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State/Territory Name: Oregon

State Plan Amendment (SPA) # 11-014

This file contains the following documents in the order listed:

1) Approval Letter
2) CMS 179 Form/Summary Form(with 179-like data)
3) Approved SPA

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Region 10
2201 Sixth Avenue, MS/RX 43
Seattle, Washington 98121

APR 11 2012

Bruce Goldberg, MD, Director
Oregon Health Authority
500 Summer Street Northeast, E-15
Salem, Oregon 97301-1097

RE: Oregon State Plan Amendment (SPA) Transmittal Number 11-014

Dear Dr. Goldberg:

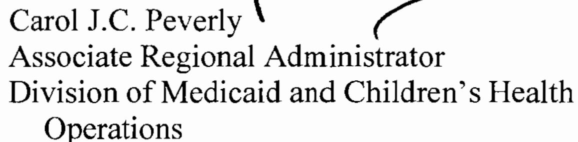
The Centers for Medicare & Medicaid Services (CMS) National Institutional Reimbursement Team (NIRT) recently approved Oregon State Plan Amendment (SPA) Transmittal Number 11-014.

Although the NIRT has already sent the State a copy of the approval for this SPA, the Seattle Regional Office (RO) is following up with an additional copy for the reason that we were in receipt of the original, signed amendment request.

Therefore, enclosed you will find a copy of the official CMS form 179, amended page(s), and copy of the approval letter from the NIRT for your records.

If you have any questions concerning the Seattle RO role in the processing of this SPA, please contact Deb Washington at (206) 615-2370 or Deborah.Washington@cms.hhs.gov.

Sincerely,



Carol J.C. Peverly
Associate Regional Administrator
Division of Medicaid and Children's Health Operations

Enclosure

cc: Judy Mohr Peterson, Administrator

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, M/S S2-26-12
Baltimore, MD 21244-1850

Centers for Medicaid and CHIP Services

Bruce Goldberg, MD, Director
Department of Human Services
Human Services Building
500 Summer Street Northeast, E-15
Salem, Oregon 97301-1097

APR 11 2012

RE: Oregon State Plan Amendment (SPA) Transmittal Number 11-014

Dear Dr. Goldberg:

We have reviewed the proposed amendment to Attachment 4.19-A of your Medicaid State plan submitted under transmittal number (TN) 11-014. The purpose of this amendment is: to increase Disproportionate Share Hospital (DSH) payments to qualifying hospitals, to establish a methodology for making inpatient and outpatient supplemental payments to privately owned or operated hospitals, and to increase inpatient and outpatient hospital supplemental payments to non-State owned or operated hospitals.

We conducted our review of your submittal according to the statutory requirements at sections 1902(a)(2), 1902(a)(13), 1902(a)(30), 1903(a) and 1923 of the Social Security Act and the implementing Federal regulations at 42 CFR 447 Subpart C.

Medicaid State plan amendment 11-014 is approved effective August1, 2011. We are enclosing the HCFA-179 and the amended plan pages.

If you have any questions, please contact Joe Fico of the National Reimbursement Team at (206) 615-2380.

Sincerely,

Cindy Mann,
Director, CMCS

cc
Jesse Anderson, State Plan Coordinator

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: **11-14**

2. STATE: Oregon

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: 8/1/11

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 440.10, 440.20

7. FEDERAL BUDGET IMPACT:
a. FFY 2011 $21,212,500
b. FFY 2012 $43,750,000

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19-A pages, 10, 16-20, 21A, 21A-1, 21B, 25-27 (P&I)
~~Attachment 4.19-A, page 20, 21A,21A-1, 21B, 25-27~~
Attachment 4.19-B, page 5, 5a, 5b & ~~5c~~
(P&I)

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
pages 10, 16-20, 21A, 21A-1, 21A-1A,21A-2 (P&I)
Attachment 4.19-A, ~~page 20, 21A,21A-1, 21B, 25& 26~~
Attachment 4.19-B, page 5, 5a **(P&I)**

10. SUBJECT OF AMENDMENT: This transmittal is being submitted to reflect a new methodology to calculate the DSH payments to DSH hospitals and to describe the Upper Payment limit calculation.

