

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

1. TRANSMITTAL NUMBER:
01-09

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
April 1, 2001

5. TYPE OF PLAN MATERIAL (Check One):

FILE COPY

- 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:
**Medicare, Medicaid, and SCHIP Benefits Improvement &
Protection Act of 2000 (BIPA)**

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

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Attachment 4.19A, pages 1, 2, 3, 3a, 3b, 3c, 3d, and 3e

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 PAGE NUMBER OF THE SUPERSEDED PLAN SECTION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

Attachment 4.19A, pages 1, 2, 3, 3a, 3b, 3c, 3d, and 3e

10. SUBJECT OF AMENDMENT:
This transmittal is submitted to reflect language added to accommodate the BIPA requirements when establishing maximum allowable rates for psychiatric hospitals and when determining whether a hospital qualifies for disproportionate share payment.

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:

Spencer Read, Deputy for Hersh Crawford *Bobby Mink*
13. TYPED NAME: **Hersh Crawford** **Bobby Mink**

16. RETURN TO:

Office of Medical Assistance Programs
Department of Human Services
500 Summer Street NE, 3rd Floor, E35
Salem, OR 97310

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

15. DATE SUBMITTED: **4-16-01**

ATTN: **Carole Van Eck**

FOR REGIONAL OFFICE USE ONLY	
17. DATE RECEIVED:	18. NAME OF OFFICIAL:
PLAN APPROVED, ONE COPY TO BE RETURNED	
19. EFFECTIVE DATE OF APPROVED MATERIAL:	20. SIGNATURE OF REGIONAL OFFICIAL:
21. TYPED NAME:	22. TITLE:
Teresa N. Trinchese	Director, Medicaid Administration
23. REMARKS:	
<p>RECEIVED 4/17 2001 <i>Salem</i></p>	

STATE PLAN UNDER TITLE XIX
OF THE SOCIAL SECURITY ACT

STATE OF OREGON

SUBJECT: Methods and Standards Used for Payment of Reasonable Costs of
Inpatient Psychiatric Hospital Services

A. Psychiatric Hospitals

Payments to certified portions of participating psychiatric hospitals for the provision of active inpatient treatment services to Title XIX eligible patients will be made by the Mental Health and Developmental Disability Services Division ("the Division") on the basis of billings submitted to the Office of Medical Assistance Programs. The method of payment is based on annual review and analysis of allowable costs reported by all participating psychiatric hospitals and features the use of interim per diem rates and retrospective (year-end and final) cost settlements capped by a maximum allowable rate for each contract period.

Establishing a Base Year Rate and Subsequent Maximum Allowable Rates

1. In order to establish a base year rate, the Division used cost statements from all Oregon Hospitals licensed as psychiatric hospitals.
2. If a psychiatric hospital's cost report was for a period either longer or shorter than 12 months, the Title XIX allowable costs reduced or increased as appropriate by multiplying the total allowable costs by the ratio that 12 months bore to the number of months in the hospital's report period. This procedure resulted in a prorated 12-month cost projection for use in establishing the statewide average per diem rate for the base period.
3. If a psychiatric hospital had a fiscal period other than the base period, the hospital's Title XIX allowable costs were adjusted by applying the relevant inflation factors from the Medicare market basket index issued by the Health Care Financing Administration so that the Title XIX costs corresponded to the base period. The inflation factors were applied to the interval between the midpoint of the hospital's fiscal period and the midpoint of the base period. The number of Title XIX patients days in the hospital's fiscal period was used as the number of days in the base period.

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4. The total Title XIX allowable costs including costs of patients receiving benefits through a managed care entity from all hospitals included in the base period divided by the total number of Title XIX patient days including such patients who receive benefits through a managed care entity from all hospitals included in the base period yielded the state-wide average per diem costs (maximum allowable rate) for the base period. The statewide average per diem cost for the base period has been used as the fixed base for determining the maximum allowable reimbursement rate for any subsequent fiscal period.
5. The maximum allowable reimbursement rate for each new fiscal period is calculated by inflating the maximum allowable reimbursement rate for the previous period by the annual Health Care Financing Administration target percentages for Prospective Payment System excluded hospitals (as published in the Federal register). This percentage increase is applied from the mid-point of the previous period to the mid-point of the 12-month period for which the rate is being established.
6. When a currently enrolled psychiatric hospital has a fiscal period other than that used by the state, July 1 through June 30, the applicable maximum allowable reimbursement rate for each month will be the same as the maximum allowable rate in effect that month for hospitals operating under the State fiscal period.

