Health Systems Division: Behavioral Health Services - Chapter 309

August 12, 2019

Round 2 Redline

Division 15. MEDICAID PAYMENT FOR PSYCHIATRIC HOSPITAL INPATIENT SERVICES

309-015-0000 Purpose and Scope~~Statutory Authority~~

(1) Purpose. These rules prescribe the eligibility criteria, methods, and standards for payments to psychiatric hospitals through the ~~Division of Medical Assistance Programs,~~ Oregon Health Authority. The rules apply to provision of psychiatric hospital inpatient services for persons eligible for medical assistance under Medicaid (Title XIX of the Social Security Act).

(2) Statutory Authority. These rules are authorized by ORS 413.042 and carry out the provisions of ORS 414.025~~,~~ and 414.065~~, and 414.085~~ and Title XIX of the Social Security Act and 42 CFR Part 441, Subparts C and D.

Statutory/Other Authority: ORS 413.042
Statutes/Other Implemented: ORS 414.025 & 414.065
History:
MHD 2-1994, f. & cert. ef. 2-24-94
MHD 12-1990, f. & cert. ef. 10-15-90
MHD 7-1987, f. & ef. 12-30-87
Reverted to MHD 21-1983, f. & ef. 12-5-83
MHD 12-1985(Temp), f. & ef. 7-1-85
MHD 21-1983, f. & ef. 12-5-83
MHD 17-1983(Temp), f. 9-30-83, ef. 10-1-83

309-015-0005 Definitions

In addition to the definitions listed in OAR 309-001-0100, the following definitions apply with respect to this OAR chapter 309, division 015.~~As used in these rules:~~

(1) "Active Treatment" means implementation of a professionally developed and supervised plan of care that is in effect within 14 days of admission and designed to achieve the patient's discharge at the earliest possible time. Custodial care is not active treatment.

(2) "Actual Costs" means all legitimate Medicaid expenditures. Since ~~Oregon's Addictions and Mental Health~~ the Division utilizes Medicare cost finding principles, actual costs will be the same as "Medicaid Allowable Costs" as defined in this rule.

(3) "Allowable Costs" means the costs applicable to the provision of psychiatric inpatient services as described in OAR 309-015-0050(3). They are derived using the Medicare cost finding principles located in the Medicare Provide Reimbursement Manual.

(4) "Annual Cost Report" means a financial report submitted to the Medicare~~/~~ or Medicaid ~~Fiscal~~ Intermediary by a hospital, on forms provided by the ~~Fiscal~~ Intermediary. This report details the actual revenues and expenses of the hospital during the latest fiscal period.

(5) "Base Year" means July 1, 1981 through June 30, 1982.

(6) "Disproportionate Share Adjusted Medicaid Rate" (DSR) means the weighted average Medicaid per diem rate (interim, year-end settlement or final settlement) for disproportionate share hospitals. This rate does not include the disproportionate share payment of uncompensated costs of participating hospital programs as provided in these rules.

(7) "Disproportionate Share Costs" means costs that are reimbursable under federal disproportionate share statutes and regulations. These costs are limited to costs of participating hospital programs which have not already been reimbursed by Medicare, Medicaid, insurance, or the patient's own resources.

(8) "Disproportionate Share Hospital" means a psychiatric hospital which has a low income utilization rate exceeding 25 percent as described in OAR 309-015-0035(5).

(9) "Disproportionate Share Payment" means the payment made quarterly to reimburse participating hospital programs for disproportionate share costs. This payment is subject to recalculation at the time of each year-end or final settlement payment.

(10) "Distinct Program" means a specialized inpatient psychiatric treatment program with unique admission standards approved by the Division. If a participating psychiatric hospital has a specialized program based upon patient age or medical condition, contains 50 or more beds, has a nursing staff specifically assigned to the program which has experience or training in working with the specialized population, and has record keeping systems adequate to separately account for expenditures and revenue to that program relative to the entire hospital, the Division may approve it as a distinct program.

(11) "Division" means the Addictions and Mental Health Division of the Oregon Health Authority.

