Pharmacy Lock-in program:

Clients with suspect utilization patterns that indicate patient safety issues or risk of drug misuse may be locked-in to a single pharmacy for a period of 18 months. The criteria used to determine who should be lock-in are, but not limited to; use of 3 or more pharmacies in 6 months; use multiple prescribers to obtain the same or comparable drugs, or exhibit patterns of drug misuse. The Oregon Drug Utilization Review (DUR) Board develops standards to be used in retrospective and prospective drug utilization review in a manner that insures that such criteria and standards are based on the compendia, relevant guidelines obtained from professional groups through consensus-driven processes, the experience of practitioners with expertise in drug therapy, data and experience obtained from drug utilization review program operations.

Once the client has been identified to be in the program a notice is sent that includes the pharmacy the client is assigned to, the effective date and the right to change the pharmacy assigned within 45 days and administrative appeal rights.

Clients are allowed to use the Departments mail-order pharmacy and/or the Pharmacy they are assigned. Clients can change the assigned pharmacy for circumstances such as a move out of the area.

Exemptions from the lock-in; if they are enrolled in Managed care, covered by Medicare part D, a child in state custody or inpatient or resident in a hospital, NF or other medical facility. Emergency situations have provisions for an exception from lock-in.

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The standards specified in paragraphs (a) and (b) on page 42 of the Plan are:

For general hospitals, psychiatric hospitals, skilled nursing facilities, intermediate care facilities and intermediate care facilities for the mentally retarded contained in Chapter 441, Oregon Revised Statutes, and rules and regulations applicable to each type of facility.

UTILIZATION REVIEW METHODS FOR INTERMEDIATE CARE FACILITIES

1. 42 CFR 456
Effective: July 1, 1985

The State of Oregon assures that it will meet the conditions of 42 CFR Part 456, Subpart F, for utilization control in Intermediate Care Facilities by review by medical professionals of the Senior Services Division.

2. 42 CFR 456
Effective: July 1, 1982

The utilization review functions in Intermediate Care Facilities for the Mentally Retarded will continue to be provided by the State of Oregon, Department of Human Resources.

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LIENS AND ADJUSTMENTS OR RECOVERIES

1. The State uses the following process for determining that an institutionalized individual cannot reasonably be expected to be discharged from the medical institution and return home:

   N/A (Oregon is not a TEFRA lien state.)

2. The following criteria are used for establishing that a permanently institutionalized individual=s son or daughter provided care as specified under regulations at 42 CFR 433.36(f):

   N/A

3. The State defines the terms below as follows:

   - **ESTATE:** For medical assistance provided prior to July 18, 1995, estate is defined as all real and personal property and other assets included within the individual's**, or the individual's surviving spouse's,** probatable estate. For medical assistance provided after July 18, 1995, estate also includes all real and personal property and other assets in which the deceased individual had any legal title or interest at the time of death including assets conveyed to a survivor, heir, or assign of the deceased individual through joint tenancy, tenancy in common, survivorship, life estate, living trust, or other similar arrangement. Under other similar arrangement, the State will pursue recovery against an annuity that was the property of the deceased Medicaid beneficiary.

   - **INDIVIDUAL'S HOME** means any dwelling unit in which an individual has an ownership interest and is used as the individual's principal place of residence; such dwelling unit may consist of a house, boat, trailer, mobile home or other habitation. It is the dwelling that the individual considers his or her fixed or permanent residence and to which, whenever absent, the person intends to return. The individual's home includes the real property on which the dwelling is located, all tangible personal property located therein, and any related outbuildings necessary to its operation. Only one dwelling unit may be considered an individual's home. Outbuildings necessary to the operation of the home include

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outdoor toilets, garage, shed, spring or well house, and barns or other buildings that house animals used for the individual's consumption. An individual's home, in most instances, is located within the state of Oregon. However, an individual's home may be located outside the state of Oregon.

o **EQUITY INTEREST IN THE HOME** means the value of an individual's home less the unpaid principal balance of any loans or other liens or encumbrance affecting the individual's home.

0 **RESIDING IN THE HOME FOR AT LEAST ONE OR TWO YEARS ON A CONTINUOUS BASIS** means uninterrupted residence by an individual in the individual's home, provided, however, that such residence may be interrupted by absences from the home if, while absent, the individual has the intent to return home.

o **LAWFULLY RESIDING** means that an individual has a legal right to reside in an individual's home.

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4. The State defines undue hardship as follows:

The Department may waive enforcement of any estate recovery claim if it finds that enforcing the claim would result in an undue hardship to the beneficiaries, heirs, or family claiming entitlement to receive the assets of the deceased client. In determining whether an undue hardship exists, the Department may consider whether enforcement of the claim would cause the waiver applicant to become eligible for public or medical assistance and become homeless. (ORS 416.340)

5. The following standards and procedures are used by the State for waiving estate recoveries when recovery would cause an undue hardship, and when recovery is not cost-effective:

At the discretion of the Department, waiver of an estate recovery claim may include, but is not limited to, forgiveness of all or part of the claim, or taking a promissory note and mortgage or trust deed in lieu of immediate enforcement of the claim.

No waiver may be granted if the Department finds that the undue hardship was created by resort to estate planning methods by which the waiver applicant or deceased client divested, transferred, or otherwise encumbered assets, in whole or in part, to avoid estate recovery.

No waiver will be granted if the Department finds that the undue hardship will not be remedied by the grant of the waiver.

The Department will provide written notice of the hardship waiver rules to the personal representative or other person handling the deceased client's estate, and other persons as described in the Department's rules.

Persons claiming entitlement to receive assets may apply for a hardship waiver by submitting a written request to the Department. The information to be included on the request is specified in the Department's rules.

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6. The State defines cost-effective as follows (include methodology/thresholds used to determine cost-effectiveness):

Each Estate Administrator has the authority to determine if an estate will be pursued for collection based on the likelihood of recovering the value of the claim as it compares to the cost of collection.

7. The State uses the following collection procedures (include specific elements contained in the advance notice requirement, the method for applying for a waiver, hearing and appeals procedures, and time frames involved):

Upon the death of a recipient of assistance subject to recovery, and provided the recipient has no surviving spouse, minor child, or a child who is blind or disabled according to SSI criteria, and provided there is no real property or titled personal property which would require the filing of an estate proceeding, (small estate or probate), the Department may claim any funds up to $25,000 which belonged to the recipient and which are on deposit with a bank (ORS 708.430), savings and loan (ORS 722.262), or credit union (ORS 723.463).

When the Estate Administration team receives a report on deceased persons meeting the conditions above, the team sends the banking letter, an affidavit, and indemnity agreement to the identified financial institution claiming the account of the decedent. Individuals who contact us and notify us of creditors who have a priority before the State are advised to send the billings to the Estate Administrator and the bill is satisfied to the extent that the assets are available, e.g., funeral expenses.

A small estate may be filed when an individual dies leaving an estate with a fair market value of $140,000.00 or less; not more than $50,000.00 attributable to personal property and not more than $90,000.00 attributable to real property. An affidavit may not be filed until 30 days after the death of the decedent. A probate proceeding can be filed at any time for an estate of any dollar value or when the value of the estate exceeds the small estate limitations.

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If, after sufficient passage of time, neither the heirs nor devisees have filed an estate proceeding, then the Department handling the estate, under the authority of Oregon Revised Statutes, has the authority to act as the personal representative or nominate a personal representative. The practice of Estate Administration is to nominate a personal representative.

In both situations, the Estate Administration Unit files the written notice with the personal representative or claiming successor and provides a copy to the probate court of our claim as a priority creditor. The heirs or the personal representative has the right to deny the claim and a summary determination will occur in Probate Court.

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A. The following charges are imposed on the categorically needy for services other than those provided under Section 1905(a)(1) through (5) and (7) of the Act:

Service	Type of Charge Deduct.	Coins.	Copay.	Amount of Basis for Determination
Prescribed Drugs			X	$1 for each Non-Preferred PDL generic or Generics costing .$10. $0 Preferred PDL Generics $0 Preferred PDL Brands $3 All other Brands
Acupuncturist			X	$3 per visit
Physician Services			X	$3 per visit
Alcohol and Drug			X	$3 per visit, excludes dosing/dispensing or case management visits
Audiologist			X	$3 per visit
Chiropractor			X	$3 per visit
Dental Services			X	$3 per visit, excludes diagnostic or routine cleaning
Home Health			X	$3 per visit
Hospital outpatient			X	$3 per visit
Ambulatory Surgical			X	$3 per visit
Mental health			X	$3 per visit
Naturopath			X	$3 per visit
Nurse practitioner			X	$3 per visit
Occupational Therapy			X	$3 per visit
Optometrist			X	$3 per visit
Physical Therapy			X	$3 per visit
Speech therapy			X	$3 per visit
Podiatrist			X	$3 per visit

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B. The method used to collect cost sharing charges for categorically needy individuals:

_X_ Providers are responsible for collecting the cost sharing charges from individuals.

_____ The agency reimburses providers the full Medicaid rate for services and collects the cost.

C. The basis for determining whether an individual is unable to pay the charge, and the means by which such an individual is identified to providers, is described below:

Medicaid recipients who indicate to the provider that they cannot pay the co-payment at the time the service is provided cannot be refused services because of their inability to pay. However, recipients are liable for the copayment and are expected to pay the co-payment when they are able to do.

Providers are informed that they cannot refuse services to a Medicaid recipient solely because of the recipient's inability to pay the co-payment. The provider can use any other legal means to collect.

The procedures for implementing and enforcing the exclusions from cost sharing contained in 42 CFR 447.53(b) are described below.

Adjustments to provider reimbursement amounts and exclusions from cost sharing requirements are programmed into the Point-of sale System (POS)

Individuals under 19: The MMIS and POS system automatically verifies benefits and age requirements and will override the co-payment for recipients under 19. Additionally the medical ID card shows the recipients date of birth should the provider wish to verify age prior to collection of co-payment.

Pregnant Women: The MMIS and POS reporting codes will identify and exclude pregnant woman from cost share. If the case has not been previously identified and coded the provider is instructed to contact provider services for an override of the co-payment.

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Institutionalized Individuals: The MMIS and POS reporting codes will identify and exclude residence to nursing facilities or other institutionalized residence from cost share. If the case has not been previously identified and coded the provider is instructed to contact provider services for an override of the co-payment. Providers have been instructed not to collect cost sharing from these institutionalized individuals. Facilities have been instructed to assure that staff accompanying recipients out of the facility for health care visits advises providers of the recipient's institutional status.

Emergency Services: The providers have been instructed not to collect cost sharing amounts from individuals seeking or obtaining emergency services. The provider identifies that the service provided was an emergency by entering a code in the appropriate field on the POS system.

Family Planning Services and supplies: The POS System will identify and exclude family planning drugs such as birth control pills, and supplies from cost share.

HMO Enrollees: All individuals identified to the provider through the POS system, are exempt from co-payments for those services which are covered by the plan.

IHS/Tribal Health Facilities under Section 638: All items and services furnished to an Indian directly by an Indian health care provider (i.e., Indian Health Service, an Indian Tribe, Tribal Organization, or Urban Indian Organization) or through referral under contract health services. The MMIS & POS will identify & exclude co-payments for individuals utilizing services by the listed provider types.

Mail Order Prescription: The POS system will identify and exclude prescription drugs dispensed through the mail order drug program.

Tobacco Cessation Contractor (Quit Line): Nicotine Replacement Therapy is exempt from co-payments.

E. Cumulative maximums on charges:

X State policy does not provide for cumulative maximums.

Cumulative maximums have been established as described below:

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A. The following charges are imposed on the medically needy for services:

Service	Type of Charge Deduct. Coins. Copay.	Amount of Basis for Determination

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Premiums Imposed on Low Income Pregnant Women and Infants

A. The following method is used to determine the monthly premium imposed on optional categorically needy pregnant women and infants covered under section 1902(a)(10)(A)(ii)(IX)(A) and (B) of the Act:

B. A description of the billing method used is as follows (include due date for premium payment, notification of the consequences of nonpayment, and notice of procedures for requesting waiver of premium payment):

*Description provided on attachment.

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Optional Sliding Scale Premiums Imposed on
Qualified Disabled and Working Individuals

A. The following method is used to determine the monthly premium imposed on qualified disabled and working individuals covered under section 1902(a)(10)(E)(ii) of the Act:

B. A description of the billing method used is as follows (include due date for premium payment, notification of the consequences of nonpayment, and notice of procedures for requesting waiver of premium payment):

*Description provided on attachment.

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C. State or local funds under other programs are used to pay for premiums:

/ / Yes / / No

D. The criteria used for determining whether the agency will waive payment of a premium because it would cause an undue hardship on an individual are described below:

* Description provided on attachment.

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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 mid-point 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.

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.

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.

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

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.

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.

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.

STATE OF OREGON

1. (Reserved for future use)

STATE OF OREGON

1. (Reserved for future use)

METHODS AND STANDARDS FOR PAYMENT OF INPATIENT MEDICAL HOSPITAL SERVICES

1. **TYPE A AND TYPE B RURAL OREGON HOSPITALS**

The definition of Type A and Type B hospitals is contained in ORS 442.470. The responsibility for designating Type A and Type B hospitals was assigned to the Office of Rural Health, Department of Higher Education. Type A and Type B hospitals receive retrospective cost-based reimbursement for all covered inpatient services effective with admissions occurring on or after July 1, 1991.

Costs are derived from the most recent audited Medicare Cost Report and are adjusted to reflect the Medicaid mix of services.

Type A and B hospitals are eligible for disproportionate share reimbursements, but do not receive cost outlier, capital, or medical education payments.

2**. HOSPITALS PROVIDING SPECIALIZED INPATIENT SERVICES**

Some hospitals provide specific highly specialized inpatient services by arrangement with OMAP. Reimbursement is made according to the terms of a contract between OMAP and the hospital. The rate is negotiated on a provider-by-provider basis and is a rate sufficient to secure necessary services. When the service is provided by an out-of-state hospital, the rate is generally 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.

3. **FREE-STANDING INPATIENT PSYCHIATRIC FACILITIES (IMDS)**

Free-standing inpatient psychiatric facilities (Institutions for Mental Diseases), including Oregon's state-operated psychiatric and training facilities, are reimbursed according to the
P&I terms of an agreement between the Office of Mental Health and Addition Services (OMHAS) and the hospital. The reimbursement for a unit of service is sourced from the departmental fee schedule and paid as a daily rate.

4. **SPINAL CORD INJURED PROGRAM**

Reimbursement under the Spinal Cord Injured program is made on a prospective payment basis for inpatient rehabilitative services provided by CARF or JCAHO-Rehab. certified facilities for treatment of severe disabling spinal cord injuries for persons who have exhausted their hospital benefit days. Services must be authorized by the Spinal Cord Injured Committee in order for payment to be made.

5. **INPATIENT RATE CALCULATIONS FOR OTHER HOSPITALS: DRG METHODOLOGY**

A. OREGON ACUTE CARE HOSPITALS

(1) DIAGNOSIS RELATED GROUPS

Diagnosis Related Groups (DRG) is a system of classification of diagnoses and procedures based on the International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM).

The DRG classification methodology assigns a DRG category to each inpatient service, based on the patient's diagnoses, age, procedures performed, length of stay, and discharge status.

(2) MEDICARE GROUPER

The Medicare Grouper is the software used to assign individual claims to a DRG category. Medicare revises the Grouper program each year in October.

OMAP uses the Medicare Grouper program in the assignment of inpatient hospital claims. The most recent version of the Medicare grouper will be installed each year within 90 days of the date it is implemented by Medicare. Where better assignment of claims is achieved through changes to the grouper logic, OMAP may modify the logic of the grouper program. OMAP will work with representatives of hospitals which may be affected by grouper logic changes in reaching a cooperative decision regarding changes.

(3) DRG RELATIVE WEIGHTS

Relative weights are a measure of the relative resources required in the treatment of the average case falling within a specific DRG category.

For most DRGs, OMAP establishes a relative weight based on Federal Medicare DRG weights. For state-specific Rehabilitation, Neonate, and Adolescent Psychiatric, Oregon Title XIX fee-for-service claims history is used. OMAP employs the following methodology to determine whether enough claims exist to establish a reasonable weight for each state-specific Rehabilitation, Neonate, and Adolescent Psychiatric DRG.

Using the formula N = ((Z * S)/R)^2, where Z = 1.15 (a 75% confidence level), S is the Standard Deviation, and R = 10% of the mean, OMAP determines the minimum number of claims required to set a stable weight for each DRG (N must be at least 5).

For state-specific Rehabilitation, Neonate, and Adolescent Psychiatric DRGs lacking sufficient volume, OMAP sets a relative weight using:

OMAP non-Title XIX claims data, or

Data from other sources expected to reflect a population similar to the OMAP Title XIX caseload.

When a t-test shows at the 90% confidence level that an externally derived weight is not representative of the average cost of services provided to the OMAP Title XIX population in that DRG, the weight derived from OMAP Title XIX claims history is used instead of the externally-derived weight for that DRG.

"Pen and Ink" Change

Those relative weights, based on Federal Medicare DRG weights, will be established when changes are made to the DRG Grouper logic. State-specific relative weights shall be adjusted, as needed, as determined by OMAP. When relative weights are recalculated, the overall average CMI will be kept constant. Re-weighing of the DRGs or the addition or modification of the group logic will not result in a reduction of overall payments or total relative weights.

(4) CASE MIX INDEX

The hospital-specific case mix index is the total of all relative weights for all services provided by a hospital during a period, divided by the number of discharges.

(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 Department, in accordance with 42 CFR 447.205, will make public notice of changes whenever a Unit Value adjustment is made under the provision of this subsection. Public notice of changes will be made in accordance with 42 CFR 447.205 whenever a unit value adjustment is made under the provisions of this subsection.

(6) DRG PAYMENT

The DRG payment to each hospital is calculated by multiplying the Relative Weight for the DRG by the Hospital-Specific Unit Value. This is referred to as the Operational Payment.

(7) COST OUTLIER PAYMENT'S

Cost outlier payments are an additional payment made to DRG hospitals. An outlier payment will be made at the time a claim is processed for exceptional costs or exceptionally long lengths of stay provided to Title XIX clients.

Effective for services beginning on or after March 1, 2004, the calculation to determine the cost outlier payment for all hospitals is as follows:

- Non-covered services (such as ambulance charges) are deducted from billed charges.
- The remaining billed charges are converted to hospital-specific costs using the hospital's cost-to-charge ratio derived from the most recent audited Medicare cost report and adjusted to the Medicaid case load.
- If the hospital's net costs as determined above are greater than 270 percent of the DRG payment for the admission and are greater than $25,000, an additional cost outlier payment is made.

- Costs which exceed the threshold ($25,000 or 270% of the DRG payment, whichever is greater) are reimbursed at a percentage. The percentage of net costs (costs above the threshold) to be paid is established by OMAP and may be adjusted monthly as needed to maintain total cost outlier expenditures for the 1993-95 biennium at $9.0 million in Total Funds, excluding cost outlier payments made to Oregon Health Sciences University Medical Center.

- Third party reimbursements are deducted from the OMAP calculation of payable amount.

Formula for Cost Outlier Calculation:

	Billed charges less non-covered charges
X	Hospital-specific cost-to-charge ratio
=	Net Costs
-	270% of the DRG or $25,000 (whichever is greater)
=	Outlier Costs
X	Cost Outlier Percentage
=	Cost outlier Payment

The cost outlier percentage necessary to fully expend the cost outlier pool is estimated to be 30% for the biennium. OMAP will reimburse cost outlier claims at 50% of costs above the threshold and will monitor payments to determine the relationship between projected and actual outlier payments. An adjustment to the 50% reimbursement rate will be made as needed to fully expend the cost outlier pool. The amount of the cost outlier pool will not be exceeded. Cost outlier payments made to Oregon Health Sciences University Medical Center will not be deducted from this pooled amount.

When hospital cost reports are audited, an adjustment will be made to cost outlier payments to reflect the actual Medicaid hospital-specific cost-to-charge ratio during the time cost outlier claims were incurred.

The cost-to-charge ratio in effect for that period of time will be determined from the audited Medicare Cost Report and OMAP 42, adjusted to reflect the Medicaid mix of services.

(8) 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. Oregon's Medical Assistance Programs uses the Medicare definition and calculation of capital costs. Effective October 1, 2009, the Division of Medical Assistance Programs will use the current federal fiscal year Medicare reimbursement capital cost per discharge methodology and rate for Oregon Medicaid discharges.

Capital cost per discharge is calculated as follows:

a. The capital cost reimbursement rate is established as 100% of the published Medicare capital rate for the current federal fiscal year .

b. The capital cost is added to the Unit Value and paid per discharge. Reimbursement of capital at time of claim payment enhances hospital financial health.

(9) GRADUATE DIRECT MEDICAL EDUCATION (GDME)

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 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 is included in the capitation rates paid to managed care plans under the Oregon Health Plan 1115 Demonstration Project.

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. 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%.

The Direct Medical Education Payment per Discharge will be adjusted at an inflation factor determined by the Department in consideration of inflationary trends, hospital productivity and other relevant factors. All inflationary increases will be submitted through amendments to the State plan.

Payment is made within thirty days of the end of the quarter.

(10) GRADUATE INDIRECT MEDICAL EDUCATION (GIME)

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 is included in the capitation rates paid to managed care plans under the Oregon Health Plan 1115 Demonstration Project.

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 Medical Assistance Programs 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:

Total relative weights from claims paid during the quarter
X Indirect Medical Education Factor
= Indirect Medical Education Payment

This determines the current quarters 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.

P&I

(11) 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, 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 .

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.

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 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 OMAP records for the same cost reporting period.

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

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

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 a 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 impatient 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.
- OMAP 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 OMAP, working in conjunction with representatives of Oregon hospitals, determines is necessary to establish eligibility.

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

c. Other Disproportionate Share Eligibility Requirements

To receive DSH payments under Criteria I and Criteria 2, 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 21, 1987. No hospital may qualify for DSH payments, unless the hospital has, at a minimum, a Medicaid utilization rate of one percent. 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.

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.

d. Disproportionate Share Payment Calculations

Eligibility Under Criteria 1

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 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.

Eligibility under Criteria 2

For hospitals eligible under Criteria 2 (Low Income Utilization Rate), the quarterly DSH payment is the sum of DRG weights for claims paid by OMAP 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.

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.

e. Additional 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 adjustment will be determined using the following sources:

The most recent Medicare Cost Reports.

OMAP'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 OMAP, 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
   Base year (the most recent completed fiscal year for the qualifying hospital) Medicaid charges will 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 base year to arrive at Medicaid uncompensated care costs. These costs are then adjusted to the payment year using the Consumer Price Index – Hospital and Hospital Related Services.

2. Uncompensated Care Costs for Indigent and Uninsured Patients
   The average of the three most recent base years' uncompensated care costs adjusted by the Consumer Price Index – Hospital and Hospital Related Services to the payment year will be the basis to determine the 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.

The final calculation to determine the additional DSH adjustment is summing the uncompensated care costs of the two components and reducing that amount by the graduate medical education reimbursement for public teaching hospitals (12(A)) determined for the same payment year.

The additional DSH adjustment 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.

f. Disproportionate Share Payment Schedule

Hospitals qualifying for DSH payments under section (13d) 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 (13)e will receive quarterly payments of 1/4 of the amount determined under this section.

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 (13)e, 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 (13)d (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.

(13) ONE-TIME DISPROPORTIONATE SHARE ALLOTMENT

This one time disproportionate share hospital (DSH) payment is an additional reimbursement made to hospitals which serve a disproportionate number of low-income patients with special needs and uncompensated care resulting from the 18-day hospital stay limitation. Twenty-one Oregon DRG hospitals qualify for this payment by serving a measurable percentage of low income patients with special needs whose hospital stay exceeded the 18-day hospital stay limitation. These 21 hospitals were ranked separately from the traditional DSH ranking process by calculating the individual percentage of Medicaid days to the total patient days. Each individual hospital receives their individual computed percentage applied to the uncompensated expenditures attributive to the 18-day hospital stay limitation total DSH payment of $1,646,642.64 for this one time adjustment.

The time period for expenditures for these hospitals is 9/15/06 through 3/31/07

(14) PROPORTIONATE SHARE (Pro-Share) PAYMENTS FOR PUBLIC ACADEMIC TEACHING HOSPITALS

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 Inpatient 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 Share payment is calculated by the determination of Medicare upper payment limit of the Medicaid Fee-For-Service Inpatient charges converted to what Medicare would pay, less Medicaid payments and third party liability payments. The State of Oregon Medicaid Management Information System (MMIS) is the source of the charge and payment data.

Proportionate Share payments will be made quarterly during each federal fiscal year. Payments made during federal fiscal year will not exceed the Medicare upper limit calculated from January 1, 2001 through September 30, 2001 and quarterly for each federal fiscal year thereafter.

The State has in place a public process which complies with the requirements of Section 1902(a)(l3)(A) of the Social Security Act.

B. NON-CONTIGUOUS AREA OUT-OF-STATE HOSPITALS

Non-contiguous area hospitals are out-of-state hospitals located more than 75 miles outside the Oregon border. Unless such hospitals have an agreement or contract with ONLAP for specialized services, non-contiguous area out-of-state hospitals will receive DRG reimbursement. The Unit Value for non-contiguous out-of-state hospitals will be set at the Final Unit Value for the 50th percentile of Oregon hospitals (see DRG Rate Methodology for the methodology used to calculate the Final Unit Value at the 50th percentile). No cost outlier, capital or medical education payments will be made. The hospital will receive a Disproportionate Share reimbursement if eligible.

C. CONTIGUOUS AREA OUT-OF-STATE HOSPITALS

Contiguous Area Hospitals are out-of-state hospitals located less than 75 miles outside the border of Oregon. Unless such hospitals have an agreement or contract with OMAP for specialized services, contiguous area out-of-state hospitals will receive DRG reimbursement. The Unit Value for contiguous out-of-state hospitals will be set at the Final Unit Value for the 50th percentile of Oregon hospitals (see DRG Rate Methodology, for the methodology used to calculate the Unit Value at the 50th percentile.) Contiguous area out-of-state hospitals are also eligible for cost outlier payments. No capital or medical education payments will be made. The hospital will receive a Disproportionate Share reimbursement if eligible.