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:

12. SIGNATURE OF STATE AGENCY OFFICIAL: [redacted]

13. TYPED NAME: Judy Mohr Peterson

14. TITLE: Director, Division of Medical Assistance Programs

15. DATE SUBMITTED: 9-29-11

16. RETURN TO:
Division of Medical Assistance Programs
Oregon Health Authority
500 Summer Street NE E-35
Salem, OR 97301

ATTN: Jesse Anderson, State Plan Manager

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: September 29, 2011

18. DATE APPROVED: **APR 12 2012**

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: 08/01/2011

20. SIGNATURE OF REGIONAL OFFICIAL: [redacted]

21. TYPED NAME: Carol J.C. Peverly

22. TITLE: Associate Regional Administrator, Division of Medicaid & Children's Health

23. REMARKS:

1/27/2012 - Pen & Ink changes authorized by the State (blocks 8, 9).

4/3/12 - Pen & Ink authorized by state to remove 5c

FORM HCFA-179 (07-92)

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State/Territory: OREGON

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

(5) UNIT VALUE

Per Oregon Administrative Rule 410-125-0141 effective as of October 1, 2009 as it relates to the unit value for hospitals larger than 50 beds, reimbursed using the Diagnosis Related Grouper (DRG), the Unit Value rebased methodology effective for services beginning on or after October 1, 2009 has been established as a percentage of the current year published Medicare Unit Value (Labor and Non-Labor), update each October thereafter.

The Unit Value plus the Capital amount multiplied by the claim assigned DRG relative weight is the hospital's Operational Payment.

Effective for services provided on or after March 1, 2004, the Unit Value for DRG hospitals will be determined according to subsection (5). The Department of Human Services, as informed by the Legislative Assembly, Emergency Board, or the Department of Administrative Services, will determine the aggregate reduction or increase required to adjust the Unit Value. The adjustment percentage of Medicare's Unit Value will be determined by dividing the aggregate reduction or increase by the current hospital budget. The current Unit Value for each hospital will then be multiplied by the adjustment percentage to determine the net amount of decrease or increase in the hospital's current Unit Value. This amount will be applied to each hospital's current Unit Value to determine the new Unit Value for the individual hospital. The Division, in accordance with 42 CFR 447.253 and 447.205, will make public notice of changes and amend the state plan whenever a Unit Value adjustment is made under the provision of this subsection.

APR 1 1 2012

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.

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 in accordance with 42 CFR 447.272. The upper limit review will be performed before the additional GME payment is made.

(12) 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.

To receive DSH payments under Criteria I and Criteria 2 described below, a hospital must have at least two obstetricians with staff privileges at the hospital who have agreed to provide non-emergency obstetrical services to Medicaid patients. For hospitals in a rural area (outside of a Metropolitan Statistical Area, as defined by the Executive Office of Management and Budget), the term "obstetrician" includes any physician with staff privileges at the hospital who performs non--emergency obstetric procedures. This requirement does not apply to a hospital in which a majority of inpatients are under 18 years of age, or a hospital which had discontinued or did not offer non--emergency obstetric services as of December 22, 1987. The Medicaid utilization rate is the ratio of total paid Medicaid (Title XIX, non-Medicare) days to total inpatient days. Newborn days, days in specialized wards, and administratively necessary days are included. Days attributable to individuals eligible for Medicaid in another state are also accounted for.

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: One or more standard deviations above the mean.

The ratio of total paid Medicaid inpatient (Title XIX, non Medicare) days for hospital services (regardless of whether the services were furnished on a fee-for-service basis or through a managed care entity) 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. Total paid Medicaid inpatient days is based on DMAP records for the same cost reporting period.

