

Weisman

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

FOR: HEALTH CARE FINANCING ADMINISTRATION

AUG 29 2001

1. TRANSMITTAL NUMBER: 01-11	2. STATE Oregon
3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID) Medical Assistance	
4. PROPOSED EFFECTIVE DATE October 1, 2001	

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

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:
42 CFR 412, Subpart F

7. FEDERAL BUDGET IMPACT:

a. FFY	2001	\$ -0-
b. FFY	2002	\$ -0-

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Section 4.19-A, pages 13 - 16

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 PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable):

Section 4.19-A, pages 13 - 16b

10. SUBJECT OF AMENDMENT:
This transmittal is submitted to delete Day Outliers from the state plan.

11. GOVERNOR'S REVIEW (Check One):

GOVERNOR'S OFFICE REPORTED NO COMMENT OTHER, AS SPECIFIED:
 COMMENTS OF GOVERNOR'S OFFICE ENCLOSED Per Attachment 7.3A
 NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL

12. SIGNATURE OF STATE AGENCY OFFICIAL:
Hersh Crawford - Bobby Mink

13. TYPED NAME: Hersh Crawford Bobby Mink

14. TITLE: Administrator, OMAP Director, DHS

15. DATE SUBMITTED: 8-24-01

16. RETURN TO:

Office of Medical Assistance Programs
Department of Human Services
500 Summer Street NE, 3rd Floor, E35
Salem, OR 97301

ATTN: Carole Van Eck

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: AUG 29 2001 18. DATE APPROVED: NOV 27 2001

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVAL: OCT 1 2001

21. TYPED NAME: TESSA L. TRIMBLE

20. SIGNATURE OF REGIONAL OFFICIAL: *LSI*

22. TITLE: ASSOCIATE REGIONAL ADMINISTRATOR

23. REMARKS:
DIVISION OF MEDICAID AND STATE OPERATIONS

Pa I changes authorized by the state on 11/20/01

(10) CAPITAL

The capital payment is a reimbursement to in-state hospitals for capital costs associated with the delivery of services to Title XIX, non-Medicare persons. The Office of Medical Assistance Programs uses the Medicare definition and calculation of capital costs. These costs are taken from the Hospital Statement of Reimbursable Cost (Medicare Report).

Capital cost per discharge is calculated as follows:

- a. The capital costs proportional to the number of Title XIX non-Medicare discharges during the period from July 1, 1986 through June 30, 1987 is divided by the number of Title XIX non-Medicare discharges. This results in the Title XIX Capital Cost per discharge. The Title XIX Capital Cost per discharge for each hospital above the 50th percentile will be set at the 50th percentile for Oregon hospitals receiving DRG Reimbursement.
- b. The Title XIX Capital Cost per discharge for this period is inflated forward to Oregon FY 1992, using the compounded CMS DRI market basket adjustment.

Capital Payment Per Discharge

The number of Title XIX discharges paid during the quarter for each hospital is multiplied by the Title XIX cost per discharge from 1987 trended forward as described above. This determines the current quarter's capital costs. Reimbursement is made at 85% of this amount. Payment is made within thirty days of the end of the quarter.

The capital payment per discharge will be adjusted using the same inflation factor described in subparagraph 5.A.(6)f.

(11) DIRECT MEDICAL EDUCATION

The direct medical education payment is a reimbursement to in-state hospitals for direct medical education costs associated with the delivery of services to Title XIX eligible persons. The Office of Medical Assistance Programs uses the Medicare definition and calculation of direct medical education costs. These costs are taken from the Hospital Statement of Reimbursable Cost (Medicare Report).

Direct Medical Education cost per discharge is calculated as follows:

The direct medical education cost proportional to the number of Title XIX non-Medicare discharges during the period from July 1, 1986 through June 30, 1987 is divided by the number of Title XIX non-Medicare discharges. This is the Title XIX Direct Medical Education Cost per discharge.

The Title XIX Direct Medical Education cost per discharge for this period is inflated forward to January 1, 1992, using the compounded CMS DRI market basket adjustment.

Direct Medical Education Payment Per Discharge

The number of Title XIX non-Medicare discharges from each hospital for the quarterly period is multiplied by the inflated Title XIX cost per discharge. This determines the current quarter's Direct Medical Education costs. This amount is then multiplied by 85%. Payment is made within thirty days of the end of the quarter.

The Direct Medical Education Payment Per Discharge will be adjusted using the same inflation factor described in subparagraph 5.A.(6)f.

(12) INDIRECT MEDICAL EDUCATION

The indirect medical education payment is a reimbursement made to in-state hospitals for indirect medical education costs associated with the delivery of services to Title XIX non-Medicare clients.