D. DEATH OCCURRING ON DAY OF ADMISSION

A hospital receiving DRG reimbursements will receive the DRG reimbursement for the inpatient stay when death occurs on the day of admission as long as at least one hospital benefit day is available from the fiscal year in which the admission occurred at the time the claim is processed.

E. TRANSFERS AND REIMBURSEMENT

When a patient is transferred between hospitals the transferring hospital is paid on the basis of the number of inpatient days spent at the transferring hospital multiplied by the Per Diem Inter-Hospital Transfer Payment rate.

5.E. TRANSFERS AND REIMBURSEMENT (Continued)

The Per Diem Inter-Hospital Transfer Payment rate = the DRG payment divided by the geometric mean length of stay for the DRG.

The final discharging hospital receives the full DRG payment.

Transfers from acute care to a distinct part rehabilitation unit within the same hospital shall be considered a discharge and readmission, with both admissions eligible for a separate DRG payment.

7. THIRD PARTY RESOURCES AND REIMBURSEMENT

A. The Office of Medical Assistance Programs establishes maximum allowable reimbursements for all services. When clients have other third party payers, the payment made by that payer is deducted from the OMAP maximum allowable payment.

OMAP will not make any additional reimbursement when a third party pays an amount equal to or greater than the OMAP reimbursement. OMAP will not make any additional reimbursement when a third party pays 100 percent of the billed charges, except when Medicare Part A is the primary payer.

B. When Medicare is Primary

OMAP calculates the reimbursement for these claims in the same manner as described in the Inpatient Rates Calculations sections above.

Payment is the OMAP allowable payment, less the Medicare payment, up to the amount of the deductible due. For clients who are Qualified Medicare beneficiaries OMAP does not make any reimbursement for a service which is not covered by Medicare. For clients who are Qualified Medicare/Medicaid beneficiaries OMAP payment is the allowable payment, less the Medicare payment, up to the amount of the deductible due for services covered by either Medicare or Medicaid.

C. When Medicare is Secondary

Payment is the OMAP allowable payment, less the Medicare Part B payment.

D. Clients with PCO or HMO Coverage

OMAP payment is limited to those services which are not the responsibility of the PCO or HMO. Payment is made at OMAP rates.

E. Other Insurance

OMAP pays the maximum allowable payment, less any third party payments.

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

8. UPPER LIMITS ON PAYMENT OF HOSPITAL CLAIMS

A. PAYMENTS WILL NOT EXCEED TOTAL OF BILLED CHARGES

Excepting for Type A hospitals which are reimbursed 100% of costs by Oregon statute, the total reimbursement during each hospital's fiscal year for inpatient services, including the sum of DRG payments, cost-outlier, capital, direct medical education, and indirect medical education payments shall not exceed the individual hospital's total billed charges for the period for these services.

If the total billed charges for all inpatient claims during the hospital's fiscal year is less than the total OMAP payment for those services, the overpayment shall be recovered.

B. PAYMENTS WILL NOT EXCEED FINALLY APPROVED PLAN

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

9. 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. OMAP will not reimburse for non-covered services. OMAP may disallow payment for physicians' services provided during patient hospitalizations for which prior approval was required but not obtained.

10. 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 OAR 410-120-780 through 410-120-1060 and OAR 410-125-2040 and 2060.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

Except as otherwise noted in the plan, the state developed fee schedule rates are determined by using the CMS RVU weights published in the Federal Register annually, times a conversion factor. The conversion factor was last set as of 1/1/09 and are effective for services on or after that date. The fee schedule is the same for both governmental and private providers. The Oregon Administrative Rules with the rate schedule is published in the State Register by the Secretary of State.

SUBJECT: A description of the policy and the methods used in establishing payment rates for each type of care or service listed in Section 1905(a) of the Act.

Physician: Payment for services is a state-wide fee schedule which utilizes Medicare's Resource Based Relative Value Scale with Oregon specific conversion factors.

Dentist: A state-wide fee schedule was developed from a survey of other State Medicaid Programs and the major dental insurance carrier in Oregon. The fee schedule was last updated and effective for services on or after 1/1/09.

Denturist: A state-wide fee schedule was developed from a survey of other State Medicaid Programs and the major dental insurance carrier in Oregon. The fee schedule last updated and effective for services on or after 1/1/09.

Dental hygienists with a Limited Access Permit (LAP): Same Fee schedule as referenced for Dentist above.

Naturopath: Payment for services is a state-wide fee schedule which utilizes Medicare's Resource Based Relative Value Scale with Oregon specific conversion factors.

Direct Entry Midwives: Payment is a state-wide fee schedule which utilizes Medicare's Resource Based Relative Value Scale with Oregon specific conversion factors. If no RVU exists, a flat fee, which was last updated and effective for services on or after 1/1/09.

Acupuncturists: Payment for services is a state-wide fee schedule which utilizes Medicare's Resource Based Relative Value Scale with Oregon specific conversion factors.

Private Duty Nursing Services: Payment is a state-wide fee schedule. The fee schedule was last updated and effective for services on or after 1/1/09.

Nurse Anesthetists: Payment for services is a state-wide fee schedule which utilizes Medicare's Resource Based Relative Value Scale with Oregon specific conversion factors.

Chiropractor: Payment for services is a state-wide fee schedule which utilizes Medicare's Resource Based Relative Value Scale with Oregon specific conversion factors.

Podiatrists: Payment for services is a state-wide fee schedule which utilizes Medicare's Resource Based Relative Value Scale with Oregon specific conversion factors.

Physical Therapy: Payment for services is a state-wide fee schedule which utilizes Medicare's Resource Based Relative Value Scale with Oregon specific conversion factors.

Visual Care Services: examining and dispensing: Payment is a state-wide fee schedule. The fee schedule was last updated and effective for services on or after 1/1/09.

Eyeglasses, contacts and hardware: Payment is a state-wide fee schedule. The fee schedule was last updated and effective for services on or after 1/1/08.

Home Health Services: Payment is a statewide fee schedule for each type of covered service. The state wide fee schedule is 75% of current Medicare rates. Medical supplies are covered at costs up to $75 per day without prior authorization.

Ophthalmic Materials. Payment will be based on a state-wide fee schedule.

Medical Transportation. Payment will be based on a state-wide fee schedule

Medical Supplies and Equipment.

Aged, blind and disable persons: Payment will be based on a state-wide fee schedule.

Families and children: Payment will be based on a state-wide fee schedule.

Prosthetic Devices: Payment will be based on a state-wide fee schedule

Personal Care Services. Payments are made to individual providers based on state-wide uniform hourly rates or individually negotiated rates. The state-wide uniform hourly rates are supported by a survey of Oregon wages in comparable work and payment history. Payments are also made to agencies under a contract obtained through negotiation.

Occupational Therapy.

Aged, blind and disabled persons: Payment will be based on a state-wide fee schedule.

Families and children: Payment will be based on a state-wide fee schedule.

Audiologist Services.

Aged, blind and disabled persons: Payment will be based on a state-wide fee schedule.

Families and children: Payment will be based on a state-wide fee schedule.

Clinical Laboratory and Pathology Procedures.

Payment will be based on the lesser of Medicare's fee schedule or the Division's state-wide fee schedule.

Rehabilitative Mental Health Services

Payment will be based on a statewide fee schedule or prepaid capitation rates.

Rehabilitative Alcohol and Drug Services

Payment will be based on a statewide fee schedule or prepaid capitation rates.

Additional Services to Pregnant Women

Payment will be based on a statewide fee schedule.

EPSDT Services

The following describes the reimbursement methodologies for required EPSDT services not covered elsewhere in the plan:

Hospice payment and methodology is the same as used by Medicare's program.

Respiratory Care Services payment will be based upon Medicare principles of reimbursement.

Case Management Services reimbursement, for other than Targeted Case Management, will be based on a state-wide fee schedule with payment based on 15 minute time increments and billed on a monthly basis.

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Preventive Services for HIV Infected Individuals

Payment will be based on a statewide fee schedule.

Hospice

Hospice payment and methodology is the same as used by Medicare's program and CMS guidelines issued annually that reflect rate adjustments. The Medicaid hospice payment base rates are calculated based on the annual hospice rates established under Medicare, 'I'hese rates are authorized by section I814(i)(1)(C)(ii) of the Social Security Act which also provides for an annual increase in payment rates for hospice care services. 'These rates will be adjusted by applying the hospice wage index for the geographic locale in which the hospice services are provided.

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

Disease Management reimbursement methods:

The state contracts for DM services. The State will use a method of payment based on a cost per member calculation. The State expects services to be budget neutral.

Reimbursement Methodology for Rehabilitation Services Provided in Psychiatric Day Treatment Centers

Payment will be made to private, non-profit treatment agencies using individually negotiated daily or hourly rates for each facility, negotiated by the appropriate office.

Nurse Midwives

Payment for services by nurse midwives and other licensed nurse practitioners will be at the same level as for physicians and independent clinical labs.

Behavior Rehabilitation Services

Payment for Behavior Rehabilitation Services is on a fee-for-service basis, with one day being the unit of service. Rates are set using a prospective staffing based rate model that uses data gathered by the State Department of Employment reporting the prevailing wages in the State of Oregon. Specific position classifications were selected to reflect the comparable staffing requirements needed to provide quality rehabilitation services to the identified population. A factor is used to compensate for employee benefits and facility operating costs and supplies. Board and room are not included in the Behavior Rehabilitation Service rate paid to the provider. These rates are periodically adjusted based on appropriate cost-of-living adjustments and other market indicators and program standards.

Rehabilitative School-Based Health Services

Special Rehabilitation Services Provided by Local Education Agencies

Payment will be based on a local education agency's (LEA) most recent school year's actual audited costs for total amount (federal share plus state share). LEAs shall be surveyed annually using cost worksheets approved by the Department. The cost worksheets shall establish a LEA's hourly and 15-minute increment costs for each discipline. Based upon the data received in the annual cost worksheets, the Department shall establish the maximum allowable hourly cost for each discipline and the maximum allowable cost for each visit code. The LEA shall use the annual indirect rate established for the LEA's district by the cognizant federal agency delegate, the Oregon Department of Education. A LEA shall not bill for more than its annually established cost amount. There will be no required annual cost settlement for each LEA.

LEA-specific costs for its provider disciplines, other than those for non-emergency transportation, shall be determined for each discipline, using the following table:

	Costs Attributable to Discipline	(A) Costs	(B) Percentage	(C) Adjusted
1	Total salaries and benefits for all licensed billable staff			
2	Employee travel expenses			
3	Communications			
4	Publications and printing			
5	Materials and supplies			
6	Professional service costs			
7	Memberships and subscriptions			
8	Repair of equipment used by discipline			
9	Training			
10	Advertising for personnel			
11	Management, salaries, benefits, costs			
12	Medicaid Operations salaries, benefits, costs			

13	Clerical staff salaries, benefits, costs			
	Calculation of Hourly Cost			
14	Number of licensed billable staff in unit (FTE)			
15	Average cost based on FTE			
16	Rate per hour using actual number of total hours worked per year			
17	ODE approved indirect rate			
18	Calculated hourly rate			
19	15-minute increment			

Instructions for Completing Section on Costs Attributable to Discipline

This section shall be completed using actual audited costs from the prior school year for the specified cost classifications. Actual costs shall be listed under Column A. In Column B, the percentage of the total cost listed in Column A that applies to the discipline shall be specified. Column C amount for each cost shall be the result of multiplying Column A by Column B.

Instructions for Completing Section on Calculation of Hourly Cost

This section shall be completed by entering the number of licensed billable staff in the discipline, and the total number of hours worked by all members of the discipline during the prior school year. An indirect rate approved by the Oregon Department of Education may be entered provided the costs included in the indirect rate calculation are not included elsewhere in the calculation of the hourly rate.

Payments for IEP/IFSP Transportation Services Provided by a Local Education Agency

Transportation services are provided to IDEA and Medicaid eligible children with medically necessary transportation services included on their IEP/IFSP.

By computing the total IDEA special education transportation costs, (including costs attributed to individual transportation aides), and following the formula described below to establish Medicaid transportation costs, a per trip rate is the result. The per trip rate is established using the most recent school year's audited actual costs and special education data.

Payments for IEP/IFSP Transportation Services Provided by a Local Education Agency (cont'd)

Medicaid Transportation per trip calculation	Example*
1. Total annual direct costs of all special education transportation costs	$100.00
2. Percent of Medicaid special education students	40%
3. Medicaid transportation costs	$40.00
4. Total number of actual trips per Medicaid student per year	208
5. Direct Medicaid cost per trip	$.19
6. Department of Education indirect rate	12%
7. Total Medicaid cost per trip	$.21

*The numbers used are for example purposes only and not to be recognized as an actual rate.

The following is the description of the example above. Costs will be derived from the most recent school fiscal years' audited costs. All other numbers will be actual service numbers from the same fiscal year.

1. Total IDEA special education direct transportation costs are computed following OMB Circular A-87 guidelines for allowable costs. Included in these costs will be the allowable costs attributed to the individual transportation aide when medically necessary on a regular education bus. The time of the individual transportation aide will not be included nor billed separately. This computation will not include delegated health care aides. Costs used are direct costs, and are not used in developing an indirect cost rate.

2. Established by actual data, this is the percent of special education students requiring medically necessary transportation who are Medicaid recipients. Calculation is: Divide

Payments for IEP/IFSP Transportation Services Provided by a Local Education Agency (cont'd)

the total number of Medicaid recipient students requiring transportation by the total number of special education students requiring transportation.

3. The total annual amount of direct Medicaid transportation for the LEA. Calculation is: Multiply line 1 by percent found in line 2.

4. Total number of actual trips provided to Medicaid recipients by the LEA, derived from transportation logs. Calculation is: Total number of IDEA/Medicaid recipients multiplied by the total number of trips per year provided to these Medicaid recipients; includes all trips covered (billed) and not covered (not billable) trips.

5. Direct Medicaid cost per trip cost. Calculation is: Divide line 3 by line 4 = $.19.

6. Oregon Department of Education (ODE) indirect rate (standard methodology used by LEA's statewide and regulated by ODE). Calculation is: Line 5 multiplied by line 6 (example is 12%)

7. Total Medicaid cost per trip = $.21. Calculation is: Add line 5 and result of line 6 calculation.

The calculation methodology would be the same for LEA owned transportation or LEA contracted transportation. For contract transportation, the contract amount would be line 1.

LEA would bill per trip cost for Medicaid recipient students only on those days when medically necessary transportation is provided and a Medicaid-covered service pursuant to their IEP/IFSP is provided. For example, a child may be transported 10 trips per week, yet the LEA may only bill transportation for 6 trips per week when the child receives a Medicaid covered service as specified on his/her IEP/IFSP. All transportation and service documentation will remain as required. The LEA will not bill the transportation aide separately.

For LEA's billing transportation for the first time, the most recent fiscal years' actual audited costs would still be used for line 1 as instructed, and prospective data would be used to complete the formula.

Prescribed Drugs

A. General

(1) The Department of Human Services (DHS) will pay the lesser of the provider's usual charge to the general public for a drug or the estimated acquisition cost (EAC) plus a dispensing fee. DHS determines the EAC to be the lesser of: Oregon maximum allowable cost (as defined in B.2.), the federally established maximum allowable cost or the average wholesale price minus the discount (as defined in sections B, C & D below) DHS determines usual charge to be the lesser of the following unless prohibited from billing by federal statute or regulation:

a. The provider's charge per unit of service for the majority of non-Medical Assistance users of the same service based on the preceding month's charges;
b. The provider's lowest charge per unit of service on the same date that is advertised quoted or posted. The lesser of these applies regardless of the payment source or means of payment;
c. Where the provider has established a written sliding fee scale based upon income for individuals and families with income equal to or less than 200% of the federal poverty level, the fees paid by these individuals and families are not considered in determining the usual charge. Any amounts charged to third party resources are to be considered.

(2) The DHS requires prior authorization of payment for selected therapeutic classes of drugs. These drug classes are listed in the Oregon Administrative Rules in the Oregon Pharmaceutical Services Guide. Exception to the prior authorization requirement may be made in medical emergencies.
(3) The DHS will reimburse providers only for drugs supplied from pharmaceutical manufacturers or labelers who have signed an agreement with CMS or who have a CMS approved agreement to provide drug price rebates to the Oregon Medicaid program.
(4) DHS utilizes a contracted mail order vendor, the program is voluntary for the enrollees. The vendor is selected via a standard invitation to bid process. All Medicaid program rules apply to the vendor contract, payment rates are established during the bid process.

B. Payment Limits for Multiple Source Drugs

(1) The DHS has established the payment amount for multiple source drugs as the lesser of the OMAC, CMS Federal upper limits for drug payment, average wholesale price minus discount plus a dispensing fee or the usual charge to the general public. AWP discount rate for multiple-source drugs are as follows:
(a) retail pharmacies= AWP-15%
(b) Licensed as Institutional pharmacies= AWP-11%
(c) DHS mail order vendor= AWP-68%

(2) The Oregon Maximum Allowable Cost (OMAC) is determined on selected multiple-source drugs designated as bioequivalent by the Food and Drug Administration. The upper limit of payment for a selected multiple source drug is set at a level where one bioequivalent drug product is available from at least two wholesalers serving the State of Oregon. The upper payment limit established by the OMAC listing does not apply if a prescriber certifies that an innovator multi-source drug is medically necessary.

(3) The average wholesale price is determined using information furnished by the DHS's drug price data base contractor.

(4) Payment for multiple-source drugs for which CMS has established upper limits will not exceed, in the aggregate, the set upper limits plus a dispensing fee.

(5) Oregon state law requires that no payment shall be made for a multiple source drug having a federal upper limit (FUL) for payment if a less expensive multiple source drug could have been dispensed, unless the physician certifies in his or her own handwriting that a specific brand is medically necessary for a particular recipient.

C. Payment Limits for Single-Source Drugs

(1) The DHS established the payment amount for single-source drugs as the AWP minus discount rate, plus a dispensing fee or the usual charge to the general public, whichever is lower.
AWP discount rate for single-source drugs are as follows:
(a) Retail pharmacies= AWP-15%
(b) Licensed as Institutional pharmacies= AWP-11%
(c) DHS mail order vendor= AWP-21%

(2) The usual charge to the general public is established as indicated in A. (l).

(3) The average wholesale price is determined from price information furnished by the DHS's drug price data base contractor.

(4) Payments for single-source drugs shall not exceed, in the aggregate, the lesser of the estimated acquisition cost plus a reasonable dispensing fee or the provider's usual charge to the general public.

D. Dispensing or Professional Fees

(1) The DHS establishes pharmacy dispensing fee payments based on the results of surveys of pharmacies and other Medicaid programs, and by approval of the State Legislature.

(2) The present dispensing fee payment mechanism is two tiered. The base fee is;
(a) Retail pharmacies= $3.50
(b) Licensed as Institutional pharmacies = $3.91
(c) Mail order vendor= $3.50

(3) Pharmacies dispensing through a unit dose or 30-day card system must bill the DHS only one dispensing fee per medication dispensed in a 30-day period.

(4) Compound prescription fee allowances are made for preparation time and dispensing. A prescription is considered a compound prescription when it is prepared in the pharmacy by combining two or more ingredients. Pharmacies will receive a dispensing fee of $7.50 for a compound, which contains two, or more ingredients listed in the compound. Pharmacies must list all applicable NDC numbers included in the compound.

(5) A 340B program to be phased in starting with a single clinic and adding covered entities if program is determined to be successful. The Department will establish a $10 dispensing fee and reimbursement as follows: the lesser of the acquisition cost, the federal upper limit, the Oregon Maximum Allowable Cost, or federal 340B pricing. A method to identify claims for exclusion from CMS rebate collections will be developed.

Payment Methodology for Targeted Case Management for Child Welfare and Oregon Youth Authority

Targeted case management services will be billed at a monthly rate which is based on one or more documented targeted case management services provided to each client during that month. The rate will be based on the cost of providing the monthly service. The rate will be derived through a formula which divides the provider's costs of providing targeted case management, as determined by the State Medicaid agency, by the number of clients served.

The monthly rate for targeted case management services is based on the total average cost per client served by the provider. The cost used to derive the monthly rate will be limited to the provider's direct service and administrative costs associated with targeted case management service delivery.

The monthly rate is established on a prospective basis. In the first year, the rate will be based on estimates of cost and the number of clients to be served. For subsequent years, the rate will be based on actual targeted case management costs for previous year, adjusted for anticipated changes in the actual costs and number of clients to be served for the coming year. A cost statement will be completed at the end of each state fiscal year once the actual costs incurred have been determined.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
Medical Assistance Program
State/Territory: _OREGON_____

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

(Reserved for future use)

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

(Reserved for future use)

Payment Methodology for Targeted Case Management for Persons with HIV Disease

Payment for case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose**.**

The fee schedule developed for the Targeted Case Management is designed for specific tasks related exclusively to case management functions for this target group. The fee schedule is constructed by using the market value of the individual's time (the Bureau of Labor Statistics wage level) augmented by a margin for Program Related expenditures (supervisory staff, transportation, program supplies etc.), Employment Related expenditures (mandated and other benefits), and General and Administrative (Indirect). The assumptions from which the fees are developed are expressed in the service standards, and the fees are predicated on fifteen minute increments.

The program intends to establish and maintain a maximum number of fifteen minute increments which can be performed and billed for any single day. This maximum will be twenty four units (24 fifteen minute increments) in any given calendar day (midnight to midnight) which corresponds to an assumption that no more than six hours would ever be provided for the same client, by the same case manager in any twenty four hour calendar day.

The program will be utilizing an authorization methodology to monitor and control for this utilization limit.

The agency's rates were established as of 04/01/2008 and are effective for services on or after that date. All rates are published on the Agency's website.

State developed fee schedule rates are the same for governmental and private providers of HIV/AIDS Targeted Case Management services and the fee schedule and any annual/periodic adjustments to the fee schedule.

Payment Methodology for Targeted Case Management for EI/ECSE program

The cost based rate developed for EI/ECSE Targeted Case management is based on the ESD contractor's or EI/ECSE subcontractor's prior year audited costs reported to Oregon Department of Education annually and reviewed and accepted by the Department for activities related exclusively to the provision of EI/ECSE Targeted Case Management services. Such services are provided by Service Coordinators/Targeted Case Managers furnished to preschool children with disabilities in the target group, eligible under the State Plan, to assist and enable the eligible child to gain access to needed medical, social, educational, developmental and other appropriate services in conjunction with the child's Individualized Family Service Plan (IFSP). . An ESD contractor or EI/ ECSE subcontractor shall not bill for more hourly units than that of which was used to establish the costs which have previously been reviewed and accepted by the Department. The ESD contractor or EI/ECSE Subcontractor's established hourly cost based rate is divided by 60 and yields a per minute cost amount. The per minute cost amount multiplied by actual number of minutes for services provided results in the ESD contractors or EI/ECSE subcontractors billing Medicaid no more than their cost to provide these services. If applicable, a finalized indirect rate established for the current year and approved by the cognizant federal agency delegate, Oregon Department of Education, may be applied, provided the costs included in the indirect cost calculation are not also included elsewhere in the calculation of the hourly cost based rate. As the above methodology utilizes cost based rates which are based on prior year costs, there will not be any need for reconciliation nor annual cost settlement required for payment made for TCM services provided by each ESD contractor or EI/ECSE subcontractor.

If the ESD contractor or EI/ECSE subcontractor does not have a full prior year cost to establish a TCM cost based rate, an estimate can be established based on the lesser of budgeted costs for the current year or an estimate of actual costs expended during the current year which prorates cost to the end of that year, however the Department will not require that a cost reconciliation be completed at the end of the year for ESD contractor or EI/ECSE subcontractor cost based rates.

The ESD contractor or EI/ECSE subcontractor targeted case management cost based rate will be derived by considering the following expenditures directly attributable to Targeted Case Management Staff:

- Targeted case management staff salaries and other personnel expenses
- Supervisory salaries and other personnel expenses
- Administrative support salaries and other personnel expenses: Services and supply expenses
- Various Overhead expenditures, if not already considered in the Oregon Department of Education's indirect rate

The agency's rates were established as of 04/01/2008 and are effective for services on or after that date. All rates are published on the Agency's website.

State developed fee schedule rates are the same for governmental and private providers of Tuberculosis Targeted Case Management services and the fee schedule and any annual/periodic adjustments to the fee schedule.

Payment for case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose**.**

The fee schedule developed for Tuberculosis Targeted Case Management is designed for specific tasks related exclusively to case management functions for this target group. The fee schedule is constructed by using the market value of the individual's time (the Bureau of Labor Statistics wage level) augmented by a margin for Program Related expenditures (supervisory staff, transportation, program supplies etc.), Employment Related expenditures (mandated and other benefits), and General and Administrative (Indirect). The assumptions from which the fees are developed are expressed in the service standards, and the fees are predicated on fifteen minute increments.

The program intends to establish and maintain a maximum number of fifteen minute increments which can be performed and billed for any single day. This maximum will be twenty four units (24 fifteen minute increments) in any given calendar day (midnight to midnight) which corresponds to an assumption that no more than six hours would ever be provided for the same client, by the same case manager in any twenty four hour calendar day.

The program will be utilizing an authorization methodology to monitor and control for this utilization limit.

young Children

Payment for Medicaid eligible individuals in the target group will be based on 15 minute units of service with a maximum of sixteen (16) units per month. Billing providers will document the scope, frequency and duration of services;

Rates will be developed using a market based payment methodology utilizing statewide usual and customary data for case management services currently in effect prior to the implementation date of this amendment. The rates utilized are the same for private and governmental providers. Rates are reviewed at least every two (2) years for approved cost of living adjustments authorized by the Oregon Legislative. Fee schedule was last updated 1/1/09 and are effective for services on or after that date.

Statewide fee schedule rates and any annual/periodic adjustments to those rates will be published on the Department's website.

