Table of Contents

State/Territory Name: Oregon

State Plan Amendment (SPA) # 12-003

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

MAY 1 5 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 12-003

Dear Dr. Goldberg:

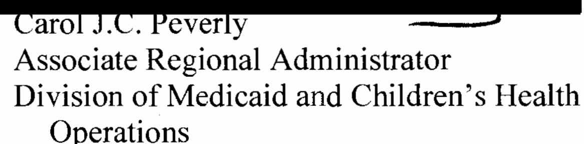
The Centers for Medicare & Medicaid Services (CMS) National Institutional Reimbursement Team (NIRT) recently approved Oregon State Plan Amendment (SPA) Transmittal Number 12-003.

Although the NIRT has already sent the State a copy of the approval for this SPA, the Seattle Regional Office 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 Regional Office 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:
MaryAnne Lindeblad, Assistant Secretary
Jesse Anderson, State Plan Coordinator

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

MAY 15 2012

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

RE: Oregon State Plan Amendment (SPA) Transmittal Number 12-003

Dear Dr. Goldberg:

We have reviewed the proposed amendment to Attachments 4.19-A and 4.19-B of your Medicaid State plan submitted under transmittal number (TN) 12-003. The purpose of this amendment is to make technical changes to the State Plan

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) of the Social Security Act and the implementing Federal regulations at 42 CFR 447 Subpart C.

Medicaid State plan amendment 12-013 is approved effective January 1, 2012. 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: **12-03**

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: 1/1/12

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

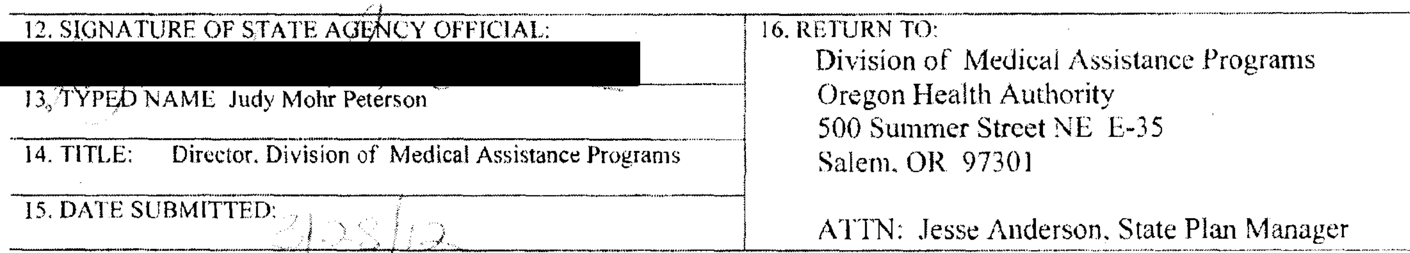
7. FEDERAL BUDGET IMPACT:
a. FFY 2012 $ 0
b. FFY 2013 $ 0

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19-B, Page 5
Attachment 4.19-A, Page 21 (P&I)

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.19-B, Page 5
Attachment 4.19-A, Page 21 (P&I)

10. SUBJECT OF AMENDMENT: This transmittal is being submitted to for technical corrections made when SPA approved prior to 11-14. This incorporates the language with appropriate dates.

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:

13. TYPED NAME: Judy Mohr Peterson

14. TITLE: Director, Division of Medical Assistance Programs

15. DATE SUBMITTED: 3/28/12

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: **MAR 28 2012**

18. DATE APPROVED: **May 15, 2012**

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: **January 1, 2012**

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME: **Carol J.C. Peverly**

22. TITLE: **Associate Regional Administrator Division Of Medicaid and Children's Health Operations**

23. REMARKS:

04/17/2012 - Pen and Ink (P&I) changes authorized by State for Block #8 and #9.

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

- DMAP'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 subsides paid to the hospital during the same reporting period.
- Any other information which DMAP, working in conjunction with representatives of qualifying Oregon hospitals, determines necessary to establish cost.

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
   For the qualifying hospitals Medicaid charges for the state plan year 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 state plan year to arrive at Medicaid uncompensated care costs.

2. 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.

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 based on the most recent Medicare payment methodology established by the Centers for Medicare and Medicaid Services under the Outpatient Prospective Payment System using the Ambulatory Payment Classification (APC) methodology.

The APC 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.