Indirect medical education costs are those indirect costs identified by Medicare as resulting from the effect of teaching activity on operating costs.

Indirect medical education payments are made to in-state hospitals determined by Medicare to be eligible for such payments. The indirect medical education factor in use by Medicare for each of these eligible hospitals at the beginning of the State's fiscal year is the Office of Medical Assistance Program's indirect medical education factor. This factor is used for the entire Oregon fiscal year.

The calculation for the Indirect Medical Education Factor is as follows:

$$\begin{array}{r} \text{Total relative weights from claims paid during the quarter} \\ \times \quad \text{Indirect Medical Education Factor} \\ = \quad \text{Indirect Medical Education Payment} \end{array}$$

This determines the current quarter's Indirect Medical Education payment. Indirect medical education payments are made quarterly to each eligible hospital. Payment for indirect medical education costs will be made within thirty days of the end of the quarter.

12(A) Graduate Medical Education Reimbursement for Public Teaching Hospitals

The Graduate Medical Education (GME) payment is reimbursement to an institution for the costs of an approved medical training program. The State makes GME payments to non-Type A and B inpatient acute hospitals based on the number of fee-for-service hospital inpatient discharges as provided in (11) Direct Medical Education and (12) Indirect Medical Education. Funding for GME is not included in the "capitation rates" paid to managed care plans under the Oregon Health Plan resulting in hospitals with medical teaching programs not being able to capture GME costs when contracting with managed care plans. Since a significant portion of Medicaid payments for acute inpatient hospital discharges are made through managed care plans, an additional payment for GME is necessary to ensure the integrity and quality of medical training programs.

The additional GME payment is a reimbursement to any in-state public acute care hospital providing a major teaching program, defined as a hospital with more than 200 residents or interns. This reimbursement is in addition to that provided under (11) Direct Medical Education or (12) Indirect Medical Education.

For each qualifying public hospital, the payment amount is initially determined based on hospital specific costs for medical education as reported in the Medicare Cost Report for the most recent completed reporting year (base year). Total Direct Medical Education (DME) costs consist of the costs for medical residency and the paramedical education programs. Title XIX DME costs are determined based on the ratio of Title XIX days to total days applied to the total DME costs.

Indirect Medical Education (IME) costs are derived by first computing the percent of IME to total Medicare inpatient payments. This is performed by dividing the IME Adjustment reported in the Medicare Cost Report by the sum of this amount and Medicare payments for DRG amount - other than outlier payments, inpatient program capital, and organ acquisition. The resulting percent is then applied to net allowable costs (total allowable costs less Total DME costs, computed as discussed in the previous paragraph). Title XIX IME costs are then determined based upon the ratio of Title XIX days to total days.

The additional GME payment is calculated as follows:

Total Title XIX GME is the sum of Title XIX IME and DME costs. Payments for Title XIX fee-for-service IME and DME are then subtracted from the Total Title XIX

GME leaving the net unreimbursed Title XIX GME costs for the base year. The net unreimbursed Title XIX GME costs for the base year is then multiplied by CMS PPS Hospital Index. The additional GME payment is rebased yearly.

The additional GME reimbursement is made quarterly . ~~Reimbursement is limited to the availability of public funds, specifically, the amount of public funds available for GME attributable to the Title XIX patient population.~~ (P+I)

Total payments including the additional GME payments will not exceed that determined by using Medicare reimbursement principles. The Medicare upper limit will be determined from the most recent Medicare Cost Report and will be performed ~~for all inpatient acute hospitals and separately for State operated inpatient acute hospitals~~ in accordance with 42 CFR 447.272(a) and (b). The upper limit review will be performed before the additional GME payment is made. (P+I)

(13) DISPROPORTIONATE SHARE

The disproportionate share hospital (DSH) payment is an additional reimbursement made to hospitals which serve a disproportionate number of low-income patients with special needs.

A hospital's eligibility for DSH payments is determined at the beginning of each State fiscal year. Hospitals which are not eligible under Criteria 1 may apply for eligibility at any time during the year under Criteria 2. A hospital may be determined eligible under Criteria 2 only after being determined ineligible under Criteria 1. Eligibility under Criteria 2 is effective from the beginning of the quarter in which eligibility is approved. Out-of-state hospitals are eligible for DSH payments if they have been designated by their state Title XIX Medicaid program as eligible for DSH payments within that state.

- a. Criteria 1: The ratio of total paid Medicaid inpatient (Title XIX, non-Medicare) days to total inpatient days is one or more standard deviations above the mean for all Oregon hospitals.

Information on total inpatient days is taken from the most recent Medicare Cost Report.