Information on total paid Medicaid days is taken from Division of Medical Assistance Programs (DMAP) reports of paid claims for the same fiscal period as the Medicare Cost Report.

b. Criteria 2: A low Income Utilization Rate exceeding 25 percent.

The low income utilization rate is the sum of percentages (1) and (2) below:

(1) The Medicaid Percentage: The total of Medicaid inpatient and outpatient revenues paid to the hospital for hospital services (regardless of whether the services were furnished on a fee-for-service basis or through a managed care entity) plus any cash subsidies received directly from State and local governments in the most recent Medicare cost reporting period. This amount is divided by the total amount of inpatient and outpatient revenues and cash subsidies of the hospital for patient services in the most recent Medicare cost reporting period. The result is expressed as a percentage.

(2) The Charity Care Percentage: The total hospital charges for impatient hospital services for charity care in the most recent Medicare cost reporting period, minus any cash subsidies received directly from State and local government in the same period, is divided by the total amount of the hospital's charges for inpatient services in the same period. The result is expressed as a percentage.

Charity care is care provided to individuals who have no source of payment, including third party and personal resources.

Charity care shall not include deductions from revenues or the amount by which inpatient charges are reduced due to contractual allowances and discounts to other health insurance or third party payers, such as HMO'S, Medicare, Medicaid, etc.

The information used to calculate the Low Income Utilization rate is taken from the following sources:

- The most recent Medicare Cost Reports.
- DMAP records of payments made during the same reporting period.
- Hospital provided financial statements, prepared and certified for accuracy by a licensed public accounting firm for the same reporting period.
- 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 DMAP, working in conjunction with representatives of Oregon hospitals, determines is necessary to establish eligibility.

DMAP determines within 30 days of receipt of all required information if a hospital is eligible under the Low Income Utilization rate criteria.

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

Information on total paid Medicaid days is taken from DMAP reports of paid claims for the same fiscal period as the Medicare Cost Report.

c. Disproportionate Share Payment Calculations

All hospitals that have been deemed DSH hospitals will always qualify for DSH payments under Criteria 1 or Criteria 2. Hospital ranking is done on an annual basis for all hospitals. Once the eligible hospitals are determined DMAP calculates the standard deviations for the hospitals to determine if they will be eligible under Criteria 1 or Criteria 2.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State/Territory: Oregon
METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

Criteria 1: One or more standard deviations above the mean.

The quarterly DSH payments to hospitals eligible under Criteria I is the sum of DRG weights for paid Title XIX non-Medicare claims for the previous quarter multiplied by a percentage of the hospital-specific Unit Value in effect for the current federal fiscal year. This determines the hospital's DSH payment for the current quarter. The Unit Value used for eligible Type A and Type B hospitals is the current Unit Value set at the 50th percentile. The calculation is as follows:

(1) For eligible hospitals more than one standard deviation and less than two standard deviations above the mean, the disproportionate share percentage is 5%. The total of all relative weights is multiplied by the hospital's unit value. This amount is multiplied by 5 % to determine the DSH payment.

(2) For eligible hospitals more than two and less than three standard deviations above the mean, the percentage is 10%. The total of all relative weights is multiplied by the hospital's unit value. This amount is multiplied by 10% to determine the DSH payment.

(3) For eligible hospitals more than three standard deviations above the mean, the percentage is 25%. The total of all relative weights is multiplied by the hospital's unit value. This amount is multiplied by 25 % to determine the DSH payment.

Criteria 2: A low Income Utilization Rate exceeding 25 percent.
For hospitals eligible under Criteria 2 (Low Income Utilization Rate), the quarterly DSH payment is the sum of DRG weights for claims paid by DMAP 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 current federal fiscal year unit value. The Unit Value used for eligible Type A and Type B hospitals is the current Unit Value set at the 50th percentile.

Type A and Type B hospitals are assigned a DRG based upon the claim diagnosis code as all other hospitals are. The payment Type A and Type B hospital claim payment is not based upon the DRG but on the methods described in this state plan Attachment 4.19-A, page 6.

