

<b>TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL</b>		1. TRANSMITTAL NUMBER: 01-04	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 January 1, 2001	
5. TYPE OF PLAN MATERIAL (Check One):			
<input type="checkbox"/> NEW STATE PLAN <input type="checkbox"/> AMENDMENT TO BE CONSIDERED AS NEW PLAN <input checked="" type="checkbox"/> AMENDMENT			
COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)			
6. FEDERAL STATUTE/REGULATION CITATION: 42 CFR 447		7. FEDERAL BUDGET IMPACT: a. FFY 2001      \$ 1,000,000 b. FFY 2002      \$ 2,400,000	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:  Section 4.19-A, pages 5a		9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable):	
10. SUBJECT OF AMENDMENT: This transmittal is submitted to provide for an additional payment for unreimbursed O/P Medicaid charges.			
11. GOVERNOR'S REVIEW (Check One):			
<input type="checkbox"/> GOVERNOR'S OFFICE REPORTED NO COMMENT <input checked="" type="checkbox"/> OTHER, AS SPECIFIED: <input type="checkbox"/> COMMENTS OF GOVERNOR'S OFFICE ENCLOSED      Per Attachment 7.3A <input type="checkbox"/> NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL			
12. SIGNATURE OF STATE AGENCY OFFICIAL: <i>Hersh Crawford</i> <i>Bobby Mink</i>		16. RETURN TO: Office of Medical Assistance Programs Department of Human Services 500 Summer Street NE, 3 <sup>rd</sup> Floor Salem, OR 97310  ATTN: Carole Van Eck	
13. TYPED NAME: Hersh Crawford      Bobby Mink			
14. TITLE: Administrator, OMAP      Director, DHS			
15. DATE SUBMITTED: 3-27-01			
<b>FOR REGIONAL OFFICE USE ONLY</b>			
17. DATE RECEIVED: 3-29-01		18. DATE APPROVED: JUN 7 2001	
<b>PLAN APPROVED - ONE COPY ATTACHED</b>			
19. EFFECTIVE DATE OF APPROVED MATERIAL: JAN 1 2001		20. SIGNATURE OF REGIONAL OFFICIAL: <i>LSI</i>	
21. TYPED NAME: TERESA L. TRINGLE		22. TITLE: ASSOCIATE REGIONAL DIVISION OF MEDICAL ASSISTANCE	
23. REMARKS:			

**FILE COPY**

28 2001

OUTPATIENT HOSPITAL SERVICES (Continued)

Outpatient Proportionate Share will be made to public academic teaching hospitals in the State of Oregon with 200 or more interns or residents. Proportionate Share payments are subject to the federal Medicare upper payment limit for Outpatient hospital payments. The Medicare upper payment limit analysis will be performed prior to making the payments.

Eligible academic hospitals will be classified as either a (i) State owned or operated hospital, or (ii) non-State government owned or operated hospital. The Proportionate Share payment will be specific to each classification and determined as follows:

The federal upper payment limit is determined in accordance with the specific requirements for each hospital classification for all eligible hospitals during the State Fiscal Year 2001. The proportionate payment is calculated by the determination of the Medicare upper payment limit of Medicaid Fee-For-Service Outpatient charges converted to what Medicare would pay, less Medicaid payments, third party liability payments, and the net Outpatient cost settlement payment determined in the Medicaid Cost Settlement (Form 42). The State of Oregon Medicaid Management Information System (MMIS) and the provider's Medicare Cost Report are the source of the charge and payment data.

Outpatient Proportionate Share payment will be made annually following the finalization of the Medicaid Cost Settlement. The Outpatient Proportionate Share payment will not exceed the Medicare upper payment limit calculated from January 1, 2001 through September 30, 2001 and annually for each federal fiscal year thereafter.

TN # 01-04  
SUPERSEDES TN #

DATE APPROVED 06-07-01  
EFFECTIVE DATE January 1, 2001