~~(12) "Fiscal Intermediary" means:~~

~~(a) Blue Cross of Oregon for Medicare, Parts A and B; and~~

~~(b) Division for Medicaid services provided under the provisions of this rule;~~

~~(c) The Division's Assistant Administrator for Administrative Services, is the designated Fiscal Intermediary.~~

(12~~3~~) "Inpatient Psychiatric Services" means active treatment services provided under the direction of a licensed physician by a participating psychiatric hospital.

(13~~4~~) "Interim Per Diem Rate" means the daily rate established with and paid to each provider for the agreement period during which reimbursable services are to be provided.

(14~~5~~) "Low Income Utilization Rate" means the sum of the ratio of a hospital's Medicaid revenues (plus governmental subsidies) to total revenue added to the ratio of a hospital's proportion of charity care expenditures (less governmental subsidies) to total inpatient psychiatric services charges (as outlined in OAR 309-015-0035(5)).

(15~~6~~) "Maximum Allowable Rate" means the statewide average per diem cost for services as derived in accordance with OAR 309-015-0020 and 309-015-0021.

~~(17) "Medicaid" means Title XIX of the Social Security Act.~~

(16~~8~~) "Medicaid Allowable Costs" means that portion of total costs determined to be eligible for Medicaid reimbursement. Medicaid allowable costs are determined based on the amount of allowable cost for inpatient services by making the following calculations:

(a) For all providers, determine the reasonable cost of covered services furnished by multiplying the ratio of Medicaid patient days to total patient days by total allowable inpatient costs;

(b) For proprietary providers, determine the allowable return on equity capital invested and used for the provision of patient care by following the general rule outlined in 42 CFR 413.157(b);

(c) Adding the results of the calculations in subsections (a) and (b) of this section to establish the full Medicaid allowable cost.

(17~~9~~) "Medicaid Intermediary" ~~for the purpose of services provided under this rule,~~ means the Division or its designee~~Assistant Administrator for Administrative Services, Addictions and Mental Health Division~~.

(18~~20~~) "Medicaid Patient Days" means the accumulated total number of days, including therapeutic leave days, during which psychiatric inpatient services were provided to Medicaid-eligible patients during a cost reporting period. The ~~Fiscal~~ Medicaid Intermediary shall determine the total number of Medicaid patient days on the basis of dates of service per patient by provider and fiscal period.

(1921) “Medicaid Inpatient Utilization Rate” means the following fraction (expressed as a percentage) for a hospital:

(a) “Numerator”: The hospital’s number of inpatient days attributable to patients who (for such days) were eligible for Title XIX medical assistance under the state Medicaid plan and for whom the Division of Medical Assistance Programs made payment during the fiscal period;

(b) “Denominator”: The total number of the hospital’s inpatient days for the same period.

(202) “Medicare Market Basket Percentage Increase” means the annual allowable increase factor for a standard array of hospital services nationwide as published annually by the Health Care Financing Administration. The percentage is a component of the “Target Rate Percentage Increase” as defined in section (29) of this rule.

(213) “Non-Allowable Costs” means any costs excluded under the provisions of state and federal statutes, regulations, and administrative rules.

(224) “Participating Psychiatric Hospital” means those portions of a licensed psychiatric hospital certified to provide services to Medicaid patients.

~~(25) “Patient Eligibility” means persons eligible for medical assistance under Medicaid who meet the criteria for admission to psychiatric hospital inpatient services as defined in these rules and OAR 309-031-0200 through 309-031-0255.~~

~~(26) “Resident in the Hospital” means a patient who is in the facility at least 12 hours of each day, including the hours of sleep. The day of admission is exempt from this 12 hour rule; however, to be counted for residence purposes, the day of admission must extend through midnight (2,400 hours). The day of discharge is not counted.~~

(237) “Sanction” means a disciplinary action against a provider, as described in ~~:~~

~~(a) Termination of contract with the Division to provide psychiatric hospital services for Medicaid eligible patients;~~

~~(b) Suspension of contract with the Division to provide psychiatric hospital services for Medicaid eligible patients; or~~

~~(c) Suspension or withholding of payments to a provider. (See~~ OAR 309-015-0052 ~~for further information.)~~

(248) “Separate Cost Entity” means an entity of a hospital for which Medicare has approved the submission of a separate cost report.