Interim Rate Setting

At least annually, the Division will establish an interim Medicaid per diem rate for each participating psychiatric hospital, separate cost entity or distinct program within a hospital:

- a. If a hospital requests an interim per diem rate, the Division will review the request. The Division will consider the hospital's prior year cost report, inflation factors, changes in patient populations and programs, appropriate capital allowances, whether the hospital will qualify as a disproportionate share hospital, and other relevant factors. Based upon the findings of the review, the Division will either approve the interim rate as proposed or establish a different interim rate;
- b. If a hospital does not request an interim per diem rate, the Division will establish an interim rate using the relevant factors from subsection "a" of this part of the State plan.

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Retrospective Settlement Rate (Year-End) and Quarterly Disproportionate Share Payments

1. A retrospective year-end settlement rate will be determined for each participating hospital, separate cost entity or distinct program within a hospital on the basis of Division review of actual allowable costs reported in the hospital's cost statement.
 - a. Each settlement rate will be the rate determined by dividing the applicable Title XIX allowable costs by the applicable number of Title XIX patient days, including therapeutic leave days, or the maximum allowable reimbursement rate, whichever is less. Therapeutic leave days are a planned and medically authorized period of absence from the hospital not exceeding 72 hours in 7 consecutive days.
 - b. A "separate cost entity" is determined by Medicare.
 - c. A "distinct program" is determined by the Division. The criteria used to make the determination are:
 - A. The inpatient psychiatric hospital must be participating in Medicaid;
 - B. The hospital must have a specialized inpatient active psychiatric treatment program of 50 or more beds based upon patient age or medical condition;
 - C. The program must have unique admission standards;
 - D. The nursing staff must be specifically assigned to the program and will have experience or training in working with the specialized population; and
 - E. The program must have a record-keeping system that accounts for revenues and expenditures for the program separate from those for the general psychiatric hospital.

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2. Payment to disproportionate share hospitals. A participating psychiatric hospital may be reimbursed for allowable costs in excess of the maximum rate if it meets the criteria in section 1923(b) and (d) of the Social Security Act:
- a. The hospital serves disproportionate numbers of low-income persons: i.e., has a low income utilization rate which exceeds 25 percent using the following formula:
 - A. The total Medicaid revenues paid to the hospital for patient services under the State plan, plus the amount of the cash subsidies for patient services received directly from state and local governments in a cost reporting period, divided by the total amount of revenues of the hospital for patient services (including the amount of such cash subsidies) in the same cost reporting period. The percentage derived in A. shall be added to the following percentage:
 - B. The total amount of the hospital's charges for inpatient psychiatric services attributable to charity care (care provided to individuals who have no source of payment, third-party or personal resources) in a cost reporting period, less the portion of any cash subsidies for inpatient services received directly from state and local governments described in "A" above in the period attributable to inpatient hospital services, divided by the total amount of the hospital's charges for inpatient psychiatric services in the hospital in the same period. The total inpatient charges attributed to charity care shall not include contractual allowances and discounts (other than for indigent patients not eligible for Medical Assistance under an approved Medicaid State Plan).

The sum of percentages derived in "A" and "B" shall exceed 25 percent in order to qualify as a disproportionate share hospital; or

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- b. The hospital's Medicaid inpatient utilization rate is at least one standard deviation above the mean Medicaid inpatient utilization rate for hospitals receiving Medicaid payments in the State. The term "Medicaid inpatient utilization rate" means a fraction (expressed as a percentage), the numerator of which is the hospital's number of inpatient days attributable to patients who (for such days) were eligible for medical assistance regardless of whether such patients receive medical assistance on a fee-for-service basis or through a managed care entity under an approved Oregon State plan in a period, and the denominator of which is the total number of the hospital's inpatient days in that period. The term "inpatient day" includes each day in which an individual (including a newborn) is an inpatient in the hospital, whether or not the individual is in a specialized ward and whether or not the individual remains in the hospital for lack of suitable placement elsewhere; and
- c. The hospital has, at a minimum, a Medicaid inpatient utilization rate of one percent. The Medicaid utilization rate is the ratio of total paid Medicaid (Title XIX) inpatient days regardless of whether those days are attributable to patients who receive medical assistance on a fee-for-service basis or through a managed care entity to total inpatient days. Information on total inpatient days is taken from the most recent audited Medicare and Medicaid cost reports. Information on total paid Medicaid days is taken from the Division's reports of paid claims for the same fiscal period as the Medicare Cost Report; and
- d. The hospital has 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 under the State plan.

NOTE: This requirement does not apply to a hospital -

- i. the inpatients of which are predominantly individuals under 18 years of age; or
- ii. which does not offer non-emergency obstetric services to the general population as of December 21, 1987.

3. If the hospital has more than one settlement rate, the average Medicaid settlement rate for the hospital may not exceed the maximum allowable rate unless the hospital meets the disproportionate share criteria. The average Medicaid settlement rate is developed by multiplying each proposed settlement rate by Medicaid patient days for that, rate adding the products together, and dividing the resulting sum by total Medicaid patient days for the hospital.