All services will be documented as required by Oregon Administrative Rule and/or Department procedure. Providers of targeted case management services will submit a CMS 1500 form to the Department's Medicaid Management Information System (MMIS) detailing the encounter as follows:

Date of Service
Name of Individual
Performing Provider Information
Procedure Code
Units of Service
Place of Service
U&C Charge

Payment Methodology for Tribal Targeted Case Management

"Unit" is defined as a month. A unit consists of at least one documented contact with the individual (or other person acting on behalf of the individual) and any number of documented contacts with other individuals or agencies identified through the case planning process.

Payment for tribal targeted case management will be made using an estimated monthly rate based on the total average monthly cost per client served by the provider during the last fiscal year for which audited financial statements have been filed with the Department. The costs used to derive the monthly tribal targeted case management rate will be limited to the identified costs divided by the number of clients served. Tribal targeted case management costs, direct and related indirect costs that are paid by other Federal or State programs must be removed from the cost pool. The cost pool must be updated, at a minimum, on an annual basis using a provider cost report. The rate is established on a prospective basis. In the first year, the rate will be based on estimates of cost and the number of clients served. For subsequent years, the rate will be based on actual case management costs from the previous year. A cost report must be submitted to the Department at the end of each state fiscal year (at a minimum), and will be used to establish a new rate for the following fiscal year.

"Unit" is defined as one encounter per visit. A unit consists of at least one documented contact with the individual (or other person acting on behalf of the individual) and any number of documented contacts with other individuals or agencies identified through the case planning process. Case management providers are paid on a unit-of-service basis that does not exceed 1 unit (encounter) per day.

The rate for reimbursement of the case management services is computed as follows:

Compute the	Total Annual Medicaid Encounters
Compute the	Total Annual Program Expenditures
Divide	Calculate Average Cost Per Encounter
Examine	Extreme values, develop "reasonable range"
Equals	AVERAGE COST PER ENCOUNTER

The total annual expenditures of providing targeted case management includes:

- Targeted case management staff salary and other personnel expenses;
- Supervisory salary and other personnel expenses;
- Administrative support salary and other personnel expenses;
- Services and supply expenses; and
- Expenses (General government service charges, worker's comp, property insurance, etc).

The Agency's rates are statewide rates, both public and private provider receive the same rate. The rates are set as of 7/1/2010 and are effective for services on or after that date. All rates are published on the Agency's website at http://www.dhs.state.or.us/policy/healthplan/guides/tcmngmt/main.html. Annual expenditures and rates will be reviewed no less than every two years.

Payment Methodology for Targeted Case Management for Persons with Developmental Disabilities Comp waiver services.

Oregon will pay for qualifying targeted case management activities on a per-contact-per-day

methodology. Oregon will limit payment to one targeted case management contact per individual per day. If two distinct, qualifying targeted case management contacts are provided to a single individual in a single day, Oregon will only pay for one targeted case management contact for that individual.

The agency's state-wide rates were set as of (07/01/2009) and are effective for services on or after that date. All rates are published on the agency's website. The fee schedule and any annual/periodic adjustments to the fee schedule are published on the departments website at http://www.oregon.gov/DHS/spd/provtools/.

The targeted case management rate is derived using the following formula:
Total cost to Seniors and People with Disabilities (SPD) Division to provide targeted case management divided by projected biennial case management contacts.

The total cost to SPD of providing targeted case management includes:

- Targeted case management staff salary and other personnel expenses;
- Supervisory salary and other personnel expenses in support of TCM services; and
- Indirect expenses (General government service charges, worker's comp, property insurance, etc).

The sum of these expenses is then multiplied by 95%.

SPD will monitor targeted case management utilization to ensure services are being administered economically and efficiently. Adjustments to the targeted case management rate may be made periodically during the biennium if targeted case management contacts are materially different from beginning-of-biennium projections.

New targeted case management contact rates will be established at the beginning of each state biennium period using this same methodology.

Payment Methodology for Targeted Case Management for Persons with Developmental Disabilities Accessing Support Services

Oregon will pay for qualifying case management contacts on a per-contact-per-day methodology. Oregon will limit payment to one targeted case management contact per individual per day. If more than one qualifying targeted case management contacts are provided to a single

individual in a single day, Oregon will only pay for the first targeted case management contact for that individual.

Payment for targeted case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

Payment for targeted case management services under the Self-Directed Support Services waiver are made only for participants of the Self-directed Support Services 1915(c) waiver program (#0375). A system edit confirms the participant's enrollment in the Support Services waiver and that a support services brokerage is designated as the provider of the targeted case management service. This system edit prevents targeted case management payments from being made under both the Comprehensive Services waiver and Self-Directed Support Services waiver.

The agency's state-wide rates were set as of 7/01/2009 and are effective for services on or after that date. The fee schedule and any annual/periodic adjustments to the fee schedule are published on the department's website under "Reports and Other Documents" at: http://www.oregon.gov/DHS/spd/provtools/.

Targeted Case Management for persons with Developmental Disabilities accessing support services is only provided by private entities.

The targeted case management cost-based rate is derived using the following formula:
Total cost to Seniors and People with Disabilities (SPD) to provide targeted case management divided by projected biennial case management contacts.

The total cost to SPD of providing case management includes:

- Targeted case management staff salary and other personnel expenses;
- Supervisory salary and other personnel expenses in support of TCM services; and
- Indirect expenses (General government service charges, worker's comp, property insurance, etc).

The sum of these expenses is then multiplied by 95%.

SPD will monitor targeted case management utilization to ensure services are being administered economically and efficiently. Adjustments to the targeted case management rate may be made periodically during the biennium if targeted case management contacts are materially different from beginning-of-biennium projections.
New targeted case management contact rates will be established at the beginning of each state biennium period using this same methodology.

Payment Methodology for Targeted Case Management

Rate Determination: The monthly rate for case management services for parents is based on the total average monthly cost per client served by the provider. The monthly rate will be limited to

the provider's direct service and administrative costs associated with case management service delivery.

The rate is computed by taking the provider's monthly case management cost divided by the monthly number of clients that are provided case management services.

The rate is established on a prospective basis. In the first year, the rate will be based on estimates of cost and the number of clients to be served. For subsequent years, the rate will be based on actual case management costs for previous years. A cost statement will be completed at the end of each state fiscal year once the actual costs incurred have been determined.

Payment Methodology: Payment will be made through MMIS. The provider will bill at the full monthly rate for each client provided case management services during that month. The client is considered to have been provided some case management services if there has been an encounter between a case manager and the client during that month. Each encounter will be documented to support the billing.

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, except for clinical laboratory. The interim payment for clinical laboratory is the lesser of billed charges or the OMAP fee schedule. A cost settlement based on the most recent finalized Medicare cost

report is then applied to Medicaid covered charges billed and paid for the cost reporting year. 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, except for clinical laboratory . The interim reimbursement for clinical laboratory is the lesser of billed charges or the OMAP fee schedule. A cost settlement based on the most recent finalized Medicare cost report is then applied to Medicaid covered charges billed and paid for the cost reporting year. The final reimbursement for each DRG hospital is then calculated by applying an administratively established percentage to the costs. This calculation results in these hospitals receiving less than 100% of costs.

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 OMAP fee schedule. There is no cost settlement.

Effective December 1, 2002, in state fiscal years the Department of Administrative Services, will determine the aggregate reduction or increase required to meet the projected budget. The adjustment percentage will be determined by dividing the aggregate reduction or increase by the current outpatient hospital budget resulting in an adjustment percentage. The current percentage will then be multiplied by the adjustment percentage to determine the net percentage. This net percentage will be applied to each hospital's current reimbursement percentage to determine the new reimbursement percentage for the out-of-state hospitals. The Department, in accordance with 42 CFR 447.205, will make public notice of changes whenever a reimbursement adjustment is made under the provision of the section.

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

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 state fiscal year thereafter

On and after January 1, 2005 the outpatient proportionate share will be calculated using the Medicare aggregate upper payment limit and the Medicaid Cost Settlement. Payments made during the state fiscal year will not exceed the Medicare aggregate upper payment limit calculated from January 1, 2005 through September 30, 2005 and annually for each state fiscal year thereafter.

FQHC and RHC

A. Reimbursement for FQHC

For dates of service on or after January 1, 2001, payment for FQHC services will conform to section 702 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act (BIPA) included in the Consolidated Appropriations Act of 2000, Public Law 106-554.

This payment is set prospectively using the total of the center’s reasonable costs for the center’s fiscal years 1999 and 2000, adjusted for any increase or decrease in the scope of

services furnished during the center's fiscal year 2001. These costs are divided by the total number of visits for the two-year period to arrive at a cost per visit. The cost per visit is the prospective rate for calendar year 2001. Beginning in the center's fiscal year 2002, and for each fiscal year thereafter, each center is paid the amount (on a per visit basis) equal to the amount paid in the previous center's fiscal year, increased by the percentage increase in the Medicare Economic Index (MEI) for primary care services, and adjusted for any increase or decrease in the scope of services furnished by the center during that fiscal year. The center is responsible for supplying the needed documentation to the State regarding increases or decreases in the center's scope of services. The per visit payment rate shall include costs of all Medicaid covered services.

Until the State transitions to the prospective payment system on October 1, 2001, the State will reimburse FQHCs based on the provisions contained in the State Plan as of December 31, 2000. Once the prospective payment system is in place, the State will retroactively cost settle FQHCs to the effective date of January 1, 2001, according to the BIPA 2000 requirements.

In the case of any FQHC that contracts with a managed care organization, supplemental payments will be made no less frequently than every 4 months to the center for the difference between the payment amounts paid by the managed care organization and the amount to which the center is entitled under the prospective payment system.

For newly qualified FQHCs after the center's fiscal year 2000, initial payments are established based on payments to the nearest center with a similar caseload, or in the absence of such center, by cost reporting methods. After the initial year, payment is set using the MEI methods used for other centers and adjustment for any increase/decrease in the scope of services furnished by the center during that fiscal year.

B. Reimbursement for RHC

For dates of service on or after January 1, 2001, payment for Rural Health Clinic services will conform to section 702 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act (BIPA) included in the Consolidated Appropriations Act of 2000, Public Law 106-554 .

This payment is set prospectively using the total of the clinic's reasonable costs for the clinic's fiscal years 1999 and 2000, adjusted for any increase or decrease in the scope of services furnished during the clinic's fiscal year 2001. These costs are divided by the

total number of visits for the two-year period to arrive at a cost per visit. The cost per visit is the prospective rate for calendar year 2001. Beginning in the clinic's fiscal year 2002, and for each fiscal year thereafter, each clinic is paid the amount (on a per visit basis) equal to the amount paid in the previous clinic's fiscal year, increased by the percentage increase in the Medicare Economic Index (MEI) for primary care services, and adjusted for any increase or decrease in the scope of services furnished by the clinic during that fiscal year. The clinic is responsible for supplying the needed documentation to the State regarding increases or decreases in the clinic's scope of services. The per visit payment rate shall include costs of all Medicaid covered services.

Until the State transitions to the prospective payment system on October 1, 2001, the State will reimburse RHCs based on the provisions contained in the State Plan as of December 31, 2000. Once the prospective payment system is in place, the State will retroactively cost settle RHCs to the effective date of January 1, 2001, according to the BIPA 2000 requirements.

In the case of any RHC that contracts with a managed care organization, supplemental payments will be made no less frequently than every 4 months to the clinic for the difference between the payment amounts paid by the managed care organization and the amount to which the clinic is entitled under the prospective payment system.

For newly qualified RHCs after the clinic's fiscal year 2000, initial payments are established based on payments to the nearest clinic with a similar caseload, or in the absence of such clinic, by cost reporting methods. After the initial year, payment is set using the MEI methods used for other clinics and adjustment for any increase/decrease in the scope of services furnished by the clinic during that fiscal year.

Independent Rural Health Clinic (RHC) Alternate Payment Methodology (APM) for Obstetrics (OB) Care Delivery Procedures

(1) A Medicare certified independent RHC, as defined below, may be eligible for an obstetrics (OB) alternate payment methodology (APM) encounter rate for delivery procedures. The OB APM delivery encounter rate includes additional OB delivery-related costs incurred by a clinic as a cost-based payment in addition to the Prospective Payment System (PPS) medical encounter rate. The intent of the OB APM is to maintain access to OB care, including delivery services, in frontier and remote rural areas and to compensate eligible clinics for professional costs uniquely associated with OB care, not to exceed 100% of reasonable cost.

(1) To be eligible for the OB APM delivery encounter rate, a Medicare certified independent RHC must meet all Office of Medical Assistance Programs (OMAP) requirements applicable to an RHC, qualify as either "frontier" or "remote rural" as defined in (a) and (b) below, be located in a service area with unmet medical need defined in (c) below, and must request to participate in writing pursuant to participation requirements specified in (3) and (5) below.

(a) Frontier RHC is defined as located in a frontier county as designated by the Oregon Office of Rural Health;

(b) Remote rural RHC is defined as located in a remote rural service area as designated by the Oregon Office of Rural Health;

(c) A frontier or remote rural RHC must be located in a service area of unmet medical need as determined by the Oregon Office of Rural Health for the year in which the written request for OB APM was made.

(2) If the frontier or remote rural RHC qualifies under (2) and other requirements outlined by OMAP, the clinic must submit a written request to OMAP including all required documentation necessary to qualify for the OB APM delivery encounter rate in (5) below.

(3) Care status changes:

(a) OMAP reserves the right to request periodic review of utilization, cost reporting and to re-evaluate OB care access including delivery services in a community to determine the continued need to pay an OB APM delivery encounter rate for frontier and remote rural RHCs;

(b) Prior to making any changes in the RHC's status and rates, OMAP will re-evaluate the following:

(i) If OB care access including delivery services in a community has changed;

(ii) If the RHC no longer meets the requirements for the OB APM:

(A) An RHC's agreement with the Secretary of Health and Human Services, Center for Medicare and Medicaid Services is terminated, or

(B) The location of an RHC does not qualify as an unmet medical need service area as determined by the Oregon Office of Rural Health for five consecutive years;

(iii) The stability of new providers supplying additional OB care access including delivery services.

(4) Determining OB APM Delivery Encounter Rate: The frontier or remote rural RHC requesting an OB APM delivery encounter rate, and meeting the OMAP requirements, will have an OB APM delivery encounter rate which is the sum of a clinic's PPS medical encounter rate and an OB cost-based payment. The OB payment is calculated from costs uniquely associated with OB delivery services and which were not used in the calculation of a clinic's PPS medical encounter rate as outlined in the state plan.

(a) Qualification of the OB APM delivery encounter rate is not considered a change of scope.

(b) The Medicare Economic Index (MEI) adjustment, as required by the PPS, will apply to the OB APM delivery encounter rate once established.

(c) OMAP will use the information listed below to determine the eligible RHC's initial OB payment. With the written request for an OB APM delivery encounter rate, both an existing and new clinic must provide:

(i) Total number of delivery encounters;

(ii) Malpractice premiums for all physicians and certified nurses performing OB deliveries for the current and next year; and

(iii) On-call time coverage.

(d) Delivery encounters include vaginal and cesarean delivery professional services provided by the RHC.

(i) Clinics performing deliveries prior to written request for an OB APM delivery encounter rate must provide the most recent full year of claims data for deliveries; and

(ii) Clinics that have not previously provided delivery services must provide a reasonable projection of delivery encounters for the forecasted year.

(iii) Clinics with actual or projected delivery encounters less than 100, will have their OB payment calculated using a base number of 100 OB delivery encounters.

(e) OMAP will calculate an additional projected cost of malpractice (liability) premiums to be included in the OB cost-based payment, outside of costs included and which have already been accounted for in the PPS medical encounter rate, as follows:

(i) For both an existing and new clinic, OMAP will calculate malpractice premiums that are based on the average costs for the current and next year based on the date the clinic applies for the OB APM delivery encounter rate, as projected by the RHC's malpractice carrier. Costs are the premiums the clinic or individual actually pays, accounting for any reductions or credits.

(ii) For existing clinics, OMAP will determine the malpractice premiums reported for physicians and certified nurses performing OB deliveries when the RHC initially enrolled with OMAP and the PPS medical encounter rate was calculated. Premium amounts used in the initial PPS medical encounter rate calculation will be adjusted by the MEI for each subsequent year of enrollment, up to the year of written request for an OB APM delivery encounter rate. The premium(s) adjusted by MEI is an amount included in the current PPS medical encounter rate.

(iii) For new clinics, OMAP will determine the actual malpractice premiums for OB physicians and certified nurses performing OB deliveries for the current year.

(iv) OMAP will subtract the premiums calculated in either (ii) or (iii) above, and accounted for in the calculation of the clinic's PPS medical encounter rate, from the average cost of OB malpractice premiums in (i) above, to calculate the projected portion of OB malpractice premiums to be included in calculating the OB payment.

(f) OMAP will calculate the cost of physician on-call time for OB care by multiplying a clinic's adjusted OB on-call hours of coverage by the fixed rate of $20.00 per hour. A clinic's adjusted OB on-call coverage hours will be calculated as follows:

(i) Reducing total clinic coverage hours per year by the clinic daily office hours, and

(ii) Reduced by physician vacation hours, and

(iii) Calculated at 60 percent of adjusted on-call time.

(g) The OB payment will be the sum of the difference of averaged malpractice premiums and current actual premiums (e), and the cost of on-call coverage (f), divided by the total number of OB care delivery encounters (d).

(h) The OB APM delivery encounter rate is the sum of the OB payment (g) and the PPS medical encounter rate.

(5) Rural Health Clinics providing managed care services are provided a supplemental payment by the state so that total payments to an RHC are at full cost as required by federal statute. The state payment reconciliation process for such supplemental payments occurs as follows:

(a) RHC bills managed care organization (MCO) for costs;

(b) MCO pays RHC the rate paid to any other provider for like services;

(c) RHC submits claims data to OMAP;

(d) OMAP matches RHC claims data with MCO encounter data;

(e) OMAP pays the difference up to the OMAP established PPS or APM delivery encounter rate if the amount received from the MCO is less, to ensure RHC is paid 100% of reasonable costs.

Nurse Practitioner Services

Payment will be based upon a state-wide fee schedule.

STATE OF OREGON

Certified Psychiatric Facility Services (Non-Hospital)

This section applies to non-hospital child/adolescent residential psychiatric facilities providing inpatient psychiatric treatment services for individuals under age 21. The facilities are accredited by one of the following:

the Joint Commission on Accreditation of Healthcare Organizations;
the Council on Accreditation of Services for Families and Children;
the Commission on Accreditation of Rehabilitation Facilities; or
any other accrediting organization, with comparable standards, that is recognized by the State.

The facilities provide services under the terms of a written agreement with the Mental Health and Developmental Disability Services Division (the Division). The Division pays for such services on the basis of a prospective daily rate schedule determined by the State to represent 100% of the reasonable costs of economically and efficiently operated facilities, consistent with quality of care. Providers must submit billings that are based upon allowable costs as set forth in Office of Management and Budget Circular A-122, "Cost Principles for Non-Profit Organizations". In no case may billings exceed the prevailing charges in the locality for comparable services under comparable circumstances.

RATE SETTING

To establish maximum billing rates, the Division periodically renews a per diem rate schedule that represents 100% of the reasonable costs of economically and efficiently operated facilities providing services in conformity with applicable state and federal laws, regulations, and quality and safety standards. The rates are adequate to assure reasonable access to necessary psychiatric treatment services, taking into account geographic location, type of child/adolescent served and reasonable travel time.

AUDITING

The Division will periodically review the financial records of each participating child/adolescent residential psychiatric facility, allowing reasonable notification time to the facility.

The Division will subject patient utilization of child/adolescent residential psychiatric facilities to periodic professional review to determine appropriateness. If review of a Medicaid patient's records reveals that a patient has received an inappropriate level of care, i.e., less than active treatment, the Division will not allow payment.

Enhanced Teaching Physician and Other Practitioners Fee-For-Service Reimbursement:

Effective April 1, 2005, physician services and other practitioner services provided by physicians and other practitioners affiliated with a public academic medical center that meets the following eligibility standards shall be eligible for a supplemental teaching physician and other practitioners payment for services provided to eligible recipients and paid for directly on a fee-for-service basis. Other practitioners include Clinical Psychologists and Psychiatrists, Dentists, Optometrists, Physician Assistants, Nurse Practitioners and Registered Nurses, Physical Therapists, and Occupational Therapists. Payment shall be equal to the difference between the physicians' and other practitioners' Medicare allowable for such services and Medicaid reimbursement received.

(1) The hospital must be located within the State of Oregon (border hospitals are excluded); and

(2) The hospital provides a major medical teaching program, defined as a hospital with more than 200 residents or interns.

Payments shall be at least annually during each federal fiscal year, based on the annual difference between physicians' and other practitioners' Medicare allowable and Medicaid allowable by eligible physicians and other practitioners for the most recently completed state fiscal year. Services included are physician and other practitioners' services with RVU weights and physician injectible drugs.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State /Territory: OREGON

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
OTHER TYPES OF CARE

Payment of Medicare Part A and Part B Deductible/Coinsurance

Except for a nominal recipient copayment (as specified in Attachment 4.18 of this State plan), if applicable, the Medicaid agency uses the following general method for payment:

1. Payments are limited to State plan rates and payment methodologies for the groups and payments listed below and designated with the letters "SP".

   For specific Medicare services which are not otherwise covered by this State plan, the Medicaid agency uses Medicare payment rates unless a special rate or method is set out on Page 3 in item A of this attachment (see 3. below).

2. Payments are up to the full amount of the Medicare rate for the groups and payments listed below, and designated with the letters.

3. Payments are up to the amount of a special rate, or according to a special method, described on Page 3 in item ___ of this attachment, for those groups and payments listed below and designated with the letters "NR".

4. Any exceptions to the general methods used for a particular group or payment are specified an Page 3 in item ___ of this attachment (see 3. above).

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State /Territory: OREGON

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - OTHER TYPES OF CARE

Payment of Medicare Part A and Part B Deductible/Coinsurance

QMBs:	Part A	SP	Deductibles SP	Coinsurance
	Part B	SP	Deductibles SP	Coinsurance
Other Medicaid Recipients	Part A	SP	Deductibles SP	Coinsurance
	Part B	SP	Deductibles SP	Coinsurance
Dual Eligible (QMB Plus)	Part A	SP	Deductibles SP	Coinsurance
	Part B	SP	Deductibles SP	Coinsurance

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State /Territory: OREGON

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - OTHER TYPES OF CARE

Payment of Medicare Part A and Part B Deductible/Coinsurance

A. Payment for coinsurance and deductibles for Medicare non-institutional services not covered by Medicaid will be at 51% of Medicare's rate for the service.

STATE OF OREGON

1. (Reserved for future use)

"Pen & Ink" change

STATE OF OREGON

1. (Reserved for future use)

"Pen & Ink" change

II. The following limitations apply to residents in intermediate care facilities for the mentally retarded or persons with related conditions:

A. The Division may make a reserved bed payment for those residents whose Plan of Care provides for home visits and/or development of community living skills. Reserved bed payments may be made for temporary absence due to hospitalization. The MR/DD Specialist must be notified in writing of any resident's absence from the facility.

B. Prior to the resident's departure for leave to exceed 14 consecutive days, the facility must submit a written request to the MR/DD Specialist for authorization of reserved bed payments. In case of emergency, notification should be made as soon as possible; but in any event not later than the working day following the resident's departure.

1. Absences of less than 14 days do not require prior authorization, but the Division reserves the right to decline payment, if appropriate.

2. The MR/DD Specialist must notify the Division's Chief, MR/DD Medicaid Services, of any temporary absence in excess of 30 consecutive days. Prior authorization of such absences requires the signature of both the MR/DD Specialist and the Chief, MR/DD Medicaid Services.

C. The MR/DD Specialist shall notify the local AFS branch office in writing of any reserved bed denials. Reserved bed payments will not be made for a resident who does not return to the facility on or before expiration of any temporary or prior authorized absence unless the facility terminated the leave of absence and discharged the resident immediately upon learning the resident would not return to the facility.

D. Reserved bed payments shall be limited to 14 days in any 30-day period, except for those absences prior authorized by the MR/DD Specialist.

E. Failure of the facility to comply with the provisions of this rule shall relieve the Division and the Title XIX resident of all responsibility to make payment to the facility during the resident's absence. The provisions of this section are separate and apart from OAR 309-41-043.

F. Residents temporarily absent overnight or longer from the facility on activities under the supervision of and/or at the expense of the facility shall be considered as

remaining in the facility. This includes special trips of an educational or training nature, and recreational activities such as camping, fishing, hiking, etc.

G. If respite care is provided in a reserved bed, Title XIX billing shall be reduced by the amount of money received for this service. The AFS-483 billing form must indicate the name of the person receiving respite care and show a credit for the amount of money received for that care.

NURSING FACILITIES

Reimbursement for services provided by Nursing Facilities is made by means of rates determined in accordance with the following principles, methods, and standards which comply with 42 CFR Part 447, Subpart C.

I. Reimbursement Principles.

The payment methodology is based on the following:

A. Reimbursement by the Senior and People with Disabilities Division of the Department of Human Services is based on a prospective, all-inclusive rate system which constitutes payment in full for services which are not reimbursed through another Medicaid payment source. The rates established for these long-term care services include reimbursement for services, supplies, and facility equipment required for care by state and federal standards. Costs which are or can be reimbursed by Medicare Part B or a third party payor are not allowed;

B. A standard, statewide flat rate which bears a fixed relationship to reported allowable costs;

C. A complex medical needs add-on rate which bears a fixed relationship to the standard flat rate;

D. A pediatric rate for Medicaid residents under the age of 21 who are served in a pediatric facility or a self-contained pediatric unit; and

E. Annual review and analysis of allowable costs for all participating nursing facilities. Allowable costs are the necessary costs incurred for the customary and normal operation of a facility, to the extent that they are reasonable and related to resident care.

F. All Nursing Facility Financial Statements are subject to desk review and analysis to determine that the provider has included its costs in accordance with Generally Accepted Accounting Principles and the provisions of the Oregon Administrative Rules.

II. Nursing Facility Rates.

A. The Basic Rate.

1. The Division shall pay the basic rate to a provider as prospective payment in full for a Medicaid resident in a nursing facility.