Criteria 2: A low Income Utilization Rate exceeding 25 percent(Cont)

In-State public academic medical centers that provide a major medical teaching program, defined as a hospital with more than 200 residents or interns shall receive an additional 25% to the disproportionate share percentage described in criteria 1 and criteria 2 under the disproportionate share payment calculations.

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 DMAP are reimbursed according to the terms of the agreement or contract. The rate is negotiated on a provider-by-provider basis at 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.

d. Public Academic Medical Center Disproportionate Share Adjustments

Public academic medical centers that meet the following eligibility standards are deemed eligible for additional DSH payments up to 175% through June 30, 2005 and then revert to 100% thereafter of their 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.

Uncompensated care costs for hospitals qualifying for this DSH payment will be determined using the following sources:

- The most recent Medicare Cost Reports.

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

The final calculation to determine the additional DSH payment is summing the uncompensated care costs of the two components and reducing that amount by the graduate medical education reimbursement for public teaching hospitals (11) determined for the same payment year.

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

e. Additional Disproportionate Payments

For all hospitals with a Medicaid utilization rate above 1% of all payer utilization, the DSH payment is the ratio of the hospital's low income shortfall to the low income shortfall for all eligible hospitals multiplied by the total Federal disproportionate share allotment remaining after disproportionate share payments have been made under c. and d. The low income shortfall is defined as Medicaid costs for inpatient and outpatient hospitals services plus uncompensated care for the uninsured costs for inpatient and outpatient hospital services less total Medicaid and self-pay payments for inpatient and outpatient hospitals services.

f. Disproportionate Share Payment Schedule

Hospitals qualifying for DSH payments under section (12)c and (12)e 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 (12)d will receive quarterly payments of 1/4 of the amount determined under this section.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

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.

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 (12)d, 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 (12)c (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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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

The State has in place a public process which complies with the requirements of Section 1902(a)(13)(A) of the Social Security Act.

SUPPLEMENTAL PAYMENTS

a. Private Hospital Supplemental Payments

b. From the private upper payment limit gap calculated in paragraph 8 of this section, payments shall be made to all private DRG hospitals in the form of a per discharge payment applied to hospital specific Medicaid fee-for-service discharges from the quarter preceding the month of payment. This payment will be equal to one quarter of the gap amount divided by the total private DRG hospital Medicaid fee-for-service discharges from the quarter preceding the month of payment. The supplemental payments for Private Hospitals will not exceed the UPL for inpatient hospital services.

c. Non-State Government Owned Hospital Supplemental Payments

d. From the non-state government owned hospital upper payment limit gap calculated in paragraph 8 of this section, payments shall be made to all non-state government owned DRG hospitals in the form of a per discharge payment applied to hospital specific Medicaid fee-for-service discharges from the quarter preceding the month of payment. This payment will be equal to one quarter of the gap amount divided by the total non-state government owned DRG hospital Medicaid fee-for-service discharges from the quarter preceding the month of payment. The supplemental payments for Non-State Government Owned Hospitals will not exceed the UPL for inpatient hospital services.

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

The DMAP will not make any additional reimbursements when a third party payor (other than Medicare) pays an amount equal to or greater than the DMAP reimbursement, or 100 percent of billed charges.

UPPER LIMITS ON PAYMENT OF HOSPITAL CLAIMS

A. CALCULATION OF UPPER PAYMENT LIMIT FOR DRG HOSPITALS

The following describes the steps followed in calculating the inpatient upper payment limit for Oregon for DRG hospitals. The data in this calculation comes from the most recently filed Medicare cost reports for each hospital and the corresponding Medicaid MMIS data.