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4. For inpatient psychiatric hospitals that meet the disproportionate share criteria, as defined in Section 2 above, there shall be an additional quarterly disproportionate share reimbursement in excess of the maximum allowable rate after the end of each quarter. The disproportionate share adjusted rate will be calculated as follows:
- a. The disproportionate share reimbursement for all psychiatric hospitals except those meeting the additional criterion in Section 4b will be 135 percent of the maximum allowable rate.
 - b. If a psychiatric hospital has a low-income rate of at least 60 percent and also receives 60 percent or more of its service revenue from any combination of the following:
 - o public funds, excluding Medicare and Medicaid
 - o bad debts
 - o free care,The hospital qualifies to receive disproportionate share payment at a rate based on 100 percent of the costs of uncompensated care during the facility's previous fiscal year.
 - c. The Division will base quarterly disproportionate share reimbursements on the estimated costs for each facility during the current fiscal year and will review and adjust the reimbursements, after conclusion of the fiscal period, to correspond with actual costs encountered during the period. Total reimbursement from disproportionate share and other sources will not exceed actual costs.
 - d. Effective April 1, 1995, and in accordance with the Omnibus Budget Reconciliation Act of 1993, disproportionate share payments to public hospitals will not exceed 100 percent of the unpaid costs, defined as follows:
 - (1) The inpatient costs for services to Medicaid patients, less the amounts paid by the State under non-disproportionate share hospital payment provisions of the State plan, plus;
 - (2) The inpatient costs for services to uninsured indigent patients, less any payments for such services. An uninsured indigent patient is defined as an individual who does not have health insurance coverage that will reimburse any of the costs of the services delivered nor access to other resources to cover such costs. The costs attributable to uninsured patients are determined through disclosures in the Medicare and Medicaid cost reports and state records on indigent care.

Public hospitals that qualify under the "Transition Year Rule" as a high disproportionate share hospital may receive disproportionate share payments not to exceed 200 percent of the unpaid costs discussed previously. A high disproportionate share public hospital must have a Medicaid utilization rate at least one standard deviation above the mean Medicaid inpatient utilization rate for hospitals receiving Medicaid payments in the State. The Governor of the State of Oregon, through signatory delegation to the Director of the Department of Human Resources, will also certify that the "applicable minimum amount" will be used for health care services. The applicable minimum amount is the difference between the amount of the disproportionate share hospital payment and the amount of the unpaid cost.

The State has a contingency plan to ensure that disproportionate share hospital payments will not exceed the "State Disproportionate Share Psychiatric Hospital Allotment." In order to assure compliance with the requirements of section 1923(f) of the Social Security Act, the State will review the "Allotment" to make sure that each quarter's payments do not exceed the allotment. If the anticipated payments exceed the allotment, payments will be reduced until these anticipated payments are equal to the amount of the allotment. Reductions will apply equally to all psychiatric hospitals, based on a prior quarterly disproportionate share payment for each hospital compared to total disproportionate share payments in the same quarter. If previous payments in the Federal Fiscal Year exceed that year's allotment, the current quarterly payment will not be paid to the provider until the overpayment has been recovered. A Hospital's payment adjustment will also be reduced in this manner if the payment adjustment exceeds the cost limits expressed by Section 1923(g) of the Social Security Act.

The overpayment will be withheld from interim payments if the recovery cannot otherwise be made within 60 days of the date of the findings.

5. The year-end settlement will be determined by multiplying the average settlement rate by the total number of Title XIX patient days, including therapeutic leave days or, for disproportionate share hospitals, multiplying the disproportionate share adjusted rate by the total number of Title XIX patient days, including therapeutic leave days.

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6. In the aggregate, payments for hospitals will not exceed the upper limits described in 42 CFR 447.253. Disproportionate share payment adjustments to the Medicaid settlement rate will be subtracted from aggregate hospital payments before findings with regard to 42 CFR 447.253 are made.
7. Payments to providers will not be increased, solely as a result of change of ownership in excess of the increase which would result from applying 1861(v)(1)(0) of the Social Security Act as applied to owners of record on or after July 18, 1984.

Retrospective Settlement Rate (Final)

1. The final settlement process will be as follows:
 - a. Upon receipt of the final Medicare Cost Report from the Medicare Intermediary, the hospital provider will prepare a final Medicaid cost report.
 - b. Using the final Medicaid cost report developed in subsection "a" of this part of the State plan, the Division will calculate the final settlement rate and settlement for each participating hospital, separate cost entity or distinct program within a hospital, following the steps outlined in parts 1 through 7 of the previous section.

Appeals Procedure

Letters will be sent notifying the provider of the interim per diem rate, the year-end settlement rate, the final settlement rate, or the quarterly disproportionate share finding. A provider shall notify the Division in writing within 15 days of receipt of a letter if the provider wishes to appeal the rate or finding. Letters of appeal must be postmarked within the 15-day limit.

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