2. "Basic rate" means the standard, statewide payment for all long term care services provided to a resident of a nursing facility except for services reimbursed through another Medicaid payment source.

3. The basic rate is an all-inclusive rate constituting payment in full, unless the resident qualifies for the complex medical needs add-on rate (in addition to the basic rate) or the all-inclusive pediatric rate (instead of the basic rate). The methodology for calculating the basic rate is described in Section III.

B. The Complex Medical Needs Add-on Rate.

1. If a Medicaid resident of a nursing facility qualifies for payment at the basic rate and if the client's condition or care needs are determined to meet one or more of the medication procedures, treatment procedures or rehabilitation services described in paragraph 2 of this subsection, the Division may pay the basic rate plus the complex medical add-on rate for the additional licensed nursing services needed to meet the client's increased need to a provider as prospective payment in full.

2. "Complex Medical Needs Add-on Rate" means the standard, statewide supplemental payment for a Medicaid client of a nursing facility whose care is reimbursed at the basic rate if the client needs one or more of the following medication procedures, treatment procedures or rehabilitation services for the additional licensed nursing services needed to meet the client's increased needs.

a. Medication Procedures

(1) Administration of medication(s) at least daily requiring skilled observation and judgment for necessity, dosage and effect for example new anticoagulants, etc**.** (This category does not include routine medications, any oral medications or the infrequent adjustments of ~~a~~ current medication**s)**;

(2) Intravenous injections/infusions, heparin locks used daily or continuously for hydration or medication;

(3) Intramuscular medications for unstable condition used at least daily;

(4) External infusion pumps used at least daily. This does not include external infusion pumps when the client is able to self bolus;

(5) Hypodermoclysis daily or continuous use;

(6) Peritoneal dialysis, daily. This does not include clients who can do their own exchanges;

b. Treatment Procedures

(1) Nasogastric,Gastrostomy or Jejunostomy tubes used daily for feedings;

(2) Nasopharyngeal suctioning twice a day or more. Tracheal suctioning as required for a client who is dependent on nursing staff to maintain airway;

(3) Percussion, postural drainage, and aerosol treatment when all three are performed twice per day or more often;

(4) Care and services for a ventilator dependent client who is dependent on nursing staff for initiation, monitoring, and maintenance;

(5) Is limited to Stage III or IV pressure ulcers which require aggressive treatment and are expected to resolve. The Pressure Ulcer is eligible for add-on until the last day the ulcer is visibly a Stage III pressure ulcer;

(6) Open wound(s) as defined by dehisced surgical wounds or surgical wounds not closed primarily, which require aggressive treatment and are expected to resolve;

(7) Deep or infected stasis ulcers with tissue destruction equivalent to at least a Stage III. Eligible for add-on until the last day the ulcer is equivalent to a Stage III. If the stasis ulcer is chronic, it is eligible for add-on only until it returns to previous chronic status.

(8) Unstable Insulin Dependent Diabetes Mellitus (IDDM) in a client who requires sliding scale insulin; and

(i) Exhibits signs/symptoms of hypoglycemia and/or hyperglycemia; and

(ii) Requires nursing or medical interventions such as extra feeding, glucagon or additional insulin, transfer to emergency room; and

(iii) Is having insulin dosage adjustments.

While all three criteria do not need to be present on a daily basis, the client must be considered unstable. A Client with erratic blood sugars, without a need for further interventions, does not meet this criteria.

(9) Professional teaching. Short term, daily teaching pursuant to discharge or self-care plan;

(10) Emergent medical/surgical problems requiring short term licensed nursing observation and~~/or~~ assessment. This criteria requires pre-authorization from the Division's Complex Medical Add-On Coordinator. Eligibility for add-on will be until the client no longer requires additional licensed nursing observation and assessment for this medical/surgical problem); or

(11) Emergent behavior problems which involve a sudden, generally unexpected change or escalation in behavior of a client that poses a serious threat to the safety of self or others and requires immediate intervention, consultation and care planning. This criteria requires pre-authorization from the Division's Complex Medical Add-On Coordinator. Eligibility for add-on will be until the client no longer requires additional licensed nursing observation and assessment for this medical problem);

c. Rehabilitation Services. Utilization of rehabilitation services in the frequencies specified below are used only to determine qualification for payment of the "complex Medical Needs Add-On Rate". No separate reimbursement will be made for these services outside the approved State Plan.

(1) Physical therapy performed at least 5 days every week;

(2) Speech therapy performed at least 5 days every week;

(3) Occupational therapy performed at least 5 days every week;

(4) Any combination of physical therapy, occupational therapy and speech therapy performed at least 5 days every week; or

(5) Respiratory Therapy at least 5 days every week by a respiratory therapist. These services must be authorized by Medicare, Medicaid Oregon Health Plan or a third party payor.

3. The basic rate plus the complex medical needs add-on rate is the all-inclusive rate constituting payment in full for a Medicaid resident of a nursing facility who qualifies for a supplemental payment for complex medical care in addition to the basic rate. The methodology for calculating the basic rate is described in Section III.

C. Pediatric Rate.

1. Notwithstanding subsections A and B, if a Medicaid resident under the age of 21 is served in a "pediatric nursing facility" or a "self-contained pediatric unit", as those terms are defined in Section III.C. the Division shall pay the pediatric rate stated in Section III.C.2. as prospective payment in full.

2. "Pediatric rate" means the standard, statewide payment for all long term care services provided to a Medicaid resident under the age 21 who is a resident of a pediatric nursing facility or a self-contained pediatric unit except for services reimbursed through another Title XIX payment source.

3. The pediatric rate is the all-inclusive rate constituting payment in full for a Medicaid resident under the age of 21 who is a resident of a pediatric nursing facility or a self-contained pediatric unit. The methodology for calculating the pediatric rate is described in Section III.

D. Other Payments.

1. Medicare. The Division shall pay the coinsurance rate established under Medicare, Part A, Hospital Care for care rendered to an eligible client from the 21st through the 100th day of care in a Medicare certified nursing facility.

2. Swing Bed Eligibility. To be eligible to receive a Medicaid payment under this rule, a hospital must:

(a) Have approval from the Centers for Medicare and Medicaid Services (CMS) to furnish skilled nursing facility services as a Medicare swing-bed hospital;

(b) Have a Medicare provider agreement for acute care; and

(c) Have a current signed provider agreement with the Seniors and People with Disabilities Division to receive Medicaid payment for swing-bed services.

(1) NUMBER OF BEDS:

(a) A Critical Access Hospital (CAH) that is not located within a 30 mile geographic radius of a licensed nursing facility as of March 13, 2007 may provide swing bed services to up to 20 Medicaid residents at one time. The CAH must maintain at least five beds or twice the average acute care daily census, whichever is greater, for exclusive acute care use;

(b) Other hospitals providing swing bed services under this rule may not receive provide such services to more than five Medicaid residents at one time. In addition, the residents must have a documented need for and receive services that meet the complex medical add-on requirements outlined in OAR 411-070 as of July 1, 2009, This OAR contains relevant details of the States's NF reimbursement methodology and as such is adhered to by the State;

(c) If circumstances change so that a CAH receiving payment for Medicaid services pursuant to section (2)(b) of this rule meets the criteria set out in section (2)(a) of this rule after March 13, 2007, the CAH may petition the Division for authorization to receive such payment pursuant to section (2)(a) of this rule. The Division will evaluate all available long-term care resources within a 30 mile geographic radius of the CAH and the amount of unmet long-term care need in the same area and determine if the CAH will be authorized to receive payment pursuant to section (2)(a) of this rule.

(2) PAYMENT:

(a) Daily Rate. Medicaid payment for swing-beds will be equal to the rate paid to Oregon's Medicaid certified nursing facilities.

(b) Medicare Co-payment. Medicaid payment for Medicare co-insurance for Division clients will be made at a rate which is the difference, if any, between the Medicare partial payment and the facility Medicaid rate.

(3) ADMISSION OF CLIENTS. Prior to determination of Medicaid payment eligibility in the swing bed, the case manager must determine there is no nursing facility bed available to the client within a 30 mile geographic radius of the hospital. For the purpose of this rule, "available bed" means a bed in a nursing facility that is available to the client at the time the placement decision is made.

3. Out-of-State Rate. When an Oregon Medicaid resident is cared for temporarily in a nursing facility in a state contiguous to Oregon while an appropriate in-state care setting is being located, the Division shall pay the lesser of:

   a. The Medicaid rate for the resident's level of care established by the state in which the nursing facility is located; or

   b. The rate for which the resident would qualify in Oregon which is either the Basic Rate with a possible Complex Medical Needs Add-on payment or an Extreme Outlier Client Add-on payment, or the pediatric rate.
   c. In order to approve a temporary out-of-state rate, the Division must be furnished a written statement from the resident's physician that specifies an anticipated date of discharge or length of stay.

4. Outlier Client Add-On

   a. The Division may make an outlier client add-on payment when a client has a combination of extraordinary medical, behavioral and/or social needs and no satisfactory placement can be made within the established payment categories.

   b. The add-on will be specific to the client's care needs, based on an outlier care plan approved by the Division at the beginning of outlier care and at six month intervals thereafter, and the facility-specific direct care costs related to the client's outlier care plan.

   c. The outlier add-on will be calculated using the latest audited facility-specific unit price of the direct care component(s) whose

costs are increased due to the outlier care plan.

5. Nurse Aide Training and Competency Evaluation.

The administrative expenses incurred by nursing facilities for nurse aide training and competency evaluation will be reported on a quarterly basis, and the facility will be reimbursed the eligible portion of these costs. Payments made under this provision will be on a pass-through basis outside the approved reimbursement system.

6. Trustee.

When a trustee is appointed temporarily by the court to manage a facility for protection of the health and welfare of residents, costs related to the operation of the facility which are not covered by the facility's revenue sources, including regular Medicaid rates and the State's trust fund, will be reimbursed as administrative costs under Section 6.2 of the approved State Plan.

7. Certified Nursing Assistant (CNA) Staffing Standard.

a. The Division shall add to the basic rate and the pediatric rate a Certified Nursing Assistant staffing standard payment to work toward implementation of a new minimum CNA staffing standard of 2.46 hours per resident day (HPRD).

(1) Raise HPRD to 2.07 on March 1, 2008

(2) Raise HPRD to 2.31 on April 1, 2009

(3) Raise HPRD to 2.46 on July 1, 2009

b. The Division shall collect quarterly staffing updates from nursing facilities and monitor staffing compliance.

III. Financial Reporting, Facility Auditing, and the Calculation of the Standard Statewide Basic Rate and Complex Medical Needs Add-on Rate.

A. Financial Reporting and Facility Auditing.

1. Effective July 1, 1997, each facility files annually and for the period ending June 30 a Nursing Facility Financial Statement (Statement) reporting actual costs incurred during the facility's most recent fiscal reporting period. The Statement can be filed for a reporting period other than one year only when necessitated by a change of ownership or when directed by the Division.
2. Each Statement is subject to desk audit within six months after it has been properly completed and filed with the Division. The Division may conduct a field audit which, if performed, will normally be completed within one year of being properly completed and filed with the Division.

B. Calculation of the Standard Statewide Basic Rate and Complex Medical Needs Add-on Rate.

1. Basic Rate and Complex Medical Needs Add-on Rate.

a. Basic Rate. For the first year of each biennium (the Rebasing Year), the Basic Rate is based on the Statements received by the Division by September (or postmarked by October 31, if an extension of filing has been approved by the Division) for the fiscal reporting period ending on June 30 of the previous even-numbered year, e.g., for the biennium beginning July 1, 1999, Statements for the period ending June 30, 1998 are used. Statements for pediatric nursing facilities are not used to determine the Basic Rate. The Division desk reviews or field audits these Statements and determines for each nursing facility, its allowable costs less the costs of its self-contained pediatric unit, if any.

For each facility, its allowable costs, less the costs of its self-contained pediatric unit (if any) is inflated from the mid-point of its fiscal reporting period to the mid-point of the first year of the biennium, hereafter referred to as the Base Year (e.g., for the biennium beginning July 1, 1999, the Base Year is the fiscal period ending June 30, 2000) by projected changes in the DRI Index.

For each facility, its Allowable Costs Per Medicaid Day is determined using the allowable costs as inflated and resident days excluding days in a self-contained pediatric unit as reported in the Statement.

The Basic Rate for the second year (Non-Rebasing Year) of the biennium is the Basic Rate for the first year, inflated by the DRI Index.

c. Complex Medical Needs Add-on Rate. The Complex Medical Needs Add-on Rate is 40 percent of the Basic Rate.

2. For the 2009 rebasing period only, the Department will limit the administrative and property cost components as follows:

a. Administrative and General costs per facility, less provider tax and employee benefits, equals the lesser of the facility's allowable cost or the 50th percentile over all facilities; and
b. When the occupancy percentage is less than 60 percent, allowable property expenses will equal the lesser of the facility's allowable expenses multiplied by the Medicaid occupancy percentage.

3. For the period beginning July 1, 2003 through June 30, 2005, new Basic Rates are computed by arraying the allowable costs of all facilities appropriate to be included in the rebasing calculation, and setting the Rate at the 63rd percentile of allowable costs (both direct and indirect).
4. For the period beginning July 1, 2005 through June 30, 2007, the Rate is set at the 70th percentile of allowable costs (both direct and indirect).
5. For the period beginning July 1, 2007 through June 30, 2013, the Rate is set at the 63rd percentile of allowable costs (both direct and indirect).
6. The Basic Rate established in steps 3 and 5 above is inflated by the DRI Index in the second year (the Non-Rebasing Year).
7. Complex Medical Needs Add-on Rate. The Complex Medical Needs Add-on rate is 40 percent of the Basic Rate.

C. Pediatric Nursing Facilities.

1. Pediatric nursing facility means a licensed nursing facility, 50% of whose residents entered the facility before the age of 14 and all of whose residents are under the age of 21.

2. Pediatric nursing facilities will be paid a per diem rate of $188.87 commencing on August 1, 1999, which rate will:

a. Be prospective;
b. Not be subject to settlement; and
c. The per diem rate will be calculated as follows:

The per resident day total cost from the desk reviewed or the field audited cost report for all pediatric nursing facilities are summed and divided by the total pediatric resident days.

The base year will be 1998. Once the weighted average cost is determined, the rebase relationship percentage (90.18%), determined in the implementation of the flat rate system in 1997, is applied to set the new rate. Before computing the weighted average cost, the facility-specific total costs are inflated by a change in the DRI Index to bring the cost to the rebase year.

On July 1 of each non-rebase year after 1999, the pediatric rate will be increased by the annual change in the DRI Index, as measured in the previous 4th quarter. Beginning in 2001 rate setting will occur in alternate years. Rebasing of pediatric nursing facility rates will be calculated using the method described above.

3. Pediatric nursing facilities must comply with all requirements relating to timely submission of Nursing Facility Financial Statements.

D. Licensed Nursing Facility With a Self-Contained Pediatric Unit.

1. A nursing facility with a self-contained pediatric unit means a licensed nursing facility that cares for pediatric residents (residents under the age of 21) in a separate and distinct unit within or attached to the facility.

2. Nursing facilities with a self-contained pediatric unit will be paid in accordance with subsection C.2. of this section for pediatric residents cared for in the pediatric unit.

3. Nursing facilities with a self-contained pediatric unit must comply with all requirements related to timely submission of Nursing Facility Financial Statements and must file a separate attachment, on forms prescribed by the Division, related to the costs of the self-contained pediatric unit.

IV. Public Process

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

INTERMEDIATE CARE FACILITIES FOR MENTALLY RETARDED AND OTHER DEVELOPMENTALLY DISABLED PERSONS (ICFs/MR)

Reimbursement for services provided by Intermediate Care Facilities for the Mentally Retarded (ICFs/MR) for Medicaid recipients is made by the Mental Health and Developmental Disability Services Division (the Division). The Division determines rates in accordance with the following principles, methods, and standards which comply with 42 CFR 447.250 through 447.256.

I. Reimbursement Principles

The payment methodology for ICFS/MR is based on the following:

A. Development of model budgets which represent 100% of the reasonable costs of an economically and efficiently operated facility;

B. Annual review and analysis of allowable costs;

C. The use of interim rates (per diem) and retroactive year-end cost settlements, capped by a maximum allowable cost for each facility based on the type of facility and resident classification; and

D. The lower of allowable costs or maximum costs.

II. Classification of ICF/MR Facilities

Three classes of ICFs/MR have been established based on classification of residents, size of the facility, and staffing requirements.

A. "Small Residential Training Facility" (SRTF) means a Title XIX certified facility having fifteen or less beds and providing active treatment.

B. "Large Residential Training Facility" (LRTF) means a Title XIX certified facility having from 16 to 199 beds that provides active treatment. The LRTF model budget may be applicable to a SRTF which is constructed and programmed to serve residents who are not capable of self-preservation in emergency situations.

C. "Full Service Residential Training Facility" (FSRTF) means a facility having 200 or more certified ICF/MR beds providing the full range of active medical and day treatment services required in state and federal rules and regulations. The facility may be less than 200 beds if it meets all of the following criteria:

1. It is a certified ICF/MR and is licensed as a nursing home for the mentally retarded;

2. It serves a high percentage of clients who are non-ambulatory, medically fragile or in some other way seriously involved;

3. Its location is such that professionals with the knowledge of medical and dental needs of people with severe mental and physical handicaps are not generally available and must be hired as permanent staff;

4. It serves any and all clients referred by the Division.

III. Classification of Residents

The classification of each resident in an ICF/MR is determined by use of the Division's Resident Classification Instrument.

A. "Class A" includes any of the following:

1. Children under six years of age;

2. Severely and profoundly retarded residents;

3. Severely physically handicapped residents; and/or

4. Residents who are aggressive, assaultive or security risks, or manifest severely hyperactive or psychotic-like behavior.

B. "Class B" includes moderately mentally retarded residents requiring habilitative training.

C. "Class C" includes residents in vocational training programs or sheltered employment. These training programs or work situations must be an integral part of the resident's active treatment program.

IV. Rate Setting - SRTFs and LRTFs

A. For each SRTF and LRTF, the Division develops an interim rate based upon the actual licensed capacity and staffing ratios

required under the administrative rules to serve the anticipated mix of class A, B, and C residents. See pages 7 through 10 of this portion of the State plan for examples of the model interim rate worksheets. Each interim rate is calculated as the lesser of the facility's model budget rate (1) or projected net per them cost (2).

1. The model budget represents 100% of reasonable per them costs of efficiently and economically operated facilities of that size.

   a. The model budget consists of two major cost categories: Base Costs and Labor Costs.

      i. Base Costs (e.g., rent, utilities, administration, general overhead) are based on amounts determined by the State to be reasonable in similar sizes and types of residential facilities. The model budget rate consists of a standard per diem rate per resident for each class of facility.

      ii. Labor Costs (e.g., for direct care, active treatment, and support staff) are broken into various components. The model budget cost-for each component is developed based on requirements in federal regulations, State regulations, the State's experience in State-operated ICFs/MR, and costs determined to be reasonable in similar facilities. Each component within the labor category has a model budget rate developed.

   b. The facility's model budget rate is adjusted by the most recently available resident occupancy information, but not lower than 95% of the facility's licensed bed capacity.

      i. The model budget rate at 100% occupancy is multiplied by the number of resident days at 100% occupancy to yield the ceiling amount in dollars.

      ii. The ceiling amount is divided by the greater of:

      The number of resident days projected for the facility for the upcoming fiscal period; or

      95% of the total possible resident days available for a facility of that licensed capacity for the fiscal period.

   c. Model budgets for SRTFs and LRTFs are reviewed annually and adjustments are made based on inflation, economic

trends or other evidence supporting rate changes, such as directives from the legislature or changes in program design.

d. Model budgets will be rebased as a result of desk or field audits of the providers' cost statements.

2. The projected net per diem cost is usually derived from the facility's latest ICF/MR Cost Statement, revised to include any adjustments applied to the per them reimbursement rate schedule for subsequent periods. Adjustments have historically fallen into four categories:

a. Corrections to depreciation;

b. Modifications of indirect cost allocations;

c. Unallowable costs; or

d. Offsets of expenses against income and donations as described in the administrative rules.

However, if requested by the facility and agreed to by the Division, the facility may substitute actual allowable costs gathered from at least three months of data more recent than the latest ICF/MR Cost Statement, revised to include any adjustments applied to the per them reimbursement rate schedule for subsequent periods.

a. The Division will consider recent data which is the equivalent of an interim cost report by the facility.

b. The Division will compare actual allowable costs derived from the recent data with the model budget rate and will assign a new interim rate based upon the lesser of the two.

3. The facility or the Division may request a per diem rate adjustment if a significant change in allowable costs can be substantiated.

4. The Division pays an interim rate to each SRTF and LRTF through the end of each fiscal year. The actual (final) payment, called the year-end settlement, is discussed in part B of this section.

In the year-end settlement, the Division takes into account the interim rate payments already made and compares those payments with the settlement rate.

B. For each SRTF and LRTF, the Division establishes a year-end settlement rate on a retrospective basis for the period covered by the respective cost statements and issues an official notice to each facility indicating the exact amount of the retroactive settlement. The settlement rate is calculated as the lower of the ceiling rate (1) or the actual net per them cost (2):

1. Ceiling rate: The facility's model budget rate will be revised, using the worksheets shown at pages 8 through 10 of this portion of the State plan, to reflect the actual number and classification of residents for the period. The product of the resulting revised rate at 100% occupancy and the number of resident days at 100% occupancy shall be the ceiling amount in dollars. The quotient of the ceiling amount and actual resident days in the period will be the ceiling rate subject to the following modifications:

   a. If the facility is occupied at 95% or more of its licensed bed capacity in the area designated for ICF/MR services, the quotient of the ceiling amount and actual resident days in the period shall be the ceiling rate.

   b. If the facility is occupied at less than 95% of its licensed bed capacity in the area designated for ICF/MR services, the quotient of the ceiling amount and product of 95% of the licensed bed capacity and the number of calendar days in the fiscal period shall be the ceiling rate.

2. Actual net per diem cost The quotient of actual allowable costs, as adjusted in accordance with this plan, and actual resident days for the period, shall be the actual net per diem cost.

3. The methodology for calculating the year-end settlement rate and amount for SRTFs and LRTFs is shown on pages 11 and 12 of this portion of the State plan.

V. Rate Setting - FSRTFs

A. For each FSRTF, the Division develops an interim rate based on the facility's projected costs. The facility or the Division may request a rate adjustment if the basis for the prospective rate has changed and a significant change in projected costs can be substantiated.

B. For each FSRTF, the Division develops a year-end settlement rate based upon actual costs.

VI. Costs and Services Billed

A. Reimbursement by the Division is based on an all-inclusive rate, which constitutes payment in full for ICF/MR services. The-rate established for an ICF/MR includes reimbursement for services, supplies, and facility equipment required for care by state and federal standards. Payment for costs outside of the all inclusive rate may be authorized in specific circumstances according to criteria established in Oregon Administrative Rules. These include: the circumstance of an individual admitted to or residing in a privately operated ICF/MR who needs diversion or crisis services in order to avoid admission to a state-operated ICF/MR; the circumstance of an individual not admitted to, but residing in, a privately operated ICF/MR who is occupying a vacant or reserved bed and needs diversion or crisis services; and the circumstance of costs incurred which are related to the approved plan for diversion or crisis services.

B. Billings to the Division shall in no case exceed the customary charges to private clients for any like item or service charged by the facility.

C. The Division may make a reserved bed payment for those residents whose Individual Program Plan provides for home visits and/or development of community living skills. Reserved bed payments may be made for temporary absences due to hospitalization or convalescence in a nursing facility. Reserved bed payments shall be limited to 14 days in any 30 day period unless prior authorized by the Division. Reimbursement will only be made to providers who accept Title XIX payment as payment in full.

VII. Cost Statements Audited

The Division shall audit each ICF/MR cost statement within six (6) months after it has been properly completed and filed with the Division. The audit will be performed either by desk review or field visit.

VIII. Provider Appeals

A letter will be sent notifying the provider of the interim per diem rate and/or the year-end settlement rate. Providers shall notify the Division in writing within 15 days of receipt of the letter, if the provider wishes to appeal the rate. Letters of approval must be postmarked within the 15 day limit.

EXAMPLE ONLY

Calculation of Interim Rate
July 1, 1991

Cost From Fiscal Year 1989-90 Audit Report	$96.69 (1)
July 1, 1990 Inflation Factor	1.04
	100.56
July 1, 1991 Inflation Factor	1.044
Projected Net Per Diem Cost	$104.98
Adjusted Model Budget Rate	$ 99.50
Lower Amount is New Interim Rate	$ 99.50

(1) Cost statement and desk review for FY 1990-91 not available at time of interim rate calculation.