1. The following Medicare payments subject to case mix were summed:
Worksheet E Part A lines 4.04, 17, 19, 20 and 26 less line 21.01
Worksheet E-3 Part I lines 5, 7, 9 and 17 less line 11.01
Worksheet E-3 Part I Subprovider I lines 5, 7, 9 and 17 less line 11.01
Worksheet E-3 Part I Subprovider II lines 5, 7, 9 and 17 less line 11.01
Worksheet E-3 Part II lines 20, 23 and 30 less line 25.01

2. The total from 1 was divided by the Medicare cases to determine a per case rate. Medicare cases for this were from. Medicare cases for this were from Worksheet S-3 Part I Col. 13 lines 12, 14 and 14.01.

3. The Medicare per case rate from 2 was divided by the hospital's applicable Medicare CMI to determine a per case rate with case mix removed.

4. Medicaid payments outlined in 4.19-A paragraph 5 sections 1-11 and 13-14 and cases subject to case mix were extracted from the OR MMIS Medicaid data.

5. The Medicare neutralized payments per case from 3 were multiplied by the hospital's Medicaid CMI to determine the hospital's estimated Medicaid payment per case based on the Medicaid case mix.

6. The estimated CMI-adjusted Medicaid payment per case was then multiplied by the hospital's Medicaid cases to determine the upper payment limit.

7. The Medicaid payments in 4. were then subtracted from that upper payment limit in 6. to establish the upper payment limit gap. Gaps across the state owned, non-state government owned, and private classes of hospitals were summed separately across classes and added to the amount calculated in B. to establish the aggregate upper payment limit gap for each class.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State/Territory: OREGON

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

B. CALCULATION OF UPPER PAYMENT LIMIT FOR NON-DRG HOSPITALS

The following describes the steps followed in calculating the inpatient upper payment limit for Oregon for non-DRG hospitals. The data in this calculation comes from the most recently filed Medicare cost reports for each hospital and the corresponding Medicaid MMIS data.

1. The following Medicare costs were summed:
Worksheet D-1 Part II line 49
Worksheet D-1 Part II Subprovider I line 49
Worksheet D-1 Part II Subprovider II line 49
Worksheet E-3 Part IV column 1 line 24
Worksheet D-6 Part III column 1 line 61

2. The following Medicare charges were summed:
Worksheet D-4 column 2 lines 25, 26, 27, 28, 29, 30 and 103
Worksheet D-4 Subprovider I column 2 line 103
Worksheet S-3 Part I column 4 line 14 divided by Worksheet S-3 Part I column 6 line 14 multiplied by Worksheet G-2 column 1 line 2
Worksheet D-4 Subprovider II column 2 line 103
Worksheet S-3 Part I column 4 line 14.01 divided by Worksheet S-3 Part I column 6 line 14.01 multiplied by Worksheet G-2 column 1 line 2.01
Worksheet D-6 Part III column 3 line 61

3. The total Medicare costs in 1. were then divided by the total Medicare charges in 2. to establish the CCR

4. Medicaid charges and payments were extracted from Medicaid data.

5. Medicaid charges were multiplied by the CCR in 3. to establish estimated Medicaid costs

6. Medicaid payments from 4. were then subtracted from the total in 5. to find the inpatient upper payment limit gap for the non-DRG hospitals. Gaps across the state owned, non-state government owned, and private classes of hospitals were summed separately across classes and added to the gaps calculated in A. to establish the aggregate upper payment limit gap for each class.

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

C. PAYMENTS WILL NOT EXCEED FINALLY APPROVED PLAN

Total reimbursements to a State operated facility made during DMAP's fiscal year (July 1 through June 30) may not exceed any limit imposed under Federal law in a finally approved plan.

Total aggregate inpatient reimbursements to all hospitals made during DMAP's fiscal year (July 1 through June 30) may not exceed any limit imposed under Federal law in a finally approved plan.

DISALLOWED PAYMENTS

Payment will not be made to hospitals for non-emergency admissions if the appropriate prior authorization has not been obtained. Payment will not be made to hospitals for admissions determined not to be medically necessary. DMAP will not reimburse for non-covered services. DMAP may disallow payment for physicians' services provided during patient hospitalizations for which prior approval was required but not obtained.

