
500 Summer Street NE, 3rd Floor
Salem, OR 97310

ATTN: Carole Van Eck

14. TITLE: Director, OMAP, DHS Director, DHS

15. DATE SUBMITTED: 9/29/00

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: OCT 2 2000

18. DATE RECEIVED: OCT 2 2000

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
July 1, 2000

20. SIGNATURE OF REGIONAL OFFICIAL:
Teresa L. Trimble

21. TYPED NAME:
Teresa L. Trimble

22. TITLE:
Associate Regional Administrator

23. REMARKS:

9/29 (DATE) Salem (CITY/STATE)
"P & I" changes were authorized by the State.

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.

"P&I" 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

"P&I" uncompensated care costs for serving Medicaid 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.

"P&I" Uncompensated care costs for hospitals qualifying for this DSH adjustment will be determined using the following sources:

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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 "P&I" representatives of qualifying Oregon hospitals, determines necessary to establish cost.

"P&I" Separate calculations will be used to determine the uncompensated care costs for Medicaid clients and the uncompensated care costs for indigent and uninsured patients for each qualifying hospital.

1. Uncompensated Care Costs for Medicaid Clients

Base year (the most recent completed fiscal year for the qualifying hospital) Medicaid charges will be converted to Medicaid costs using the ratio of total costs to total charges. The resulting Medicaid costs are next reduced by Medicaid payments for the base year to arrive at Medicaid uncompensated care costs. These costs are then adjusted to the payment year using the Consumer Price Index – Hospital and Hospital Related Services.

2. Uncompensated Care Costs for Indigent and Uninsured Patients

"P&I" The average of the three most recent base years' uncompensated care costs adjusted by the Consumer Price Index – Hospital and Hospital Related Services to the payment year will be the basis to determine the uncompensated care costs for indigent and uninsured patients. The uncompensated care costs for each year will be determined using the same methodology employed to determine the uncompensated care costs for Medicaid clients, but specifically related to indigent and uninsured patients.

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The final calculation to determine the additional DSH adjustment is summing the uncompensated care costs of the two components and reducing that amount by the graduate medical education reimbursement for public teaching hospitals (12(A)) determined for the same payment year.

The additional DSH adjustment will be determined annually and is not subject to "P&I" retrospective settlements/adjustments, except for adjustments for actual uncompensated care costs. Payment adjustments will be made quarterly.

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:
- (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.

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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.

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