INTERIM RATE
FOR JULY 1, 19

EXAMPLE ONLY

Category		Original Model Budget	Adjustments	Adjusted Model Budget
I	Base Costs	$0.00	$0.00	$0.00
II	Administration			
A.	Administrator	0.00		0.00
B.	Assistant Administrator	0.00		0.00
C.	Other Administration	0.00		0.00
	Sub-Total	0.00	0.00	0.00
III	Active Treatment			
A.	Psychology	0.00		0.00
B.	Social Work	0.00		0.00
C.	Speech Therapy	0.00		0.00
D.	Physical Therapy	0.00	0.00 3.	0.00
E.	Occupational Therapy	0.00		0.00
F.	Recreational Therapy	0.00		0.00
	Sub-Total	0.00	0.00	0.00
IV	Direct Care Staffing	0		0
A.	Direct Care Staff	0.00	0.00 4.	0.00
B.	Supervisory Staff	0.00	0.00 5.	0.00
	Sub-Total	0.00	0.00	0.00
V	Other Staff			
A.	Skill Trainer/QMRP	0.00		0.00
B.	Nursing	0.00		0.00
C.	Pharmacist	0.00		0.00
D.	Dentist	0.00		0.00
E.	Dietitian	0.00		0.00
F.	Food Service	0.00		0.00
G.	Laundry	0.00		0.00
H.	Housekeeping	0.00		0.00
I.	Maintenance	0.00		0.00
J.	In-Service Training	0.00		0.00
K.	Receiving/Warehousing	0.00		0.00
	Sub-Total	0.00	0.00	0.00
VI	Medical Services	0.00	0.00	0.00
VII	Day Programs	0.00	0.00	0.00
	TOTAL	$0.00	$0.00	$0.00

INTERIM RATE
FOR JULY 1, EXAMPLE ONLY

1. Period	Days in Period	X	Licensed Beds	=	Capacity Days
7-1-90 thru 6-30-91	365		0		0

2. Residents by Classification (By Cottage)	Resident Days	/	Days in Period	=	Average Residents by Classification
A.	0		365		0.00
B.	0		365		0.00
C.			365		0.00
Total	0		365		0.00

3. Physical Therapy Classification	Hours Per Day per Resident	X	Average Residents Per Day	=	Resident Hours Per Day
A.	0.11		0.00		0.00
B.	0.04		0.00		0.00
C.	0.01		0.00		0.00
Total	0.16		0.00		0.00

Hourly Rate	14.04
Daily Rate (Total * Hourly Rate)	0.00
Average Residents per Day	0
Per Resident Day (Daily Rate*Average Residents)	
Per Resident Day Adjustment	1.16
Total per Resident Day	

INTERIM RATE
FOR JULY 1, 19 EXAMPLE ONLY

4. Direct Care Staff

Classification	Average Res. Days	/=	Shift	/=	Shift	/=	Shift	Total
A.	0	8	0.000	8	0.000	16	0.000	
B.	0	16	0.000	8	0.000	16	0.000	
C.	0	32	0.000	16	0.000	32	0.000	
Total	0		0.000		0.000		0.000	
Rounded Total			0		0		0	= 0
Posting Factor								X 1.63
Total Staff								0.00
Rounded								1

0 Staff X 40 Hrs X 52 Wks / 365 Days / 84 Avg Res Per Day

X $6.26 Hourly Rate X 1.2395 OPE = 0.00 Rate Per Resident Day.

5. Direct Care Supervisory Staff

0 Direct Care Staff / 7 = 0.00 Supervisors Rounded 0
0 Staff X 40 Hrs X 52 Wks 365 Days / 84.00 Avg Res Per Day

X $6.16 Hourly Rate X 1.2395 OPE = 0.00 Rate Per Resident Day.

EXAMPLE ONLY

SETTLEMENT COMPUTATION
For the Period 7-1-90 through 6-30-91

	7/1/90 Through 6/30/91
Model Budget @ 100% Capacity	$95.32
Capacity Days	3,650
Ceiling Dollars	$347,918.00
Actual Resident Days	3,554
Ceiling Rate	$97.89
Total Expenditures Per Cost Statement	$341,072.00
Less: Adjustments	.00
Net Allowable ICF/MR Expenditures	$341,072.00
Actual Resident Days	3,554
Actual Net Per Diem Cost	$95.97
Settlement Rate (Lesser of Ceiling	
or Actual Net Per Diem Cost)	$95.97

EXAMPLE ONLY

COMPUTATION OF SETTLEMENT AMOUNT
For the Period 7-1-90 through 6-30-91

The following computation for the period 7-1-90 through 6-30-91 discloses that:

1. The ICF/MR owes the Mental Health Division
or
2. The Mental Health Division owes the ICF/MR $1,916.40

ICF/MR FACILITY VENDOR #

Mo./Yr. Service	Settlement Rate	Interim Rate	Settlement rate minus Interim Rate	Resident Days	Amount
7/90	$95.97	$96.59	(1) ($.62)	310	($192.20)
8/90	95.97	95.32	.65	310	201.50
9/90	95.97	95.32	.65	270	175.50
10/90	95.97	95.32	65	279	181.35
11/90	95.97	95.32	.65	270	175.50
12/90	95.97	95.32	.65	305	198.25
1/91	95.97	95.32	.65	310	201.50
2/91	95.97	95.32	.65	280	182.00
3/91	95.97	95.32	.65	310	201.50
4/91	95.97	95.32	.65	300	195.00
5/91	95.97	95.32	.65	310	201.50
6/91	95.97	95.32	.65	300	195.00
			Total		$1,916.40

Facility _____
_____
_____

(1) This interim rate was paid prior to the rate revision in the letter dated 7-30-90.

Instructions for Preparation of the Newly Revised AFS ICF/MR Cost Statement

INTRODUCTION

The following instructions, based on the rules in the ICF/MR provider guide, will help clarify and give direction in completing the ICF/MR Cost Statement. Additional explanation to specific questions may be obtained by contacting Adult and Family Services Division. FSRTFs may disregard these instructions and use the Medicare Form 2552 portion of the ICF/MR Cost Statement and chart of accounts.

FILING OF ICF/MR COST STATEMENT

Generally, cost statements are filed on an annual basis, and are due within 90 days of the facility's REPORTING period end. Improperly completed or incomplete cost statements will be returned for proper completion, to be returned to AFS within 30 days. See Rule 461-17-920 of the ICF/MR provider guide for further explanation.

MIXED LEVEL-OF-CARE FACILITIES

If a facility provides either a skilled or semi-skilled level of care in addition to the ICF/MR level of care, the Nursing Home Cost Statement shall be completed first, so that only those dollar amounts related to the ICF/MR level of care are entered on the ICF/MR Cost Statement.

If a legal entity operating an ICF/MR program also operates programs or businesses not reimbursable under Title XVIII or Title XIX, at its discretion, the facility may decide to separate the non-ICF/MR costs before the cost statement is done, or in the adjustment column of the cost statement.

Page 1

The first page of the cost statement is used to identify the facility, list the facility's public billing rates, provide space for signature by the responsible parties, and provide space for other related information.

SIGNATURES

Both the preparer, if not an employee of the provider, and the owner or individual who normally signs the Federal Income Tax Return or other report shall sign the ICF/MR Cost Statement.

Page 2

The second page is used to identify the owners and officers, their ownership interest in the facility, services they performed for the facility, and other related information.

Page 3

The third page is used to identify other businesses with which the owners are involved, the facility administrator, and other related information.

ADMINISTRATOR SUMMARY

Include all of the designated administrators for the cost statement period and their dates of service as administrator of the facility. Also, list the current administrator. AFS 43A (10/78

TN# 80-31 Date Approved: 1/20/81
Supersedes TN # --- Effective Date : 1/1/81

ST. OR SA Approved 12/22/80 RO Approved 1/20/81

Effective 1/1/81

Page 4

The fourth page provides space for additional explanation of any item on the cost statement, and space for information on the facility and equipment.

Page 5

Page 5 is the beginning of the financial section of the cost statement.

FINANCIAL SECTION

The financial section of the cost statement has been designed so that a provider can determine his net allowable costs, and determine by cost finding his per diem cost for the ICF/MR program.

REVENUE SCHEDULE

The provider shall include all of his revenue by appropriate account as described in the chart of accounts.
Except for those facilities providing a skilled or semi-skilled level of care, the first column shall include all revenue of the facility and shall be reconcilable to the facility's Income Statement or Profit and Loss Statement, and to the appropriate IRS Reports. For those facilities providing a skilled or semi-skilled level of care, see "Mixed Level-of-Care Facilities" above.

Any difference between net income per ICF/MR Cost Statement and net income per IRS report shall be reconciled on Schedule A.

The second column shall include revenues allocable from a home office net of adjustments and reclassifications.

The third column is designed so the provider can make adjustments and reclassifications to the gross revenue shown in the first column. These adjustments and reclassifications shall be made according to the provisions of the ICF/MR provider guide before the cost statement is submitted.

The first three columns total to the fourth column.

Page 6

Page six is the beginning of the base cost schedule.

BASE AND LABOR COST SCHEDULES

The provider shall include all of his expenses by appropriate account as described in the chart of accounts.

Except for those facilities providing a skilled or semi-skilled level of care, the first column shall include all expenses of the facility, and shall be reconcilable to the facility's Income Statement or Profit and Loss Statement, and to the appropriate IRS reports. For those facilities providing a skilled or semi-skilled level of care, see "Mixed Level-of-Care Facilities" above.

The second column shall include expenses allocable from a home office. This column shall be reconcilable to the home office financial statements and records. The amounts allocated shall be net of reclassifications and adjustments per provisions of this guide. See Rule 461-17-890 of the ICF/MR provider guide.

The third column is designed so the provider can make adjustments and reclassifications to the gross facility expenses in the first column per provisions of the ICF/MR provider guide. These adjustments and reclassifications shall be made before the ICF/MR Cost Statement is submitted to the Division.

If an adjustment is for a revenue producing activity relating to a non-allowable cost, the revenue shall be offset against the appropriate expense if the revenue is less than two per cent of the total provider expense. If the revenue is greater than two percent of the total provider expense, costs must be allocated to this area as described in the discussion for Cost Area Allocations.

The fourth column shall include only the net allowable costs attributable to the provider per the provisions of this guide. The first three columns total to the fourth column.

Page 7

Page seven is the last page of the base cost schedule.

Page 8

Page eight is the beginning of the labor cost schedule. See the instructions for base and labor costs above.

Page 9

Page nine is the last page of the labor cost schedule.

Page 10

Page ten shows in total the payroll taxes which are to be allocated to the various labor cost categories, and provides a form for the return on owner's equity calculation.

SCHEDULE OF PAYROLL TAXES AND EMPLOYEE BENEFITS

The allowable Total Employee Benefits and Taxes (Acct. #3200), is to be allocated to the appropriate payroll and employee benefits account in each "Labor Cost" category on the cost statement by actual cost, or by percentage of payroll category amount to the total facility payroll.

RETURN ON EQUITY

The return on owner's equity is calculated on page 10 of the cost statement. The rate of return is identified in Rule 461-17-860 of the IFC/MR provider guide. This same rule defines allowable equity to be included in the per diem rate. Non-profit corporations should not make this calculation since they are not allowed a return on equity.

Page 11

Page 11 is the first page of the balance sheet, and is used to identify the facility's assets.

The balance sheet must be completed as it is presented in the ICF/MR Cost Statement. Substituting another balance sheet will not suffice.

Page 12

Page 12 is the last page of the balance sheet, and is used to show the facility's liabilities and capital.

Page 13

COST AREA ALLOCATIONS SCHEDULE FOR FACILITIES WITH OTHER REVENUE PRODUCING PROGRANIS

This schedule is designed to develop the ratios to be used in allocating costs to different levels of care. If a facility provides either a skilled or semiskilled level of care in addition to the ICF/MR level of care, or operates programs or businesses not reimbursable under Title XVIII or Title XIX, see "Mixed Level of Care Facilities" above. If there is no revenue producing activity related to non-allowable cost5 which generates revenue in excess of 2-, of the total gross expenses, this schedule need not be completed.

If an allocation method other than that specified in the schedule is Used, an explanation of the method and reason for its use must be provided on page 4 of the cost statement. A supplement to the schedule may be needed if there is insufficient space to adequately show a different allocation. The use of a different allocation method is to be used only if it is more reasonable and accurate than the prescribed method, and is subject to approval by the Division.

Each level-of-care column should contain the resident days or square related to that level-of-care by cost area as designated on the schedule. If the designation is for resident days, resident days by licensed bed in the designated ICF/MR area should be used. If the designation is for square footage of common areas, including dining, administrative offices, etc. should not be included in the square footage totals where they are used, in the same proportionate ratio by all levels of care.

The allocation base column is the total of the level-of-care columns for each cost area.

The net cost area expense column shows the dollar amount of net allowable expenses for each cost area.

The multipliers shown in the last column are used to develop the dollar amounts for the Allocated Costs schedule. Each multiplier is computed by dividing the net cost area expense by the allocation base for that cost area. If costs can be directly related to a level of care, such as might be the case for certain salaries, a multiplier should not be developed since the costs can be entered directly on the Allocated Costs schedule.

Page 14

ALLOCATED COSTS SCHEDULE

This schedule is designed to show allowable costs for the ICF/MR program by cost area, and to calculate the ICF/MR cost per day.

If no allocation via the Cost Area Allocations schedule is required, the dollar amount for each cost area will be the total net allowable expense from the base and labor cost schedules. If the allocations schedule was used, the dollar amount for each cost area is the product of the multiplier for that cost area and the level-of-care sub-total from page 13.

The grand total of the ICF/MR cost areas divided by resident days by licensed bed in the designated ICF/MR service area determines the ICF/MR cost per day.

Page 15

Page 15 provides space for explanation of the miscellaneous accounts and other accounts as needed, and space for reconciliation calculations.

Page 16

RESIDENT CLASSIFICATION REPORT

If the resident day count by level of care is the same as the resident day count by licensed bed, this should be-indicated on the second schedule of this report instead of unnecessarily repeating the day count.

Page 17

BED CAPACITY SCHEDULE

The "change" columns of this schedule should indicate the total number of beds at the date of change in the number of beds.

STAFFING RATIO REPORT FOR DIRECT CARE STAFF

Only the direct care staff as defined in the ICF/MR provider guide and direct care supervisors that worked during the shift, and the total number of hours they worked for that shift should be included in this report.

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STAFFING RATIO REPORT FOR SECURE WARD STAFF

Only the secure ward staff and supervisors that worked during the shift, and the total number of hours they worked for that shift should be included in this report.

CHART OF ACCOUNTS

RESIDENT REVENUES

The Private Resident, Other Governmental Supported Resident, and Medicaid Resident revenue accounts are for routine care charges. Revenues generated by charges for ancillary services and supplies are to be included in one of the other appropriate revenue accounts.

Acct. 2120 - Private Resident - ICF/MR
This account includes revenues for routine services provided to private residents that come under the ICF/TIR classification as defined in Rule 461-17-600.

Acct. 2140 - Private Resident.- Other
This account includes revenues for routine services provided to private residents that do not come under the ICF/MR, skilled, or semi-skilled classifications. The classifications and amounts should be specified on Schedule A.

Acct. 2250 - Other Governmental Supported Resident
This account includes revenues for routine services from other governmental programs, such as VA. Programs and amounts should be specified on Schedule A.

Acct. 2320 - Medicaid Resident - ICF/MR
This account includes revenues for routine services provided to Medicaid residents that are classified as ICF/MR by the Division.

Acct. 2400 - Physical Therapy
This account includes revenue for ancillary physical therapy services, not provided as part of routine care.

Acct. 2410 - Speech Therapy
This account includes revenue for ancillary speech therapy services, not provided as part of routine care.

Acct. 2420 - Occupational Therapy
This account includes revenue for ancillary occupational therapy services. not provided as part of routine care.

Acct. 2500 - Nursing Supplies
This account includes revenue for nursing supplies not provided as part of routine care.

Acct. 2510 - Prescription Drugs
This account includes revenue for prescription drugs not provided as part of routine care.

Acct. 2520 - Laboratory
This account includes revenue for laboratory work, supplies and services, not provided as part of routine care.

Acct. 2530 - X-Ray
This account includes revenue for x-ray work, supplies, and Services not provided as part of routine care.

Acct. 2600 - Barber and Beauty Shop
This account includes revenue for barber and beauty services and supplies not provided as part of routine care.

Acct. 2610 - Personal Purchase Income
This account includes revenue from resident purchases of incidental items not accounted for in any other revenue account and not provided as part of routine care.

Acct. 2700 - Miscellaneous Resident Revenue
If revenue is included in this account, items and amounts are to be specified on Schedule A.

Other Revenue

The following accounts are to be used to record revenues not as likely to come directly from residents as the foregoing revenues.

Acct. 2800 - Grants
This account includes income from grants.

Acct. 2810 - Donations
This account includes income from donations.

Acct. 2820 - Interest Income
This account includes interest income generated by loans.

Acct. 2830 - Rental Income
This account includes revenue generated by rental of equipment and facilities.

Acct. 2840 - Staff and Guest Food Sales
This account includes revenue from sale of food to staff and guests.

Acct. 2850 - Concession Income
This account includes revenue from concession sales, including candy machines, soft drink machines, and cigarette machines.

Acct. 2900 - Miscellaneous Revenue
If revenue is included in this account, items and amounts are to be specified on Schedule A.

Base and Labor Costs

The following accounts are to be used to classify expenses.

Base Costs

These accounts are for costs other than salaries and certain consulting fees.

General & Administrative

Acct. 3310 - Office Supplies and Printing
All office supplies, printing, small equipment of an administrative use not requiring capitalization, postage, printed materials including manuals and educational materials are to be included in this account.

Acct. 3510 - Legal and Accounting
Legal fees applicable to the facility and attributable to resident care are to be included in this account. Retainer fees are not a specific resident related cost and shall be adjusted as non-allowable. Legal fees attributable to a specific resident shall also be adjusted as non-allowable. Accounting and bookkeeping expenses of a non-duplicatory nature including accounting related data processing costs are also to be included in this account.

Acct. 3520 - Management fees
Management fees as defined in Rule 461-17-895 are to be included in this account.

Acct. 3530 - Donated Services
Donated services by non-paid workers as defined in Rule 461-17-810 are to be included in this account. The account should show the actual expenses in Column 1. Adjustments and reclassifications to appropriate salary accounts shall be made in Column 3. Attach worksheet to show adjustments and reclassifications.

Acct. 3610 - Communications
Telephone and telegraph expenses are to be included in this account.

Acct. 3711 - Travel - Motor Vehicle - Medical
This account includes medically related costs attributable to vehicle operation for facility and resident care use only. Personal use shall be separated from this account as an adjustment. Other expenses of auto insurance, repairs and maintenance, gas and oil, and reimbursement of actual employee expenses attributable to facility business should be included in this account. Auto allowances that are not documented by actual expenses will be reclassified to the appropriate salary or payroll account or adjusted as a non-allowable expense.

Acct. 3712 - Travel - Motor Vehicle - Non-Medical
This account includes the same kinds of costs described for Acct. 3711, Travel – Motor Vehicle - Medical, except they are not medically related. See Rule 461-17-656 of the ICF/MR provider guide.

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Acct. 3721 - Travel - Other - Medical
This account includes all medically related travel expenses not related to the use of a vehicle belonging to the facility or an employee, including board and room on business trips, airline and bus tickets. These expenses should be attributable to and related to resident care or this account should be adjusted for expenses attributable to non-resident care travel.

Acct. 3722 - Travel - Other - Non-Medical
This account includes the same kinds of costs described for Acct. 3721, Travel - Other - Medical, except they are not medically related. See Rule 461-17-656 of the ICF/MR provider guide.

Acct. 3809 - Other Interest Expense
Only interest not related to purchase of facility and equipment (including vehicles) is to be included in this account.

Acct. 3810 - Advertising and Public Relations
Advertising and public relations expenses are to be included in this account. See Rule 461-17-910 for definition of non-allowable portion.

Acct. 3320 - Licenses and Dues
License and dues expenses are to be included in this account.

Acct. 3830 - Bad Debts
Bad debts associated with Title XIX recipients are allowable. All other bad debts shall be adjusted as non-allowable.

Acct. 3840 - Freight
This account includes shipping charges paid by the provider, unless they should be capitalized as part of a capital asset.

Acct. 3910 - Miscellaneous
This account includes general and administrative expenses not otherwise includable in the General and Administrative Cost Area. These expenses are to be described on Schedule A.

Shelter

Acct. 4310 - Repair and Maintenance
This account contains all material costs entailed in the maintenance and repair of the building and departmental equipment.

Acct. 4510 - Purchased Services
This account contains all expenses paid for outside services purchased in the maintenance and repair of building, building equipment and department equipment. It is also to include items such as lawn care by an outside service, security service, etc.

Acct. 4610 - Real Estate and Personal Property Taxes
Real estate and personal property tax expenses are to be included in this account.

Acct. 4620 - Rent
Rent attributable to the lease of a facility is to be included in this account.

Acct. 4630 - Lease
Lease expenses of equipment, vehicles, and other items separate from rent of a facility are to be included in this account.

Acct. 4640 - Insurance
This account includes all insurance expenses except auto insurance, which should be classified under Travel - Motor Vehicle.

Acct. 4710 - Depreciation - Land-Improvements
See Rules regarding capital assets and depreciation.

Acct. 4720 - Depreciation - Building
See Rules regarding capital assets and depreciation.

Acct. 4730 - Depreciation -Building Equipment
See Rules regarding capital assets and depreciation.

Acct. 4740 - Depreciation -Moveable Equipment
See Rules regarding capital assets and depreciation.

Acct. 4750 - Depreciation -Leasehold Improvements
See Rules regarding capital assets and depreciation.

Acct. 4809 - Interest
Interest attributable to the purchase of facility and equipment is to be included in this account.

Acct. 4910 - Miscellaneous
This account includes shelter expenses not otherwise includable in the Shelter Cost Area.

Utilities

Acct. 5610 - Heating Oil
Heating oil expense is to be included in this account.

Acct. 5620 - Gas
Gasoline for autos included in Travel - Motor Vehicles.

Acct. 5630 - Electricity
Electricity expense is to be included in this account.

Acct. 5640 - Water, Sewage and Garbage
Water, sewage and garbage expenses are to be included in this account.

Laundry

Acct. 6310 - Laundry Supplies
Laundry supplies expense is to be included in this account.

Acct. 6315 - Linen and Bedding
Linen and bedding expense is to be included in this account.

Acct. 6510 - Purchased Laundry Services
Laundry services purchased from an outside provider are to be included in this account.

Acct. 6910 - Miscellaneous
This account includes laundry costs not otherwise includable in the Laundry Cost Area.

Housekeeping

Acct. 7310 - Housekeeping Supplies
Housekeeping supplies expense is to be included in this account.

Acct. 7910 -Miscellaneous
This account includes housekeeping costs not otherwise includable in the Housekeeping Cost Area.

Dietary

Acct. 8310 - Dietary Supplies
This account includes expenses associated with the serving of food, such as utensils, paper goods, dishware and other items.

Acct. 8410 - Food
This account combines all the costs of prepared foods, meats, vegetables and all manner of food ingredients and supplements. Expenses for candy, food or beverages sold through vending machines, commissary or snack-bar are to be included in the expense account Concession Supplies.

Acct. 8910 - Miscellaneous
This account includes dietary costs not otherwise includable in the Dietary Cost Area.

Nursing Supplies and Services

Acct. 9310 - Nursing Supplies
This account includes costs of supplies used in nursing care covered in Rule 461-17-650 (3).

Acct. 9320 - Drugs and Pharmaceuticals Non-RX
This account includes costs of drugs and pharmaceuticals defined in Rule 461-17-650 (2) (f).

Acct. 9330 - Drugs and Pharmaceuticals - RX
This account includes drug prescription costs defined in Rule 461-17-655(1).

Acct. 9351 - Pharmacy Services and Supplies
Pharmacy supplies and outside services expenses are to be included in this account.

Acct. 9352 - Laboratory Services and Supplies
Laboratory supplies and outside services expenses are to be included in this account.

Acct. 9353 - X-Ray Services and Supplies
X-Ray supplies and outside services expenses are to be included in this account.

Acct. 9354 - Recreation Supplies and Services
Activities supplies and outside services expenses are to be included in this account.

Acct. 9355 - Rehabilitation Supplies and Services
Rehabilitation supplies and outside services expense are to be included in this account.

Acct. 9510 - Physician Fees
Outside physician fees are to be included in this account.

Acct. 9530 - Day Treatment Supplies and Services
Only FSRTF facilities are to use this account, which is to include day treatment supplies and services expense.

Acct. 9950 - Concession Supplies
This account includes costs associated with vending machines and similar resale items.

Acct. 9955 - Barber and Beauty Shop
This account includes barber and beauty related costs. Costs of services and supplies not meeting the definition in Rule 461-17-650(2)(g) shall be adjusted.

Acct. 9960 - Funeral and Cemetery
Funeral and cemetery expenses are to be included in this account.

Acct. 9965 - Personal Purchases
This account includes the costs of all items purchased for resident care and excluded in Rule 461-17-650 as part of the all-inclusive rate unless specifically included in another account. These items would include, but not be limited to, incidental items defined in Rule 461-17-660 authorized for payment from resident funds, and items not routinely furnished to all residents without additional costs.

Acct. 9990 - Miscellaneous
This account includes miscellaneous supplies and services not otherwise includable in the Nursing Supplies and Services Cost Area. Items and amounts are to be listed on Schedule A.

Labor Cost

Payroll Taxes and Employee Benefits

These accounts are to include all payroll taxes and employee benefits. The total net allowable payroll taxes and employee benefits (Acct. #3200) are to be allocated to the appropriate payroll and employee benefit account in each "Labor Cost" category on the cost statement by actual cost, or by percentage of payroll category amount to the total facility payroll.

Acct, 3200 - Total Employee Benefits & Taxes
This account is the total of Acct. 3210 Total Payroll Taxes and Acct. 3220 Employee Benefits.

Acct. 3210 - Total Payroll Taxes
This account includes the payroll taxes FICA, Acct. 3211, State Unemployment, Acct. 32l2, Federal Unemployment, Acct. 3213, Workers' Compensation, Acct. 3214, Tri-Met, Acct. 3215, and any others.

Acct. 3211 - FICA
This account includes the FICA tax.

Acct. 3212 - State Unemployment
This account includes the State unemployment insurance tax.

Acct. 3213 - Federal Unemployment
This account includes the Federal unemployment insurance tax.

Acct. 3214 - Worker’s Compensation
This account includes the Worker’s Compensation tax.

Acct. 3215 - Tri-Met
This account includes the Tri-Met payroll tax.

Acct. 3216 - Payroll Tax - Other
Any amount showing in this account must be identified.

Acct. 3220 - Employee Benefits
This account includes all employee benefits, and does not include payroll taxes for unemployment insurance and state accident insurance.

Administrative Salaries

Acct. 3110 - Administrator Salary
This account includes all of the compensation received by the administrator. Other compensation including allowances and benefits not documented by specific costs, or similarly accruing to other employees of the facility are to be included in this account as a reclassification.

Acct. 3231 - Employee Benefits & Taxes
This account includes employee taxes and benefits for the administrator, including employee insurance, vacation and sick pay, and other fringe benefits not otherwise accounted for. The costs in this account are to be allocated from Acct. #3200 Total Employee Benefits and Taxes as explained in the above section on the Schedule of Payroll Taxes and Employee Benefits.