(259) “Target Rate Percentage Increase” means the annual allowable increase factor applied to the previous year’s maximum allowable rate for psychiatric hospitals and hospital units excluded from the prospective payment system. This percentage includes the Medicare market basket percentage increase as a component and is published annually by the Health Care Financing Administration.

(2630) “Therapeutic Leave Days” means a planned and medically authorized period of absence from the hospital not exceeding 72 hours in seven consecutive days.

(2731) “Total Patient Days” means the accumulated total number of days, excluding non-Medicaid therapeutic leave days, during which psychiatric inpatient services were provided to patients during a cost reporting period. The Medicaid fiscal iIntermediary shall determine the total number of patient days on the basis of dates of service per patient by provider and fiscal period.

Statutory/Other Authority: ORS 413.042
Statutes/Other Implemented: ORS 414.025 & 414.065
History:
MHD 2-1994, f. & cert. ef. 2-24-94
MHD 12-1990, f. & cert. ef. 10-15-90
MHD 6-1989, f. & cert. ef. 11-17-89
MHD 7-1987, f. & ef. 12-30-87
MHD 21-1983, f. & ef. 12-5-83
MHD 17-1983(Temp), f. 9-30-83, ef. 10-1-83

309-015-0007 General Conditions of Payment~~of Eligibility and Treatment~~

In order for payment to be made by the Division, the following conditions must be met:

(1) Medicaid~~-~~ eligibility~~e age~~. The patient must be eligible for Medicaid benefits~~, be aged 65 or over, aged 20 or under, or aged 21 and receiving services at the time of reaching age 21~~.

(2) Written plan of care. A professionally developed written plan of care for each patient will describe treatment objectives and prescribe an integrated program of appropriate therapy activities and experiences designed to improve the patient's condition to ~~the extent that~~ a point at which inpatient care is no longer necessary.

(3) Unemancipated minor consultation. If the patient is under 18 years of age and not emancipated, the facility shall consult with the parent(s), legal guardian or others into whose care or custody the person will be released following discharge. If the youth is age 14 or over, the youth shall be present for the consultation if they so choose. The consultation shall be documented in the hospital records.

(4) Conformance with these rules. The Division has determined that admission and care of the patient who is eligible for Medicaid benefits is in accordance with these rules and regulations as evidenced by the hospital record.

(5) Service provider requirements. The service provider must meet all requirements for participation under OAR 309-015-0010.

Statutory/Other Authority: ORS 413.042
Statutes/Other Implemented: ORS 414.025 & 414.065
History:
MHD 6-1989, f. & cert. ef. 11-17-89
MHD 7-1987, f. & ef. 12-30-87

309-015-0010 Conditions of Service Provider Participation

(1) Medicaid certification. A service provider must be certified by the responsible state or federal authority as meeting federal Medicaid certification requirements for psychiatric hospital inpatient services.

(2) Written agreement with the Division. A service provider must provide medically prescribed psychiatric hospital inpatient services to Medicaid-eligible patients ~~eligible for Medicaid benefits under terms of~~ pursuant to a fully executed written agreement with the Division. The agreement must assure that the psychiatric hospital and the services provided comply with all applicable state and federal requirements. No billing for Medicaid payment will be paid until a service provider has fully executed a written agreement with the Division.

(3) Legislative compliance. A service provider must be in compliance with applicable federal and state laws, including:

(a) Title VI of the Civil Rights Act of 1964;

(b) Section 504 of the Rehabilitation Act of 1973;

(c) The Age Discrimination Act of 1975; and

(d) The Americans with Disabilities Act of 1990~~; and~~

~~(e) Any other applicable federal and state laws~~.

(4) Medicaid vendor number. A service provider must request a vendor number from the Division. No billing for Medicaid payment will be paid until a service provider has secured a Medicaid vendor number.