APPEALS

Providers may request an appeal or exception to any State decision affecting payment rates. Providers may submit additional evidence and receive prompt administrative review as referenced in Oregon Administrative Rule.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State/Territory: OREGON

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

2.a. 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. A cost settlement based on the Medicare cost report, as finalized by the fiscal intermediary for purposes of Medicare reimbursement for the respective cost reporting period. 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. A cost settlement based on the Medicare cost report, as finalized by the fiscal intermediary for purposes of Medicare reimbursement for the respective cost reporting period. The final base rate reimbursement for each DRG hospital is then calculated by applying an administratively established percentage to the costs. This calculation results in these hospitals receiving 100% of costs in aggregate, with the exception of the clinical laboratory services outlined below.

The cost-based methodology as described above does not apply to clinical laboratory services. The interim payment for clinical laboratory is the lesser of billed charges or the DMAP fee schedule as authorized in Attachment 4.19-B, page 1 of this state plan.

In addition, supplemental payments are made to non-Type A and non-Type B hospitals in an amount equal to the available gap under the applicable upper payment limit. In no instance will these payments exceed the available applicable gap. For private hospitals, payments will be limited to the total available private hospital upper payment limit gap calculated in the following section. The distribution of payments will be determined by first calculating a percentage as follows: one quarter of the upper payment limit gap divided by the total private DRG hospital outpatient Medicaid fee-for-service payments from the quarter preceding the month of payment. This percentage will then be applied to each private DRG hospital's outpatient Medicaid fee-for-service payments from the quarter preceding the month of payment to determine the individual private DRG hospital outpatient supplemental payments. This process will be repeated and payments will be made quarterly.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

2.a. OUTPATIENT HOSPITAL SERVICES (Cont)
For non-state government owned hospitals, payments will be limited to the total available non-state government owned hospital upper payment limit gap calculated in the following section. The distribution of payments will be determined by first calculating a percentage as follows: one quarter of the upper payment limit gap divided by the total non-state government owned DRG hospital outpatient Medicaid fee-for-service payments from the quarter preceding the month of payment. This percentage will then be applied to each non-state government owned DRG hospital's outpatient Medicaid fee-for-service payments from the quarter preceding the month of payment to determine the individual non-state government owned DRG hospital outpatient supplemental payments. This process will be repeated and payments will be made quarterly. Out-of-state hospitals are reimbursed at 50% of billed charges for all outpatient services except for clinical laboratory which are reimbursed at the lesser of billed charges or the DMAP fee schedule. There is no cost settlement.

Highly specialized out-of-state outpatient services are provided by written agreement or contract between DMAP 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.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State/Territory: OREGON

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

2.a. OUTPATIENT HOSPITAL SERVICES (Cont)

OUTPATIENT UPPER PAYMENT LIMIT CALCULATION

The following describes the steps followed in calculating the Medicare outpatient upper payment limit for Oregon. The data in this calculation comes from the most recently filed Medicare cost reports for each hospital and the corresponding Medicaid MMIS data.

1. The following Medicare costs were summed:
   Worksheet D Part V column 9 line 104
   Worksheet D Part V column 9.01 line 104
   Worksheet D Part V column 9.02 line 104
   Worksheet D Part V column 9.03 line 104

2. The following Medicare charges were summed:
   Worksheet D Part V column 5 line 104
   Worksheet D Part V column 5.01 line 104
   Worksheet D Part V column 5.02 line 104
   Worksheet D Part V column 5.03 line 104

3. The total Medicare costs in 1. were then divided by the total Medicare charges in 2. to establish the CCR

4. Medicaid charges and payments were extracted from Medicaid data

5. Medicaid charges were multiplied by the CCR in 3. to establish estimated Medicaid costs

7. Medicaid payments for fiscal year 2010 were then subtracted to find the outpatient upper payment limit gap for the all hospitals. Gaps across the non-state government owned, and private classes of hospitals were summed separately across classes to establish the aggregate upper payment limit gap for each class.