Other - Administrative Salaries

Acct. 3120 - Assistant Administrator Salary
This account includes all compensation received by the assistant administrator. The provisions applicable to the administrator compensation apply.

Acct. 3130 - Salaries - Other Administrative
All clerical, receptionist, ward clerk and medical records personnel salaries are to be included in this account. All home office payroll allocable to the facility is to be included in this account unless it is adequately demonstrated on an attachment to the cost statement that payroll amounts belong in another payroll account.

Acct. 3232 - Employee Benefits and Taxes
This account includes benefits and taxes for the other administrative personnel. The costs in this account are to be allocated from Acct. #3200 Total Employee Benefits and Taxes as explained in the above section on the Schedule of Payroll Taxes and Employee Benefits.

Nursing Salaries

Acct. 9110 - Salaries - DNS
Director of Nursing Service salary is to be included in this account.

Acct. 9111 - Salaries - RN
Registered Nurse salaries are to be included in this account.

Acct. 9112 - Salaries - LPN
Licensed Practical Nurse and Licensed Vocational Nurse salaries are to be included in this account.

Acct. 9291 - Employee Benefits and Taxes
This account shall include employee benefits and taxes for the DNS, RN's, and LPN's. The costs are to be allocated from Acct #3200 - Total Employee Benefits and Taxes as explained in the above section on the Schedule of Payroll Taxes and Employee Benefits.

Direct Care Salaries

Acct. 9122 - Salaries - Direct Care
Salaries for the facility's living unit personnel who train residents in activities of daily living and in the development of self-help and social skills are included in this account. This does not include salaries for other professional services included under active treatment services.

Acct. 9123 - Salaries - Direct Care Supervisors
Salaries for direct care supervisors.

Acct. 9124 - Salaries - Secure Ward Staff
Salaries for secure ward staff.

Acct. 9125 - Salaries - Secure Ward Supervisors
Salaries for secure ward supervisors.

Acct. 9292 - Employee Benefits and Taxes
This account includes employee benefits and taxes for direct care staff.
The costs are to be allocated from Acct. #3200 Total Employee Benefits and Taxes as explained in the above section on the Schedule of Payroll Taxes and Employee Benefits.

Other Salaries

Acct. 4110 - Repair and Maintenance Salaries
This account includes payroll for services related to repair, maintenance and plant operation.

Acct. 6110 - Laundry Salaries
Laundry salaries are to be included in this account.

Acct. 7110 - Housekeeping Salaries
Janitorial salaries and housekeeping salaries are to be included in this account.

Acct. 8110 - Dietary Salaries
Dietary salaries are to be included in this account.

Acct. 9130 - Salaries - Physician
Physician salaries, exclusive of physician fees and consulting services, are to be included in this account.

Acct. 9131 - Salaries - Pharmacy
Pharmacy salaries are to be included in this account.

Acct. 9132 - Salaries - Laboratory
Laboratory salaries are to be included in this account.

Acct. 9133 - Salaries - X-Ray
X-ray salaries are to be included in this account.

Acct. 9134 - Salaries - Activities (Occupational)
Activities (occupational) salaries are to be included in this account.

Acct. 9135 - Salaries - Rehabilitation
Rehabilitation salaries are to be placed in this account.

Acct. 9140 - Salaries - Religious
Relig4ous salaries are to be included in this account.

Acct. 9148 - Salaries - Receiving Warehouse
Only receiving warehouse salaries incurred by FSRTF's are to be included in this account.

Acct. 9149 - Salaries - Other
This account includes Nursing Service Salaries not otherwise includable in the Nursing Service Cost Area. Purchased nursing services are to also be included in this account. Items and amounts are to be specified on Schedule A.

Acct. 9296 - Employee Benefits and Taxes
This account includes benefits and taxes for the employees listed in the cost category. The costs are to be allocated from Acct. #3200 Total Benefits and Taxes as explained in the above section on the Schedule of Payroll Taxes and Employee Benefits.

Active Treatment Services

These accounts include all special programs, except Day Program service costs incurred by FSRTF'S, and professional medical services, except Medical Service costs incurred by FSRTF'S. Included are costs for consultation, treatment and evaluations not paid for separately by the Division. Expenses not required for certification shall be adjusted as non-allowable.

Acct. 9150 - Qualified Mental Retardation Professional
Acct. 9151 - Registered Nurse Consultant (SRTF Only)
Acct. 9152 - Psychologist
Acct. 9153 - Social Worker
Acct 9154 - Speech Therapist
Acct. 9156 - Occupational Therapist
Acct. 9157 - Recreation Therapist
Acct. 9158 - Physical Therapist
Acct. 9159 - Dietitian
Acct. 9160 - Dentist
Acct. 9161 - Pharmacist
Acct. 9162 - Skill Trainer/Program Coordinator
Acct. 9170 - Other Medical Consultants
Acct. 9297 - Employee Benefits and Taxes

This account includes benefits and taxes for the employees included in this cost category. The costs are to be allocated from Acct. #3200 Total Employee Benefits and Taxes as explained in the above section on the Schedule of Payroll Taxes and Employee Benefits.

Medical Services

These accounts include only medical service program costs incurred by FSRTF's.

Acct. 9180 - Physician Services
Acct. 9181 - Pharmacy Services
Acct. 9182 - Laboratory Services
Acct. 9183 - X-Ray Services
Acct. 9186 - Nursing Services
Acct. 9187 - Dental Services

Acct. 9188 - Central Supply Services

Acct. 9298 - Employee Benefits and Taxes
This account includes benefits and taxes for the employees included in this cost category. The costs are to be allocated from Acct. #3200 Total Employee Benefits and Taxes as explained in the above section on the Schedule of Payroll Taxes and Employee Benefits.

Day Program Services

These accounts include only Day Program service costs incurred by FSRTF'S.

Acct. 9190 - Day Program Services

Acct. 9299 - Employee Benefits and Taxes
This account includes benefits and taxes for the employees included in this cost category. The costs are to be allocated from Acct. #3200 Total Employee Benefits and Taxes as explained in the above section on the Schedule of Payroll Taxes and Employee Benefits.

ICF/MR COST STATEMENT

NAME ON LICENSE_____PROVIDER NO. MS

MAILING ADDRESS

STREET ADDRESS _____AFS BRANCH

CITY, STATE, ZIP _____ PHONE

ACCOUNTING AND OTHER DATA

PERIOD OF THIS REPORT: FROM _____ THROUGH

NUMBER OF DAYS IN ABOVE PERIOD _____ENDING MONTH OF NORMAL/FISCAL YEAR _____

TYPE OF ORGANIZATION: ☐ INDIVIDUAL ☐ PARTNERSHIP ☐ PROPRIETARY CORPORATION

☐ NON-PROFIT CORPORATION ☐ OTHER: _____

NAME OF HOME OFFICE, IF ANY

ADDRESS_____PHONE

ACCOUNTANT'S NAME AND/OR FIRM NAME

ADDRESS_____PHONE

THE BOOKS ARE KEPT AT:

PUBLIC BILLING RATES

DURING THE TIME PERIOD COVERED BY THIS COST STATEMENT, THE RATES THAT WE CHARGED OUR PRIVATE RESIDENTS FOR ICF/MR SERVICES WERE:

INCLUSIVE DATES	CLASSIFICATION UNDER WHICH RATES WERE CHARGED*					
	#1	#2	#3	#4	#5	#6

*Submit an appropriate definition of each classification on a separate schedule and submit a copy with this cost report.

This cost statement has been prepared from information furnished without independent examination by me (us). Since my (our) procedures did not constitute an examination made in accordance with generally accepted auditing standards, I (we) do not express an opinion on these statements.

_____ _____

Title Date

Under penalties of law, I declare that I have examined this cost statement, including accompanying schedules and statements, and that this material is complete, accurate and true and prepared in accordance with the rules of the Adult and Family Services Division of the State of Oregon. I understand that any false statement, claim or document or concealment of material fact herein may be prosecuted under applicable federal or state law.

TN# 80-31 Date Approved: 1/20/81

Supersedes TN # --- Effective Date : 1/1/81

IDENTIFICATION OF OWNERS, PARTNERS, LESSEES, STOCKHOLDERS, ETC., WITH 5% OR MORE OWNERSHIP IN THIS FACILITY

NAME	TITLE	RESIDENCE (CITY & STATE	%

100

COMPENSATION OF OWNERS, PARTNERS, FAMILY MEMBERS, RELATIVES, LESSEES, STOCKHOLDERS, OFFICERS

	NAME	RELATIONSHIP	SERVICE(S) PERFORMED
1			
2			
3			
4			
5			

	% of customary work week devoted to this facility business	Compensation amount included in this cost statement (omit ¢)	Account number(s) where compensation is included
1A			
2A			
3A			
4A			
5A			

OTHER FACILITIES/BUSINESSES FOR WHICH THE OWNERS EXERCISE A 5% OR MORE OWNERSHIP OR CONTROL

OWNER NAME	FACILITY/BUSINESS NAME	%	NATURE OF BUSINESS

ADMINISTRATOR SUMMARY

NAME	DATE OF SERVICE
	Current Administrator

RELATED ORGANIZATIONS*
(*Defined in Rule 461-17-600 of the ICF/MR-Provider Guide)

NAME	DESCRIPTION OF SERVICES, FACILITIES, AND SUPPLIES	NATURE OF RELATIONSHIP

Cost of goods or services to the related organization and charge to the facility shall be listed by account on Schedule A.

SPECIAL NOTES PERTAINING TO COST STATEMENT

DATA ON FACILITIES & EQUIPMENT

1 DATE THIS FACILITY ACQUIRED _____ APPROXIMATE AGE OF FACILITY

2 LAND&BUILDING: __OWNED __LEASED EQUIPMENT: __OWNED _LEASED

IF LEASED, LESSOR'S NAME & ADDRESS:
_____
_____
_____

IF LEASED, LESSOR'S NAME & ADDRESS:
_____
_____
_____

4 A COPY OF THE FACILITY LEASE, INCLUDING AMENDMENTS, PLUS A COPY OF YOUR FEDERAL OR OTHER APPLICABLE DEPRECIATION SCHEDULES ARE REQUIRED.
5 REASON IF FACILITY LEASE NOT ATTACHED _____
6 REASON IF DEPRECIATION SCHEDULE NOT ATTACHED

REVENUE

ACCOUNT #	ACCOUNT	(1) + FACILITY GROSS REVENUE	(2) + HOME OFFICE REVENUE	(3) = ADJ. & RECLASS.	(4) NET PROVIDER REVENUE
RESIDENT REVENUES					
2120	Private Resident ICF/MR				
2140	Private Resident-Other (Sch. A)				
2250	Other Governmental Supported Resident (Sch.A)				
2320	Medicaid Resident - ICF/MR				
2400	Physical Therapy				
2410	Speech Therapy				
2420	Occupational Therapy				
2500	Nursing Supplies				
2510	Prescription Drugs				
2520	Laboratory				
2530	X-Ray				
2600	Barber & Beauty Shop				
2610	Personal Purchase Income				
2700	Miscellaneous Resident Revenue (Sch. A)				
OTHER REVENUE					
2800	Grants				
2810	Donations				
2820	Interest Income				
2830	Rental Income - Facilities & Equip.				
2840	Staff & Guest Food Sales				
2850	Concession Income				
2900	Miscellaneous Revenue (Sch. A)				
	TOTAL REVENUES				

Net Income per ICF/MR Cost Statement _____
Net Income per IRS Report

Difference if any (Reconcile on Sch. A) _____

TN# 80-31 Date Approved: 1/20/81
Supersedes TN # --- Effective Date : 1/1/81

SCHEDULE OF BASE COSTS

ACCOUNT #	ACCOUNT	(1) FACILITY GROSS EXPENSE	+ (2) HOME OFFICE EXPENSE	+ (3) ADJUSTMENTS AND RECLASSIFICATION	= (4) NET ALLOWABLE EXPENSES
GENERAL & ADMINISTRATIVE					
3310	Office Supplies & Printing				
3510	Legal & Accounting				
3520	Management Fees				
3530	Donated Services				
3610	Communications				
3711	Travel-Motor Vehicle-Medical				
3712	Travel-Motor Vehicle-Non-Medical				
3721	Travel-Other-Medical				
3722	Travel-Other-Non-Medical				
3809	Other Interest Expense				
3810	Advertising & Public Relations				
3820	Licenses & Dues				
3830	Bad Debts				
3840	Freight				
3910	Miscellaneous (Sch. A)				
	TOTAL GENERAL & ADMINISTRATIVE				
SHELTER					
4310	Repair & Maintenance Supplies				
4510	Purchased Services				
4610	Real Estate & Personal Property Taxes				
4620	Rent				
4630	Lease				
4640	Insurance				
4710	Depreciation-Land Improvements				
4720	Depreciation-Building				
4730	Depreciation-Bldg. Equip				
4740	Depreciation-Moveable Equip.				
4750	Depreciation-Leasehold Improvements				
4809	Interest				
4910	Miscellaneous (Sch. A)				
	TOTAL SHELTER				
UTILITIES					
5610	Heating Oil				
5620	Gas				
5630	Electricity				
5640	Water, Sewage & Garbage				
	TOTAL UTILITIES				

TN# 80-31 **Date Approved: 1/20/81**

Supersedes TN # --- **Effective Date : 1/1/81**

SCHEDULE OF BASE COSTS

ACCOUNT #	ACCOUNT	(1) FACILITY GROSS EXPENSE	+ (2) HOME OFFICE EXPENSE	+ (3) ADJUSTMENTS AND RECLASSIFICATION	= (4) NET ALLOWABLE EXPENSES
LAUNDRY					
6310	Laundry Supplies				
6315	Linen & Bedding				
6510	Purchased Laundry Services				
6910	Miscellaneous (Sch. A)				
	TOTAL LAUNDRY				
HOUSEKEEPING					
7310	Housekeeping Supplies				
7910	Miscellaneous (Sch. A)				
	TOTAL HOUSEKEEPING				
DIETARY					
8310	Dietary Supplies				
8410	Food				
8910	Miscellaneous (Sch. A)				
	TOTAL DIETARY				
NURSING SUPPLIES & SERVICES					
9310	Nursing Supplies				
9320	Drugs & Pharmaceuticals Non-Prescription				
9330	Drugs & Pharmaceutical Prescription Drugs				
9351	Pharmacy Services & Supplies				
9352	Lab Services & Supplies				
9353	X-Ray Services & Supplies				
9354	Recreational Supplies Services				
9355	Rehabilitation Supplies & Services				
9510	Physician Fees				
9530	Day Treatment Supplies & Services (FSRTF Only)				
9950	Concession Supplies				
9955	Barber & Beauty Shop				
9960	Funeral & Cemetery				
9965	Personal Purchases				
9990	Miscellaneous (Sch. A)				
	TOTAL NURSING SUPPLIES & SERVICES				
	TOTAL BASE COSTS				

TN# 80-31 **Date Approved: 1/20/81**
Supersedes TN # --- **Effective Date : 1/1/81**

SCHEDULE OF LABOR COSTS

ACCOUNT #	ACCOUNT	(1) FACILITY GROSS EXPENSE	+(2) HOME OFFICE EXPENSE	+ (3) ADJUSTMENTS AND RECLASSIFICATION	= (4) NET ALLOWABLE EXPENSES
ADMINISTRATOR SALARIES					
3110	Administrator Salary				
3231	Employee Benefits & Taxes				
	TOTAL				
OTHER ADMINISTRATIVE SALARIES					
3120	Salary-Ass't. Administrator				
3130	Salaries-Other Admin.				
3232	Employee Benefits & Taxes				
	TOTAL				
NURSING SALARIES					
9110	Salaries-DNS				
9111	Salaries-RN				
9112	Salaries-LPN				
9291	Employee Benefits & Taxes				
	TOTAL				
DIRECT CARE SALARIES					
9122	Salaries-Direct Care Staff				
9123	Salaries-Direct Care Supervisors				
9l24	Salaries-Secure Ward Staff				
9125	Salaries-Secure Ward Supervisors				
9292	Employee Benefits &Taxes				
	TOTAL				
OTHER SALARIES					
4110	Repair & Maintenance Salaries				
6110	Laundry Salaries				
7110	Housekeeping Salaries				
8110	Dietary Salaries				
9130	Salaries-Physician				
9131	Salaries-Pharmacy				
9132	Salaries-Laboratory				
9133	Salaries-X-Ray				
9134	Salaries-Activities (Occupational)				
9135	Salaries-Rehabilitation				
9140	Salaries-Religious				
9148	Salaries-Receiving Warehouse (FSRTF only)				
9149	Salaries-Other (Sch. A)				
9296	Employee Benefits & Taxes;				
	TOTAL				

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SCHEDULE OF LABOR COSTS

ACCOUNT #	ACCOUNT	(1) FACILITY GROSS EXPENSE	+ (2) HOME OFFICE EXPENSE	+ (3) ADJUSTMENTS AND RECLASSIFICATION	= (4) NET ALLOWABLE EXPENSES
ACTIVE TREATMENT SERVICES					
9150	Qualified Mental Retardation Professional				
9151	Registered Nurse Consultant (SRTF Only)				
9152	Psychologist				
9153	Social Worker				
9154	Speech Therapist				
9156	Occupational Therapist				
9157	Recreational Therapist				
9158	Physical Therapist				
9159	Dietitian				
9160	Dentist				
9161	Pharmacist				
9162	Skill Trainer/Program Coord.				
9170	Other Medical Consultants (Sch. A)				
9297	Employee Benefits & Taxes				
	TOTAL				
MEDICAL SERVICES (FSRTF only)					
9180	Physician Services				
9181	Pharmacy Services				
9182	Laboratory Services				
9183	X-Ray Services				
9186	Nursing Services				
9187	Dental Services				
9188	Central Supply Services				
9298	Employee Benefits & Taxes				
	TOTAL				
DAY PROGRAM SERVICES (FSRTF only)					
9190	Day Program Services				
9299	Employee Benefits & Taxes				
	TOTAL				
	TOTAL LABOR COSTS				
	TOTAL BASE & LABOR COSTS				

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SCHEDULE OF PAYROLL TAXES AND EMPLOYEE BENEFITS

ACCOUNT #	ACCOUNT	(1) FACILITY GROSS EXPENSE	+ (2) HOME OFFICE EXPENSE	+ (3) ADJUSTMENTS AND RECLASSIFICATION	= (4) NET ALLOWABLE EXPENSES
3211	FICA				
3212	State Unemployment				
3213	Federal Unemployment				
3214	Worker's Compensation				
3215	Tri-Met				
3216	Other (Specify)				
3210	TOTAL PAYROLL TAXES				
3200	TOTAL EMPLOYEE BENEFITS & TAXES				

NOTE: The net allowable payroll taxes and employee benefits (column 4 above) are to be allocated to the appropriate sub-accounts in each "Labor Cost" category by actual cost, or by percentage of payroll category amount to the total facility payroll.

RETURN ON OWNER'S EQUITY CALCUIATION

_____ Net Owner's Equity at Beginning of Period

_____ Net Owner's Equity at End of Period

_____ + 2 = _____ Average Owner's Equity

x _____ Rate of Return

=_____ Return on Owner's Equity

Note: The return on owner's equity is entered on Page 12, or, if an allocation is required, on Page 13.

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BALANCE SHEET

ACCOUNT #	ACCOUNT	(1) FACILITY	+ (2) HOME OFFICE	+ (3) ADJ. & RECLASS.	= (4) NET
1101	Cash on Hand				
1102	Cash in Bank				
1103	Cash in Savings				
1150	Accounts Receivable				
1160	Notes Receivable				
1169	Provision for Doubtful Accounts				
1170	Employee Advances				
1200	Inventory-Nursing Supplies				
1201	Inventory-Food				
1202	Inventory-Other				
1250	Prepaid Expenses (Sch. A)				
1270	Other Current Assets (Sch. A)				
1310	Land				
1320	Land Improvements				
1321	Accumulated Depreciation Land Improvements				
1330	Buildings				
1331	Accumulated Depreciation-Bldg.				
1340	Equipment-Bldg. Fixed				
1341	Accumulated Depreciation-Equip. Bldg.				
1350	Equipment-Moveable				
1351	Accumulated Depreciation - Equip. Moveable				
1370	Leasehold Improvements				
1371	Accumulated Amortization-Lease Improvements				
1400	Investments (Sch. A)				
1470	Other L/T Assets (Sch. A)				
	TOTAL ASSETS				

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BALANCE SHEET

ACCOUNT #	ACCOUNT	(1) FACILITY	+	(2) HOME OFFICE	+	(3) ADJ. & RECLASS.	=	(4) NET
	LIABILITIES AND CAPITAL							
1510	Accounts Payable							
1550	Notes Payable-Other							
1560	Notes Payable - Owners							
1570	Accrued Interest Payable							
1600	Payroll Payable							
1610	Payroll Taxes Payable							
1620	Other Payroll Deductions Payable							
1630	Deferred Income (Sch. A)							
1670	Other Current Liabilities (Sch. A)							
1810	Long-Term Mortgage Payable -							
1850	Long-Term Notes Payable - Other							
1860	Long-Term Notes Payable - Owners							
1870	Other Long-Term Liabilities (Sch. A)							
	TOTAL LIABILITIES							
1910	Capital Stock							
1950	Retained Earnings							
1960	Capital Account - Proprietor or Partners							
1970	Drawing Account - Proprietor or Partners							
1980	Net Profit (loss) year to date							
	TOTAL CAPITAL							
	TOTAL LIABILITIES & CAPITAL							

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COST AREA ALLOCATIONS SCHEDULE FOR FACILITIES WITH OTHER REVENUE PRODUCING PROGRAMS

If there is no revenue producing activity related to non-allowable costs which generates revenue in excess of 2% of the total gross expenses, check here do not complete this page, and continue with the next page.
If a different allocation method is used, an explanation of the method and the reason for its use must be provided on page 4.
Each level-of-care column should contain the resident days or square feet related to that level-of-care as designated in each cost area.
For each cost area, the allocation base is the total of the level-of-care columns for that cost area.
The multiplier is the net cost area expense divided by the allocation base.
The product of the multiplier and the ICF/MR Level-of-Care column by cost area is entered on the "Allocated Costs" schedule on page 14.

COST AREA/ DESIGNATED ALLOCATION METHOD	Level-of-Care ICF/MR	Level-of-Care Other (Specify)	Level-of-Care Other (Specify)	Allocation Base	Net Cost Area Expense	Multiplier
Gen. & Admin. Resident Days						
Shelter Square Footage						
Utilities Square Footage						
Laundry Resident Days						
Housekeeping Square Footage						
Dietary Resident Days						
Nursing Supplies & Services Resident Days						
Admin. Salaries Resident Days						
Other Admin. Salaries Resident Days						
Nursing Salaries Actual Payroll						
Direct Care Salaries Actual Payroll						
Other Salaries Actual Payroll						
Active Treatment Services Actual Payroll						
Medical Services Actual Payroll						
Day Program Services Actual Payroll						
Return on Equity Resident Days						

ALLOCATED COSTS

Cost Areas	ICF/MR
BASE COSTS	
General & Administrative	
Shelter	
Utilities	
Laundry	
Housekeeping	
Dietary	
Nursing Supplies & Services	
TOTAL BASE COSTS	
LABOR COSTS	
Administrator Salaries	
Other Administrative Salaries	
Nursing Salaries	
Direct Care Salaries	
Other Salaries	
Active Treatment Services	
Medical Services	
Day Program Services	
TOTAL LABOR COSTS	
RETURN ON EQUITY	
GRAND TOTAL	

GRAND TOTAL / ICF/MR Resident Days = _____ ICF/MR Cost per Day

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SCHEDULE A

EXPLANATION OF MISCELLANEOUS ACCOUNTS

ACCT. #	EXPLANATION	AMOUNT	ACCT. #	EXPLANATION	AMOUNT

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Resident Classification Report
Resident Days By Classification and B Level-Of-Care

Month ICF/MR

	A		A-I-3		S		B		C			Other
	AFS	Other	AFS	Other	AFS	Other	AFS	Other	AFS	Other	TOTAL	(Specify)
January												
February												
March												
April												
May												
June												
July												
August												
Sept.												
October												
Nov.												
Dec.												
TOTAL												

Month Resident Days by licensed Bed

	Designated ICF/MR Area			Other (Specify)	Other (Specify)
	AFS	Other	Total		
January					
February					
March					
May					
June					
July					
August					
Sept.					
October					
Nov.					
Dec					
TOTAL					

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Bed Capacity

	Designated ICF/MR Area			Other (Specify)			Other (Specify)		
	Beginning	Change	Change	Beginning	Change	Change	Beginning	Change	Change
Licensed Bed Capacity									
Certificate of Need Capacity									
Available Capacity									
Date Changed									

STAFFING RATIO REPORT OR DIRECT CARE STAFF*

	SHIFT									
	1st				2nd				3rd	
MONTH	No. of Direct Care		No. of Hrs. Worked		No. of Direct Care		No. of Hrs. Worked		No. of Direct Care		No. of Hrs Worked	
	Staffs	Sups.	Staff	Sups.	Staff	Sups.	Staff.	Sups	Staff	Sups.	Staff	Sups.
January												
February												
March												
April												
May												
June												
July												
August												
September												
October												
November												
December												

*Direct Care Staff - See ICF/MR Provider Guide for Definition.

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STAFFING RATIO REPORT FOR SECURE WARD STAFF

	SHIFT											
	1st				2nd				3rd			
	No. of Secure Ward		No. of Hrs. Worked		No. of Secure Ward		No. of Hrs. Worked		No. of Secure Ward		No. of Hrs Worked	
	Staffs	Sups.	Staff	Sups.	Staff	Sups.	Staff.	Sups	Staff	Sups.	Staff	Sups.
January												
February												
March												
April												
May												
June												
July												
August												
September												
October												
November												
December												

DEFINITION OF A CLAIM

(1) For nursing facility services (SNF, ICF, ICF/HA, ICF-MR) and state mental hospital services (MI) and non-ancillary charges for private psychiatric hospital services, a claim is a line item on the invoice (AFS 403).

(2) For all other services, a claim is an invoice.

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

Requirements for Third Party Liability -
Identifying Liable Resources

(1) The requirements in 433.138(f) is met, as follows:

A. The frequency of the data exchange with the Employment Division (SWICA) is quarterly.

B. The frequency of the data exchange with Title IV-A is daily.

C. The frequency of the data exchange with the Motor Vehicle Division for accident report data is monthly.

D. The frequency of diagnosis and trauma code edits is daily.

E. The frequency of the data exchange with Worker's Compensation is monthly.

(2) The requirement in 433.138(g)(1)(ii) is met, as follows:

A. SWICA

Clients with earnings are in a monthly reporting system. The Monthly Change Report (AFS 859A/1199) is used to report any changes and includes a question to gather new medical insurance information.

On a quarterly basis, a match is made with the Employment Division (SWICA). A report is generated when there is an earned income discrepancy for a client which exceeds $450 for a quarter. A form is sent to the employer (AFS 851) or to the client (AFS 851F) to follow-up. These forms are used to verify earnings and to gather health insurance information.

For wages paid on or after January 1, 1990, employers in Oregon are required to furnish the Employment Division with information about health insurance coverage offered to employees or to their dependents. The Employment Division will gather the information and pass it to the Adult and Family Services Division on a quarterly basis. The IV-D Agency will develop the medical insurance information as part of the medical support enforcement activities and will pass the information to the Title XIX Agency.

B. Title IV-A

Health insurance information is passed to the Title XIX Agency via the AFS 415H form on a daily basis. Health insurance information is gathered, but not limited to, initial application and each redetermination.

Clients with earnings are in a monthly reporting system. The Monthly Change Report (AFS 859A/1199) is used to report any changes and includes a question to gather new medical insurance information.

On a quarterly basis, a match is made with the Employment Division (SWICA). A report is generated when there is an earned income discrepancy for a client which exceeds $450 for a quarter. A form is sent to the employer (AFS 851) or to the client (AFS 851F) to follow- up. These forms are used to verify earnings and gather health insurance information.

On a monthly basis, a match is made with the health insurance codes on the CMS system and the third party resources on the MMIS TPR file. A report is generated when there is a discrepancy so that the correct resource information is available for processing claims.

(3) The requirement in 433.138(g)(2)(ii) is met, as follows:

A. Health Insurance

Adult and Family Services Division (AFS), Children's Services Division (CSD), and Senior and Disabled Services Division (SDSD) employees and Type B AAA contractors of SDSD obtain health insurance information from applicants for and recipients of Medicaid. Such information is gathered during the initial application for assistance and at each subsequent redetermination of eligibility, or at any other time that new information becomes known. Information may include, but is not limited to, the policy holder's name and social security number, the group or plan number, the policy or identification number, and the name and address of the insurance company.

Eligibility staff in branch offices of these Divisions and in Type B AAA offices are responsible for assuring that all available information is recorded on Form AFS 415H, and for sending a copy of the completed form to the Third Party Recovery Unit of the AFS Recovery services Section. The branch office retains the original AFS 415H in the client's case record file.

Third Party Recovery Unit staff verify the information on the AFS 415H and then enter the information onto the MMIS Recipient Subsystem, Third Party Resource File. If the branch enters a Medicare health insurance code (HIC) on the eligibility file, the Medicare insurance information is electronically transferred to the Third Party Resource file on MMIS.

Health insurance information may also be identified by AFS State office staff, through such sources as the Title IV-D Child Support Program, BENDEX, or provider billings or refunds that indicate health insurance. In such cases, Third Party Recovery Unit staff obtain all available information, complete the AFS 41SH (and send the original to the branch office), and code the information onto the MMIS Third Party Resource file. The Buy-In Unit verifies the electronically transferred Medicare insurance on the TPR file.

The MMIS System uses the health insurance information in processing claims, in accordance with 433.139(b) through (f). Health insurance information is also entered onto the client's medical identification card.

MMIS generates a monthly report (WMMR026R-A) to the Third Party Recovery Unit for review of recovery potential whenever new insurance is added and whenever there is a change in the effective date of known insurance.

The time frame for completing this process, from the date that Division staff first discover health insurance information until the information appears on Report #WMMRO26R-A, is 60 days.

The written agreement between AFS and SDSD provides that SDSD will collect health insurance information and transmit this information to AFS.

The written agreement between AFS and CSD provides that CSD will collect health insurance information and transmit this information to AFS.

B. Worker's Compensation

Oregon's Medicaid program is in the process of implementing a data exchange with Workers' Compensation. Once this match is implemented, we will update this item.

During the implementation of this data match, we will use the data match that provides employment-related health insurance as described in section II-A above, In addition, the IV-D agency will continue to conduct a data match with Workers' Compensation and perform medical support enforcement activities involving the absent parents.

(4) The requirement in 433.138(g)(3)(i) is met, as follows:

A. Motor Vehicle Accident Report data match

The Department of Motor Vehicles provides a monthly transaction tape containing motor vehicle accident report information. These transactions are matched with clients on the MMIS Recipient file by name and date of birth. Clients with an eligibility period on or after the date of the accident are matched. The matches are then run by the Expense Avoidance file and any record that has already been followed-up will be eliminated to avoid duplication of effort.

Information from the DMV transaction tape and from MMIS will be downloaded from the mainframe to a floppy disk. The floppy disk is loaded into the Third Party Recovery Unit's DMV Accident Data Base File on a personal computer. This data base is used for generating letters and is used for tickler purposes. The follow-up steps are as follows:

a) The Third Party Recovery Unit sends a letter to each client, asking for information about the accident. An AFS 451 is sent with each letter. This is the form that clients use to report motor vehicle accident information. The data base is updated when the response is received and serves as the tickler file to keep track of those situations where no response is received within the initial 30 days.

b) If no response is received within 30 days, a follow-up letter to the recipient is generated from the data base.

c) If no response is received within 30 days of the second letter, the Third Party Recovery unit obtains a copy of the accident report from the Division of Motor Vehicles.

(5) The requirement in 433.138(g)(3)(iii) is met, as follows:

A. Motor Vehicle Accident Report data match

After follow-up, all information that identifies legally liable third party resources is entered by staff from the Third Party Recovery Unit on the MMIS Third Party Resource File or the MMI-S Expense Avoidance File; The MMIS System automatically enters an indicator in the appropriate field on the MMIS Recipient File. The time frame for incorporating the information is 60 days.

(6) The requirement in 433.138(g)(4)(i) is met, as follows:

Claims which meet the following edit criteria are suspended on a daily basis:

Through MMIS edit 417, a report is generated for claims that contain diagnosis codes 800 through 999, with the exception of code 994.6. This edit reports all impatient hospital claims where the billed amount exceeds zero, and outpatient hospital and medical claims where the billed amount exceeds $250 dollars.

Edit 406 will suspend claims which indicate auto related, with no form AFS 451 information on the Expense Avoidance file.

1) A worksheet/report is generated and is sent to the Third Party Recovery Unit. The worksheets are reviewed, with priority given to the following:

A. Claims with auto accident indicators.

B. Claims with the following diagnosis codes: 810.00, 815.03, 821.00, 850.00, 922.10, and 997.30.

This sub-group of diagnosis codes represents injuries most likely to yield recoveries based on prior experience. On an annual basis the Third Party Recovery Unit will review the related trauma diagnosis codes for medical recoveries which exceed $5000, to determine which trauma diagnosis codes should receive the highest priority for follow-up activities for the following year.

C. Claims containing diagnosis codes beginning with E, unless such claims clearly do not represent a liability situation.

D. Claims exceeding $10,000, which are not related to late effects of surgery, unless such claims clearly do not represent a liability situation.

The Third Party Recovery Unit follows-up all claims included in A -D above, with written correspondence to the client. The client is provided with an AFS 451/AFS 451NV form to complete. The AFS 451/AFS 451NV are used to report accident information to the agency. If no response is received within 30 days, a second letter is sent to the client. If there is no current address for the client, a memo is sent to the branch worker requesting assistance. on a case by case basis, information may be obtained from the medical provider.

The completed AFS 451/AFS 451NV form is reviewed by the Third Party Recovery Unit. Liens are filed in liability situations and the information incorporated into the MMIS Expense Avoidance File. In addition to lienable situations, all claims suspended are reviewed for possible other insurance. All third party resource information identified is incorporated into the MMIS third party data base files. The MMIS Recipient file is updated with an indicator whenever a Third Party Resource file or an Expense Avoidance file is created. The information is used by the MMIS system to process claims in accordance with 433.139(b) through (f).

(7) The requirement in 433.138(g)(4)(iii) is met, as follows:

After follow-up, all information that identifies legally liable third party resources is incorporated into the Third Party Recovery Unit, the MMIS Recipient File, and either the MMIS Expense Avoidance File or the MMIS Third Party Resource File, within 60 days.

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

State Laws Requiring Third Parties to Provide Coverage Eligibility and Claims Data

1902(a)(25)(I) The State of Oregon has enacted laws that require third parties to comply with the provisions, including those which require third parties to provide the State with coverage, eligibility and claims data of 1902(a)(25)(I) of the Social Security Act. The Oregon law became effective June 20, 2007.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: OREGON

Requirements for Third Party Liability -
Payment of Claims

1) The requirement in 433.139(b)(3)(ii)(C) is met, as follows:

Medical providers use a third party resource (TPR) explanation code on the claim to communicate that the service involves insurance through the absent parent in a IV-D enforcement case, and that 30 days have lapsed since the date of service, and that the provider has not received payment from the third party resource. The MMIS system will edit for the 30 day requirement. If less than 30 days have lapsed, the claim will be rejected.

On a quarterly basis, the MMIS system produces a listing of all claims processed for recipients with third party resource coverage. This report includes all claims with a TPR explanation code. This report is used by the Utilization Review group to identify any fraudulent or erroneous billings through verification with the third party carriers.

2) The requirement in 433.139(f)(2) is met, as follows:

Threshold amounts. With the implementation of the Post Payment Recovery System the threshold amount for the post payment recovery of claims are:

A) For claims involving Medicare, zero.

B) For claims involving private health insurance, zero.

C) For drug claims, $25.

D) For ICF/MR and IMD, zero.

E) For claims paid under the provisions of 433.139(b)(3), zero.

3) The requirement in 433.139(f)(3) is met, as follows:

A) Oregon accumulates drug claims to $25 before billing. If the accumulated total is less than $25 for the 60 day period prior to the billing generation, the claims will be added to the next billing cycle (every 60 days for drug claims). For all other claim types, Oregon does not accumulate billings by dollar amount or period of time and the weekly Post Payment Recovery System billing cycle is run immediately following the weekly MMIS claims cycle. All recoveries are sought within the time limits specified in 433.139(d).

THIRD PARTY LIABILITY: Payment of Health Insurance Premiums

In accord with Section 1903(a)(1) of the Act, Oregon will on a case-by-case basis pay health insurance premiums to establish or maintain coverage for Medical Assistance recipients when it is determined to be cost beneficial. Examples are:

1. When the recipient was recently separated from employment due to a layoff, medical condition or pregnancy, and retains the option to continue with the existing health coverage through the former employer.

2. When the recipient is a dependent of an employed parent or other liable party, with option to purchase such coverage.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: OREGON

Citation	Condition or Requirement
1906 of the Act	State Method on Cost Effectiveness of Employer-Based Group Health Plans

See attached

U.S. Government Printing Office : 1991 - 312-149/40352

Third Party Liability: Payment of Group Health Plan Premiums

In accord with Section 1906 of the Act, implementing Section 4402 of OBRA of 1990, Oregon requires mandatory enrollment of Medicaid recipients in cost effective group health plans as a condition of Medicaid eligibility, except for an individual who is unable to enroll on his/her own behalf. Oregon pays the group health insurance premium for Medicaid individuals if cost effective. Oregon may also pay the premium for non-Medicaid individuals if cost effective and if it is necessary in order to enroll the Medicaid recipient in the group health plan. Oregon pays, subject to state payment rates, deductibles, coinsurance and other cost sharing obligations under the group health plan for Medicaid recipients enrolled in the group health plan for items and services covered under the State Plan. Oregon pays for items and services provided to Medicaid recipients under the State Plan that are not covered in the group health plan. The group health plan will be treated as a third party resource as described in the State Plan for 42 CFR 433.138 and 433.139.

The following guidelines are used to determine cost effectiveness.

1. Determine if the group health plan is a basic/major medical policy or a health maintenance organization (HMO).

2. Determine the premium amount to be paid, converting any premiums that are not monthly, to a monthly amount.

3. Determine the number of Medicaid individuals to be covered.

4. Determine the average premium cost per Medicaid individual.

5. Determine the average monthly Medicaid cost savings for Medicaid persons who will be covered by the basic/major medical coverage or HMO coverage using the Medicaid Savings Chart.

   The Medicaid Savings Chart is updated yearly. It is based on the MMIS WMMS757R-A report which is an analysis of the costs for Medicaid recipients with third party resources versus those Medicaid recipients without third party resources. The Medicaid Savings Chart is divided into categories of assistance, as follows:

   a. Old Age Assistance
   b. Aid to Dependent Children
   c. Aid to the Blind
   d. Aid to the Disabled
   e. Foster Care

6. The Medicaid agency will pay the premium amount if the premium cost per Medicaid individual is equal to or less than the corresponding amount shown on the Medicaid Savings Chart.

The cost effectiveness of the premium payment will be reevaluated at each redetermination.

Re “Other provider(s) reimbursed on a prepaid capitation basis”, this is restricted to organizations that received grants under the Public Health Services Act in the Fiscal Year ending June 30, 1976.

Per 42 CFR 431.502: "Health maintenance organization (HMO)" means an entity determined by the Assistant Secretary for Health (Public Health Service) to meet the following requirements:

(1) It provides to its Medicaid eligible enrollees as the "basic health services" required under sec. 1301 (b) and (c) of the Public Health Service Act--

(i) Inpatient hospital services;

(ii) Outpatient services;

(iii) Laboratory and X-ray services;

(iv) Family planning services and supplies;

(v) Physician services; and

(vi) Home health services for individuals entitled to those services under the Medicaid state plan.

(2) It provides the services listed in paragraph (a) in the manner prescribed in sec. 1301(b) of the Public Health Service Act.

(3) It is organized and operated in the manner prescribed in sec. 1301(c) of the Public Health Service Act.

Per 42 CFR 431.597(b): Non-availability of FFP: The limitation under paragraph (a) of this section does not apply to HMOs or health insuring organizations meeting the criteria of sec. 1903(m)(2)(B)(i), (ii) of the Act. These organizations generally include those that received grants under the Public Health Service Act in the fiscal year ending June 30, 1976, certain rural primary health care entities, and certain entities that operated on a prepaid risk basis before 1970.

State/Territory: OREGON

Citation		Sanctions for Psychiatric Hospitals
1902(y)(1), 1902(y)(2)(A), and Section 1902(y)(3) of the Act (P.L. 101-508, Section 4755(a)(2)	(a)	The State assures that the requirements of section 1902(y)(1), section 1902(y)(2)(A), and section 1902(y)(3) of the Act are not concerning sanctions for psychiatric hospitals that do not meet the requirements of participation when the hospital's deficiencies immediately jeopardize the health and safety of its patients or do not immediately jeopardize the health and safety of its patients.
1902(y)(1)(A) of the Act	(b)	The State terminates the hospital's participation under the State plan when the State determines that the hospital does not meet the requirements for a psychiatric hospital and further finds that the hospital's deficiencies immediately jeopardize the health and safety of its patients.
1902(y)(1)(B) of the Act	(c)	When the State determines that the hospital does not meet the requirements for a psychiatric hospital and further finds that the hospital's deficiencies do not immediately jeopardize the health and safety of its patients, the State may: 1. terminate the hospital's participation under the State plan; or 2. provide that no payment will be made under the State plan with respect to any individual admitted to such hospital after the effective date of the finding; or 3. terminate the hospital's participation under the State plan and provide that no payment will be made under the State plan with respect to any individual admitted to such hospital after the effective date of the finding.
1902(y)(2)(A) of the Act	(d)	When the psychiatric hospital described in (c) above has not complied with the requirements for a psychiatric hospital within 3 months after the date the hospital is found to be out of compliance with such requirements, the State shall provide that no payment will be made under the State plan with respect to any individual admitted to such hospital after the end of such 3-month period.

State/Territory: OREGON

Citation	Sanctions for MCOs and PCCMs
1932(e) 42 CFR 428.726	P&I (a) The State will monitor for violations that involve the actions and failure to act specified in 42 CFR Part 438 Subpart I and to implement the provisions in 42 CFR 438 Subpart I, in manner specified below: (b) The State uses the definition below of the threshold that would be met before an MCO is considered to have repeatedly committed violations of section 1903(m) and thus subject to impositions of temporary management: (c) The State's contracts with MCOs provide that payments provided for under the contract will be` denied for new enrollees when, and for so long as, payment for those enrollees is denied by CMS under 42 CFR 438.730(e). ___ Not applicable; the State does not contract with MCOs, or the State does not choose to impose intermediate sanctions on PCCMs.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Oregon

METHODS FOR ISSUANCE OF MEDICAID ELIGIBILITY CARDS
TO HOMELESS INDIVIDUALS

In Oregon, the lack of a home address is not a deterrent to receiving Medicaid. Medicaid eligibility cards may be sent to anyplace the person chooses, i.e., post office box, general delivery, public shelter, etc. or the person may pick up the card at his/her local branch office.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: OREGON

REQUIREMENTS FOR ADVANCE DIRECTIVES UNDER STATE PLANS FOR MEDICAL ASSISTANCE

The following is a written description of the law of the State (whether statutory or as organized by the courts of the State) concerning advance directives. If applicable States should include definitions of living will, durable power of attorney for health care, durable power of attorney, witness requirements, special State limitations on living will declarations, proxy designation, process information and State forms, and identify whether State law allows for a health care provider or agent of the provider to object to the implementation of advance directives on the basis of conscience.

CHAPTER 761
AN ACT

Relating to health care; and prescribing an effective date.

Be It Enacted by the People of the State of Oregon:

SECTION 1. As used in sections 1 to 4 of this 1991 Act:

(1) "Health care organization" means a home health agency, hospice program, hospital, long term care facility or health maintenance organization.

(2) "Health maintenance organization" has that meaning given in ORS 750.005, except that "health maintenance organization" includes only those organizations that participate in the federal Medicare or Medicaid programs.

(3) "Home health agency" has that meaning given in ORS 443.005.

(4) "Hospice program" has that meaning given in ORS 443.850.

(5) "Hospital" has that meaning given in ORS 442.015(13), except that "hospital" does not include a special inpatient care facility.

(6) "Long term care facility" has that meaning given in ORS 442.015(13) except that "long term care facility" does not include an intermediate care facility for individuals with mental retardation.

SECTION 2. Subject to the provisions of sections 3 and 4 of this 1991 Act, all health care organizations shall maintain written policies and procedures, applicable to all capable individuals 18 years of age or older who are receiving health care by or through the health care organization, that provide for:

(1) Delivering to those individuals the following information and materials, in written form, without recommendation:

(a) Information on the rights of the individual under Oregon law to make health care decisions including the right to accept or refuse medical or surgical treatment and the right to execute directives and powers of attorney for health care;

(b) Information on the policies of the health care organization with respect to the implementation of the rights of the individual under Oregon law to make health care decisions;

(c) A copy of the directive form set forth in ORS 127.610 and a copy of the power of attorney for health care form set forth in ORS 127.530, along with a disclaimer attached to each form in at least 16-point bold type stating "You do not have to fill out and sign this form."; and

(d) The name of a person who can provide additional information concerning the forms for directives and powers of attorney for health care.

(2) Documenting in a prominent place in the individual's medical record whether the individual has disputed a directive or a power of attorney for health care.

(3) Insuring compliance by the health care organization with Oregon law relating to directives and powers of attorney for health care.

(4) Educating the staff and the community on issues relating to directives and powers of attorney for health care.

SECTION 3. The written information described in section 2(1) of this 1991 Act shall be provided

(1) By hospitals, not later than five days after an individual is admitted as an inpatient, but in any event before discharge;

(2) By long term care facilities, not later than five days after an individual is admitted as a resident, but in any event before discharge;

(3) By a home health agency or a hospice program, not later than 15 days after the initial provision of care by the agency or program but in any event before ceasing to provide care; and

(4) By a health maintenance organization, not later than the time allowed under federal law.

SECTION 4. (1) The requirements of sections 1 to 4 of this 1991 Act are in addition to any requirements that may be imposed under federal law, but this 1991 Act shall be interpreted in a fashion consistent with the Patient Self-Determination Act, enacted by sections 4206 and 4751 of Public Law 101-508. Nothing in this 1991 Act requires any health care organization, or any employee or agent of a health care organization to act in a manner inconsistent with federal law or contrary to individual religious or philosophical beliefs.

(2) No health care organization shall be subject to criminal prosecution or civil liability for failure to comply with this 1991 Act.

SECTION 5. Sections 1 to 4 of this Act are added to and made a part of ORS 127.505 to 127.583

SECTION 6. If Senate Bill 494 becomes law section 5 of this Act is repealed and section 7 of this Act is enacted in lieu thereof.

SECTION 7. Sections 1 to 4 of this 1991 Act are added to and made a part of sections 1 to 21, chapter Oregon Laws 1991 (Enrolled Senate Bill 494).

SECTION 8. This Act takes effect on December 1, 1991.

SECTION 9. Sections 1 to 4 of this Act are repealed December 1, 1993.

Approved by the Governor August 5, 1991
Filed in the office of Secretary of State August 5, 1991

SECTIONS 1-4 will follow ORS 127-650 as a "Note" entitled "Obligations of Health Care Organizations". This is based on Section 8 and 9 of this act.

127.530 Form of power of attorney. A written power of attorney for health care shall provide no other authority than the authority to make health care decisions on behalf of the principal and shall be in the following form:

POWER OF ATTORNEY FOR HEALTH CARE

I appoint _____, whose address is _____, and whose telephone number is _____, as my attorney-in-fact for health care decisions. I appoint _____ , whose address is _____ , and whose telephone number is _____ , as my alternative attorney-in-fact for heath are decisions. I authorize my-attorney-in-fact appointed by this document to make health care decisions for me when I am incapable of making my own health care decisions. I have read the warning below and understand the consequences of appointing a power of attorney for health care.

I direct that my attorney-in-fact comply with the following instructions or limitations: _____

In addition, I direct that my attorney-in-fact have authority to make decisions regarding the following.

____ Withholding or withdrawal of life-sustaining procedures with the understanding that death may result.

____ Withholding or withdrawal of artificially-administered hydration or nutrition or both with the understanding that dehydration, malnutrition and death may result.

_____
(Signature of person making appointment/Date)

DECLARATION OF WITNESSES

We declare that the principal is personally known to us, that the principal signed or acknowledged the principal's signature on this power of attorney for health care in our presence, that the principal appears to be of sound mind and not under duress, fraud or undue influence, that neither of us is the person appointed as attorney-in-fact by this document or the principal's attending physician. Witnessed By:

(Signature of Witness/Date) (Printed Name of Witness)

(Signature of Witness/Date) (Printed Name of Witness)

ACCEPTANCE OF APPOINTMENT POWER OF ATTORNEY

I accept this appointment and agree to serve as attorney-in-fact for health care decisions. I understand I have a duty to act consistently with the desires of the principal as expressed in this appointment. I understand that this document gives me authority over health care decisions for the principal only if the principal becomes incapable. I understand that I must act in good faith in exercising my authority under this power of attorney. I understand that the principal may revoke this power of attorney at any time in any manner, and that I have a duty to inform the principal's attending physician promptly upon any revocation.

(Signature of Attorney-in-fact/Date)

(Printed name)

_____
(Signature of Alternate Attorney-in-fact/Date)

(Printed name)

WARNING TO PERSON APPOINTING A POWER OF ATTORNEY FOR HEALTH CARE

This is an important legal document. It creates a power of attorney for health care. Before signing this document, you should know these important facts.

This document gives the person you designate as your attorney-in-fact the power to make health care decisions for you, subject to any limitations, specifications or statement of your desires that you include in this document.

For this document to be effective, your attorney-in-fact must accept the appointment in writing.

The person you designate in this document has a duty to act consistently with your desires as stated in this document or otherwise made known or, if your desires are unknown, to act in a manner consistent with what the person in good faith believes to be in your best interest. The person you designate in this document does, however, have the right to withdraw from this duty at any time.

DIRECTIVE- TO PHYSICIANS 127.610

127,610 Execution and revocation of directive; form; witness qualifications and responsibility. (1) An individual of sound mind and 18 years of age or older may at any time execute or re-execute a directive directing the withholding or withdrawal of life-sustaining procedures should the declarant become a qualified patient. The directive shall be in the following form:

DIRECTIVE TO PHYSICIANS

Directive made this _____ day of ___ (month, year). I _____ , being of sound mind, willfully and voluntary make known my desire that my life shall not be artificially prolonged under the circumstances set forth below and do hereby declare:

1. If at any time I should have an incurable injury, disease or illness certified to be a terminal condition by two physicians, one of whom is the attending physician, and where the application of life-sustaining procedures would serve only to artificially prolong the moment of my death and where my physician determines that my death is imminent whether or not life-sustaining procedures are utilized, I direct that such procedures be withheld or withdrawn, and that I be permitted to die naturally.

2. In the absence of my ability to give directions regarding the use of such life-sustaining procedures, it is my intention that this directive shall be honored by my family and physician(s) as the final expression of my legal right to refuse medical or surgical treatment and accept the consequences from such refusal.

3. I understand that full import of this directive and I am emotionally and mentally competent to make this directive.

Signed _____

City, County and State of Residence _____

I hereby witness this directive and attest that:

(1) I personally know the Declarant and believe the Declarant to be of sound mind.

(2) To the best of my knowledge, at the time of the execution of this directive, I:

(a) Am not related to the Declarant by blood or marriage,

(b) Do not have any claim on the estate of the Declarant,

(c) Am not entitled to any portion of the Declarant's estate by any will or by operation of law, and

(d) Am not a physician attending the Declarant, a person employed by a physician attending the Declarant or a person employed by a health facility in which the Declarant is a patient.

(1) I understand that if I have not witnessed this directive in good faith I may be responsible for any damages that arise out of giving this directive its intended effect.

Witness

Witness

(2) A directive made pursuant to subsection (1) of this section is only valid if signed by the declarant in the presence of two attesting witnesses who, at the time the directive is executed, are not:

(a) Related to the declarant by blood or marriage;

(b) Entitled to any portion of the estate of the declarant upon the decease thereof under any will or codicil of the declarant or by operation of law at the time of the execution of the directive;

(c) The attending physician or an employee of the attending physician or of a health facility in which the declarant is a patient; or

(d) Persons who at any time of the execution of the directive have a claim against any portion of the estate of the declarant upon the declarant's decease.

(3) One of the witnesses, if the declarant is a patient in a long term care facility at the time the directive is executed, shall be an individual designated by the Department of Human Resources for the purpose of determining that the declarant is not so insulated from the voluntary decision-making role that the declarant is not capable of willfully and voluntarily executing a directive.

(4) A witness who does not attest a directive in good faith shall be liable for any damages that arise from giving effect to an invalid directive.

(5) A directive made pursuant to ORS 127.605 to 127.650 and 97.990(5) to (7) may be revoked at any time by the declarant without regard to mental state or competency by any of the following methods:

(a) By being burned, torn, canceled, obliterated or otherwise destroyed by the declarant or by some person in the declarant's presence and by direction of the declarant.

(b) By written revocation of the declarant expressing intent to revoke, signed and dated by the declarant.

(c) By a verbal expression by the declarant of intent to revoke the directive.

(6) Unless revoked, a directive shall be effective from the date of execution. If the declarant has executed more than one directive, the last directive to be executed shall control. If the declarant becomes comatose or is rendered incapable of communicating with the attending physician, the directive shall remain in effect for the duration of the comatose condition or until such time as the declarant's condition renders the declarant able to communicate with the attending physician.[Formerly97.055]

YOUR RIGHT TO MAKE HEALTH CARE DECISIONS IN OREGON

DO I HAVE TO DO WHATEVER MY DOCTOR RECOMMENDS? No. You have a right to accept or refuse any proposed medical tests or treatment.

HOW WILL I KNOW HOW TO DECIDE? Your doctor will tell you what treatment or testing he or she recommends. Your doctor will then ask if you want to know more. If you-do, your doctor will tell you about the treatment or test, the available alternatives and the material risks. When you have enough information, you decide whether to have the test or treatment.

HOW CAN I PLAN AHEAD FOR A TIME WHEN I MAY BE UNABLE TO MAKE DECISIONS? Oregon has only two official forms you can sign to cover future situations where you are unable to decide. A Directive to Physician is a legal statement that you do NOT want artificial life support which would only postpone your death when you are terminally ill. A Power of Attorney for Health Care lets you designate someone you trust, your representative, to make your health care decisions for you when you can't do so yourself. It allows your representative to give most directions you could have given. Your representative cannot act for you unless you become unable to make your own decisions.

HOW DO THESE HEALTH CARE PLANNING FORMS TAKE EFFECT? If you are an adult able to make your own decisions, you can sign either or both of these forms. You do not have to fill out and sign either form if you don't want to. However, if you do, your doctor must follow it or allow you to be transferred to a doctor who will.
The forms will not affect your insurance.

HOW DO I APPOINT SOMEONE ELSE TO ACT FOR ME? By using a "Power of Attorney for Health Care" form, you may select another adult as your health care representative. You may also appoint an alternate, if you wish. The representative and any alternate must sign the form agreeing to serve. You must also decide what authority you want to give those persons. Your representative is not obligated to pay your medical bills.

HOW DO I OBTAIN AND SIGN MY WRITTEN HEALTH CARE DOCUMENTS? Health care facilities and some stationery stores have the official forms. In Oregon, the only reliable way to be sure your wishes are followed is to use the official forms. Do not change them except by filling in the blanks. Don't add anything about money or property. Each must be signed by you and two witnesses who must satisfy special requirements. Read and follow the directions. Send a copy to your doctor and to anyone you choose as a representative. Keep the original where it can be found.

JUNE 1995

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: OREGON

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Enforcement of Compliance for Nursing Facilities

The State uses other factors described below to determine the seriousness of deficiencies in addition to those described at §488.404(b)(1):

N/A - OAR 411-73-030

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: OREGON

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Enforcement of Compliance for Nursing Facilities

Termination of Provider Agreement: Describe the criteria (as required at §1919(h)(2)(A) for applying the remedy.

X Specified Remedy

(Will use the criteria and notice requirements specified in the regulation.)

OAR 411-73-110

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: OREGON

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Enforcement of Compliance for Nursing Facilities

Temporary Management: Describe the criteria (as required at §1919(h)(2)(A)) for applying the remedy.

X Specified Remedy

(Will use the criteria and notice requirements specified in the regulation.)

OAR 411-73-100

__ Alternative Remedy

(Describe this criteria and demonstrate that the alternative remedy is as effective in deterring non-compliance. Notice requirements are as specified in the regulations.)

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: OREGON

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Enforcement of Compliance for Nursing Facilities

Denial of Payment for New Admissions: Describe the criteria (as required at S1919(2)(A)) for applying the remedy.

X Specified Remedy

(Will use the criteria and notice requirements specified in the regulation.)

OAR 411-73-080

__ Alternative Remedy

(Describe the criteria and demonstrate that the alternative remedy is as effective in deterring non-compliance. Notice requirements are as specified in the regulations.)

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: OREGON

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Enforcement of Compliance for Nursing Facilities

Civil Money Penalty: Describe the criteria (as required at §1919(h)(2)(A)) for applying the remedy.

X Specified Remedy	__ Alternative Remedy
(Will use the criteria and notice requirements specified in the regulation.)	(Describe the criteria and demonstrate that the alternative remedy is as effective in deterring non-compliance. Notice requirements are as specified in the regulations.)

OAR 411-73-090

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: OREGON

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Enforcement of Compliance for Nursing Facilities

State Monitoring: Describe the criteria (as required at §1919(h)(2)(A)) for applying the remedy.

X Specified Remedy	__ Alternative Remedy
(Will use the criteria and notice requirements specified in the regulation.)	(Describe the criteria and demonstrate that the alternative remedy is as effective in deterring non-compliance. Notice requirements are as specified in the regulations.)

OAR 411-73-070

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: OREGON

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Enforcement of Compliance for Nursing Facilities

Transfer of residents; Transfer of residents with closure of facility: Describe the criteria (as required at §1919(h)(2)(A)) for applying the remedy.

X Specified Remedy	__ Alternative Remedy
(Will use the criteria and notice requirements specified in the regulation.)	(Describe the criteria and demonstrate that the alternative remedy is as effective in deterring non-compliance. Notice requirements are as specified in the regulations.)

OAR 411-73-110

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: OREGON

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Enforcement of Compliance for Nursing Facilities

Additional Remedies: Describe the criteria (as required at §1919(h)(2)(A)) for applying the additional remedy. Include the enforcement category in which the remedy will be imposed (i.e., category 1, category 2, or category 3 as described at 42 CFR 488.408).

No additional remedies under federal requirements.

STATE PLAN UNDER TITLE XIX OF TH3t SOCIAL SECURITY ACT

State/Territory: OREGON

DlSCLOSURE OF ADDITIONAL REGISTRY INFORMATION

1. Full name of nursing assistant

2. Information to identify each individual, including date of birth

3. Previous three places of employment (as a CNA)

4. Advanced training completed (medication aide, home health aide, psychiatric aide)

5. Date individual passed competency evaluation program or was deemed eligible

6. Information relating to findings of abuse, neglect or misappropriation of property

   a. Documentation of investigation

   b. Date of hearing, if any, and its outcome

   c. Individual's statement refuting allegation.

STATE PLAN UNDER TITLE XIX OF TH3t SOCIAL SECURITY ACT

State/Territory: OREGON

COLLECTION OF ADDITIONAL REGISTRY INFORMATION

1. Full name of nursing assistant
2. Social Security Number
3. Information to identify each individual, including date of birth
4. Advanced-training completed (medication aide, home health aide, psychiatric aide)
5. Previous three places of employment (as a CNA)
6. Date individual passed competency evaluation program or was deemed eligible
7. Information relating to findings of abuse, neglect or misappropriation of property
   a. Documentation of investigation
   b. Date of hearing, if any, and its outcome
   c. Individual's statement refuting allegation.

Definition of Specialized Services

For Persons With Mental Retardation/Developmental Disabilities (MR/DD):

Specialized services in nursing facilities (NFs) are services paid solely by State of Oregon funds which increase access to, and participation in, community events and activities, including community-based employment and alternatives to employment (work activity centers, senior centers, etc.). If an individual's physical condition does not permit participation in community-based services, the State will provide specialized services in the NF.

For Persons With Mental Illness (MI):

Specialized services are generally not offered in NFs, but rather in psychiatric units of JCAHO-certified hospitals. Each individual's plan of care identifies specific therapies and activities to be delivered on a continuous basis (24 hour day) to treat acute episodes of serious mental illness. Interdisciplinary teams of qualified mental health professionals (each including a physician) develop, implement and supervise the individual's services. The goal of the individual plan of care is to return the individual to his or her maximal level of functioning so that they can be maintained by less intensive services.

Categorical Determinations

I. Nursing Facility Services Needed:

For persons with either Mental Retardation/Developmental Disabilities (MR/DD) or Mental Illness (MI), the State of Oregon may make an advance group determination that nursing facility (NF) services are needed for any of the following situations:

Convalescent Care:
The individuals currently in an acute care hospital recovering from an illness or surgery, the likely stay in the NF will not exceed 30 days (60 days if MR/DD), and resources necessary to meet the individual's post-NF needs are arranged or are being developed;

Terminal Illness:
The applicant's attending physician has certified, prior to NF placement, an explicit terminal prognosis with a life expectancy of less than 6 months;

Severe Physical Illness:
The individual has a severe chronic medical condition or illness that precludes participation in, or benefit from, specialized services (examples: coma, ventilator dependence, functioning at a brain stem level, chronic obstructive pulmonary disease, Parkinson's disease, Huntington's disease, amyotrophic lateral sclerosis, and congestive heart failure);

Respite Care (DD only):
The individual requires NF services for a maximum stay of 30 days per year as a respite for his or her in-home caregivers, and resources necessary to meet the individual's post-NF needs are developed; or

Emergency Situations (DD only):
The individual is granted provisional admission, pending further assessment, in emergency situations requiring protective services. The length of such NF placement will not exceed 7 days.

Regardless of the original categorical determination status of each individual admitted to a NF, the State of Oregon will continue to monitor the need of every NF resident for a Level II assessment through the Annual Resident Review and other processes.

Categorical Determinations (continued)

II. Specialized Services Not Needed:

For persons with Mental Retardation/Developmental Disabilities (MR/DD), the State of Oregon may make an advance group determination that specialized services are not needed for any of the following situations:

Dementia In Combination With Mental Retardation:

The individual has a primary diagnosis of dementia, as defined in the most recent Diagnostic and Statistical Manual of Mental Disorders (DSM), in combination with mental retardation or a related condition;

Delirium:

The individual has a primary DSM diagnosis of delirium and the State cannot make an accurate evaluation of the need for specialized services until the delirium clears;

Emergency Situations:

The individual is granted provisional admission, pending further assessment, in emergency situations requiring protective services. Such placement in a NF will not exceed 7 days; or

Respite Care:

The individual will not be likely to experience a developmental or physical decline in the absence of specialized services during a respite stay (an individual's respite care schedule should remain as close as possible to the home environment's schedule).

PASARD12.04

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: OREGON

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Survey and Certification Education Program

The state has in effect the following survey and certification periodic educational program for the staff and residents (and their representatives) of nursing facilities in order to present current regulations, procedures, and policies.

State-wide joint trainings are offered at least annually in cooperation with the long-term care provider associations. Topics involve current regulations, policies and procedures and updates. In addition, group interviews and special exit conferences are conducted with residents and their representatives at each annual re-certification survey for the purpose of providing information about current regulations and compliance issues.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: OREGON

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Process for the Investigation of Allegations of Resident Neglect and Abuse and Misappropriation of Resident Property

The State has in effect the following process for the receipt and timely review and investigation of allegations of neglect and abuse and misappropriation of resident property by a nurse aide or a resident in a nursing facility or by another individual used by the facility in providing services to such a resident.

State law and policy/procedure specify nursing facility abuse complaints must be investigated within two hours of receipt. This function is carried out by specially trained local staff in conjunction with a Registered Nurse at the State level. Investigation reports are reviewed at the State level and sanctions are levied as indicated.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: OREGON

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Procedures for Scheduling and Conduct of Standard Surveys

The State has in effect the following procedures for the scheduling and conduct of standard surveys to assure that it has taken all reasonable steps to avoid giving notice.

All scheduling information is strictly confidential. Life safety code survey staff are not notified of the conduct of the health survey until after the entrance has occurred. Schedules are developed within a 120day window in order to avoid giving notice.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: OREGON

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Programs to Measure and Reduce Inconsistency

The State has in effect the following programs to measure and reduce inconsistency in the application of survey results among surveyors.

Quarterly trainings are held for the purpose of informing and educating survey staff in survey methods in order to reduce inconsistency. Regional office staff participate in these trainings in order to clarify regulations and policies and procedures and to interpret HCFA Central office information.

Other programs regularly incorporated into the quarterly trainings are presentations by specialty survey staff, such as dieticians and social workers; individual and group exercises to measure application of scope and frequency to citations; and exercises to measure consistency in deficiency identification by individual surveyors and survey teams.

As much as possible, survey teams are drawn from a pool for each assignment, allowing for interchange among surveyors.

Bi-weekly staff meetings include instruction on and discussion of survey consistency issues with all staff.

Additional processes to reduce inconsistency include supervisory "round table review" of survey reports together with the survey teams, and a supervisory audit procedure to review reports for consistency between offices.

Quality improvement monitoring is ongoing.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: OREGON

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Process for Investigations of Complaints and Monitoring

The State has in effect the following process for investigating complaints of violations of requirements by nursing facilities and monitors onsite on a regular, as needed basis, a nursing facility's compliance with the requirements of subsection (b), (c), and (d) for the following reasons:

(i) the facility has been found not to be in compliance with such requirements in the process of correcting deficiencies to achieve such compliance;

(ii) the facility was previously found not to be in compliance with such has corrected deficiencies to achieve such compliance, and verification of continued compliance is indicated; or

(iii) the State has reason to question the compliance of the facility with such requirements.

A complement of staff is maintained in order to investigate complaints. Referrals are made to the State level for investigation of complaints of facility-wide substandard care or patterns of non-compliance.

Follow-up is conducted to assure correction of deficiencies identified through the re-certification survey and a mechanism exists to provide for on-site monitoring of facilities whose ability to maintain compliance is questionable.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Oregon

Employee Education Regarding False Claims Recovery
Methodology of Compliance Oversight

State will oversee compliance through existing and other methodologies found to comply with requirements of Section 6032 of the Deficit Reduction Act 2005. Methods include but are not limited to contract and intergovernmental agreement approval and management; systematic quality assurance/quality improvement reviews; provider/entity enrollment procedures; provider/entity education and training; auditing. The State began to disseminate information regarding the requirements for compliance across all affected providers/entities January 9, 2007 and will follow with additional guidance through regular communication and training channels. The State will provide to all affected providers/entities basic information outlining what is necessary for compliance and material that may be used for compliance purposes. The State will continue its use of effective mechanisms available to prevent, detect and report fraud, waste and abuse in federal health care programs.

In CY 2007 affected providers/entities will be identified and provided with the information described above. Thereafter and on an annual basis, the State will obtain information on additional affected providers/entities and follow the process described above. Non MCO contracts and FFS providers/entities will be notified of the obligation to comply with state and federal regulations, contracts or agreements will be amended on the next renewal, and that the Departments oversight and compliance will begin upon receipt of notification or by September 30, 2007 which ever is first. The Department will audit provider/entities for compliance during the audit unit's regular schedule.

Managed Care contracts were amended for the term that began January 1, 2007 in order to require compliance with section 6032 referenced above. The Department reviews the MCO contractors on an annual basis for contract compliance which will also include compliance with this section.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: OREGON

STANDARDS OF PERSONNEL ADMINISTRATION

1. See ORS Chapter 240 as amended in 1973.

2. See Personnel Rules and Merit System Laws as amended August, 1972.

3. See Rules of the Public Employee Relations Board as amended February, 1974

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DEPARTMENT OF HUMAN RESOURCES	SUBJECT: NON-DISCRIMINATION IN FEDERALLY ASSISTED PROGRAMS	NUMBER A-04	PAGE 1 OF 6
	PURPOSE: To outline procedures and policy for civil rights compliance by Dept. of Health and Human Services (DHHS) funded for DHR Divisions	REVISES ~~#01-05~~ #A-04 DATED: ~~8/80-7/1/85~~ Rev. 4-89	
		EFFECTIVE: July 1, 1985	
	AFFECTS: All DHR Divisions receiving DHHS funds.	APPROVED BY: /S/	
Policies & Objectives	STATUTORY AUTHORITY: Title VI Civil Rights Act of 1964, as amended: Section 504 of the Rehabilitation Act of 1973, Age Discrimination Act of 1975.	SECTION Administration	

1. PURPOSE

This plan outlines procedures and policies by wh1ch DHHS-(formerly HEW) funded Department of Human Resources Agencies comply with Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973 as amended and Age Discrimination Act of 1975.

II. POLICY

Under the provisions of Title VI, Civil Rights Act of 1964 (42 USC 2000 d. et. seq.) with 45 CFR Part 80, Section 504 of the Rehabilitation Act of 1973 (29 USC 706) with 45 CFR Part 84 (Sub-parts A,b,C, and F), and the Age Discriminat10n Act of 1975 (42 U.S.C. 6101 et seg.) with 45 CFR Part 90 no individual shall, on the grounds of race, color, national origin, or persons with disabilities, or age shall be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under federally assisted programs and activities for which the Department of Human Resources (hereinafter called Department) has responsibility. This same policy of non-discrimination is equally applicable to all Department contractors, grantees, agents, and providers of services funded in whole or in part with Federal Funds from the Department of Health and Human Services (formerly Department of Health, Education and Welfare).

A. This policy encompasses in scope and application the civil r1ghts of employee, clients, recipients, applicants, and beneficiaries of DHHS-funded programs operated by or in behalf of the Department of Human Resources.

B. Title VI of the Civil Rights Act prohibits acts of discrimination based on race, color, and national origin.

C. Section 504 of the Rehabilitation Act prohibits discrimination based on handicap. The term “Persons with disabilities” includes such diseased or conditions as: speech, hearing, visual and orthopedic impairments, cerebral palsy, epilepsy, muscular dystrophy, HIV, multiple sclerosis, cancer, diabetes, heart disease, mental retardation, emotional illness; and specific learning disabilities such as brain dysfunction, and developmental aphasia. Alcohol and drug addicts are also considered individuals with disabilities.

D. The age discrimination act prohibits discrimination based on age in programs or activities.

The Age Discrimination Act prohibits discrimination based on age in programs of activities. The Act and the implementing regulations contain certain exceptions to the broad provision against discrimination. A program is permitted to use age distinctions in programs which have been "established under any law” such as the programs authorized by the Older Americans Act.

A facility is also permitted to take action based on age distinctions, if the action reasonably takes in to account ages as a factor necessary to the normal operation or the achievement of any statutory objective of a program or activity. An action reasonably takes into account age as a factor if all the four cond1tlons are met. These factors are referred to as the “Four Part Test".

1. Age is used as a measure or approximation of one of more other characteristics; and
2. The other characteristic(s) must be measured or approximated in order for the normal operation of the program or activity to continue, or to achieve any statutory objective of the program or activity; and
3. the other characteristic(s) can be reasonably measure or approximated by the use of age; and
4. The other characteristic(s) are impractical to measure directly on an individual basis.

III. ASSIGNMENT OF RESPONSIBILITY FOR IMPLEMENTATION OF TITLE VI AND SECTION 504, AND THE AGE DISCRIMINATION ACT.

Director

The Director, Department of Human Resources, shall designate an

Individual(s) responsible for overseeing department-wide Title VI and 504 and the Age Discrimination Act.

Division Administrator

Each Division Administrator within the Department of Human Resources and the Director shall designate Title VI and Equal Opportunity Coordinators to carry out compliance activities within the Divisions and Central Office of the Department of Human Resources.*

IV. TITLE VI AND SECTION 504 ORIENTATION AND/OR TRAINING

The administrator of a DHHS-funded Division shall be responsible for conveying to all Division staff their responsibilities under Title VI, Section 504 and the Age Discrimination Act. This shall be accomplished by providing, as part of a new employee's orientation and periodic retaining of permanent employee, information regarding the obligation, intent, and meaning of Title VI, Section 504 and the Age Discrimination Act.

The Administrator of a DHHS-funded Division shall ensure that members of his/her staff who have contact with program beneficiaries are aware of the ethnic, cultural, and language differences that may have important impact on the delivery of services to minority persons; and the needs of the handicapped, including any barriers to their full participation in the agency's program; and actions that result in denying or limiting services or otherwise discrimination on the basis of age. This shall be accomplished in a variety of ways, including training sessions and distribution of written information.

V. TITLE VI, AND SECTION 504 AND AGE DISCRIMINATION ACT COMPLIANCE BY OTHER PARTICIPANTS

The Department recognizes that its obligations for compliance extend to Its service vendors, service contractors, and other providers of services, financial aid, and other covered benefits under the agency's DHHS-funded programs. The Department shall assure that such participants in its DHHS-funded programs comply with Title VI, Section 504, the Age Discrimination Act and their respective Regulations.*

VII. TITLE VI, AND SECTION 504 AND AGE DISCRIMINATION ACT COMPLIANCE POLI CY AND PROCEDURE.

Each DHHS-funded Division shall establish a client complaint policy and procedure.*

*Details for implementation an be found in the office(s) of the Division Affirmative Action Officer and Equal Opportunity Coordinator.

VIII. RECRUITMENT AND EMPLOYMENT PRACTICES (TITLE VI AND SECTION 504)

Regard1ng Title VI, where the primary objective of the federal financial assistance to a DHR Division is to provide employment, the responsible Division shall develop policies and procedures to assure that all recruitment and employment practices for positions provided with such federal financial assistance do not discriminate on the basis of race, color, or national origin.

Even where the primary objective of the federal financial assistance is not to provide employment, each Division shall develop policies and procedures to help assure that its employment practices do not have the effect of causing discrimination in the delivery of services and benefits under its programs. -

Regarding 504, each DHR Division shall assure that no qualified "persons with disabilities" shall, on the basis of handicap, be subjected to discrimination in employment regardless of the primary objective of the federal financial assistance.

Each DHR Division shall assure that training and educational leave are provided to its employee in a non-discriminatory manner.*

IX. PLANNING, ADVISORY, AND POLICY BOARDS

Each Division shall assure that the opportunity to participate as members of planning, advisory, and policy boards, appointed or recommended by agents of the Division, which are integral parts of its program, is available to all persons in non-discriminatory manner.

X. CONTINUING COMPLIANCE

Each Division shall develop procedures for monitoring ell aspects of its operation to assure that no policy or practice is, or has the effect of, discriminating against beneficiaries or other participants on the basis of race, color, national origin, or handicap, or age. Each division shall establish a system to review all new and existing policies to determine compliance of such policies with title VI, and Section 504, and the Age Discrimination Act.*

XI. PROGRAM ACCESSIBILITY

Each Division shall assure that no qualified person with disabilities shall be denied the benefits of, be excluded from

*Details for implementation can be found in the office(s) of the Division affirmative action Officer and Equal Opportunity Coordinator.

participation in, or otherwise be subjected to discrimination under any of its programs or those of its vendors, because the facilities are inaccessible to, or unusable by persons with disabilities.

Where program accessibility has not already been achieved, because structural changes are required, each Division of the Department has set forth the steps it will take to develop its transition plan.

A system has been developed to assure that all vendors who have 15 or more employees have completed transition plans it needed.

The department shall set forth procedures for assuring that any facility or part of any facility which is constructed or altered by, on behalf of, or for their use, is made readi1y accessible to and usable by persons with disabil1ties.

XII. NEEDS A HEADING

Each Division shall assure that no person, on the bas1s of age, be denied the benefits of, be excluded from participation in, or be subject to discrimination. Any Policies which omit programs or activities on the basis of age must describe how the policy or practice takes into account age as a factor necessary to the normal operation or the achievement of a statutory objective of the program or activity. The description should include all the factors in the “Four Part Test".

XIII. CORRECTIVE REQUIREMENTS

Each Division shall take corrective action to overcome the effects of prior discrimination in instances where the Division, or its service vendors have previously discriminated against clients on the grounds of race, color, national origin, religion, sex, handicap, or age.

Even in the absence of such prior discrimination, a Division may take corrective action to overcome the effects of conditions which resulted in limiting service participation by persons of a particular race, color, national origin, or handicap, or age.

XIV. COMPLIANCE RECORDS

Each Division of the Department shall be responsible for collection and maintenance of racial/ethnic data which will show

*Details for implementation can be found in the office(s) of the Division Affirmative Action Officer and Equal Opportunity Coordinator.

the extent to which minority persons are participating in all aspects of the Division's DHHS-funded programs; i.e., day care, clinics, hospitals, sheltered workshops, etc. The Division shall require such data and information from vendors (see section on compliance by other participants).

Each Division shall make available to the Office for Civil Rights all data and information necessary to determine that Divisions compliance with Title VI of the Civil Rights Act, Section 504 of the Rehabilitation Act, the Age Discrimination Act; and its implementing Regulation, as well as the compliance status of its vendors. This information shall be reviewed by the Director, Department of Human Resources, prior to submission to the Office for Civil Rights.

TT:amsl560P

STATE OF OREGON

Transmittal #78-17
Attachment 7.3A

The Governor has delegated authority for approval of plan material which does not have a fiscal impact nor represents a significant new or revised policy, to the Director of the Department of Human Resources.

TN# 78-17
Supersedes TN# ---

Date Approved 11/22/78
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