(5) Patient admission. A service provider must obtain approval for the admission of patients to the psychiatric hospital as required by 309-091-0010 and 309-091-0015~~Addictions and Mental Health Division's OARs 309-031-0200 through 309-031-0255 (Admission and Discharge of Mentally Ill Persons)~~.

(6) Clinical records. A service provider must maintain clinical records ~~which are~~ that adequately ~~to~~ document the need for psychiatric hospital inpatient services~~,~~ and the specific services provided, including mental health assessment, diagnosis, and treatment plans.

(7) Fiscal records. A service provider must maintain fiscal records in accordance with generally accepted accounting principles.

(8) Patient funds. A service provider must provide an accounting for any funds accepted from the patient for safekeeping. Such accounts will be available for inspection by personnel designated by the Division.

(9) Records review. A service provider must maintain the availability of financial and treatment records for review without notice by authorized personnel of the Medicaid Intermediary and of the United

States Department of Health and Human Services during normal business hours at the location of its licensed psychiatric hospital.

(10) Reimbursement for services. A service provider must accept payment from the Division ~~through the Division of Medical Assistance Programs~~ as full and total reimbursement for the Medicaid services provided.

(11) Annual cost reports. A service provider must submit annually to the Division a Medicaid cost report accompanied by a copy of the provider's Medicare cost report.

Statutory/Other Authority: ORS 413.042
Statutes/Other Implemented: ORS 414.025 & 414.065
History:
MHD 12-1990, f. & cert. ef. 10-15-90
MHD 6-1989, f. & cert. ef. 11-17-89
MHD 7-1987, f. & ef. 12-30-87
MHD 21-1983, f. & ef. 12-5-83
MHD 17-1983(Temp), f. 9-30-83, ef. 10-1-83

309-015-0020 Establishing the Base Year and the Initial Maximum Allowable Rate

(1) Base year. In order to establish a base year rate, the Medicaid Intermediary used cost statements which overlapped the base period (July 1, 1981 through June 30, 1982) for all Oregon hospitals ~~who~~ that were either:

(a) Licensed as psychiatric hospitals on the effective date of these rules (10-1-83) and in operation during the base period; or

(b) Were applicants for Joint Commission on Accreditation of Hospitals (JCAH) accreditation as a psychiatric hospital on the first effective date of these rules and had operated as a licensed hospital during the base period.

(2) Reporting period adjustments. If a psychiatric hospital's cost report was for a period either longer or shorter than 12 months, the Medicaid allowable costs were 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) Inflation factor adjustments. If a psychiatric hospital had a fiscal period other than the base period, the hospital's Medicaid allowable costs were adjusted by applying the relevant inflation factors from the Medicare market basket index so that the Medicaid costs corresponded to the base period. The inflation factors were applied to the interval between the mid-point of the hospital's fiscal period and the mid-point of the base period. The number of Medicaid patient days in the hospital's fiscal period were used as the number of days in the base period.

(4) Rate calculation. The total Medicaid allowable costs from all hospitals included in the base period divided by the total number of Medicaid patient days from all hospitals included in the base period yielded the statewide average per diem cost (maximum allowable rate) for the base period.

Statutory/Other Authority: ORS 413.042
Statutes/Other Implemented: ORS 414.025 & 414.065
History:
MHD 6-1989, f. & cert. ef. 11-17-89
MHD 21-1983, f. & ef. 12-5-83
MHD 17-1983(Temp), f. 9-30-83, ef. 10-1-83

309-015-0021 Establishing the Maximum Allowable Rate for Years Following the Base Period

(1) Base rate usage. 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 all fiscal periods following the base period.

(2) Subsequent period rate calculations. The maximum allowable reimbursement rate for each new fiscal period affected by these rules is now calculated by inflating the maximum allowable reimbursement rate for the previous period by the annual Health Care Financing Administration target percentages for PPS — 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.

(3) Hospitals with other fiscal periods. When a psychiatric hospital has a fiscal period other than that used by the State of Oregon, July 1 through June 30, the applicable maximum allowable 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.

Statutory/Other Authority: ORS 413.042
Statutes/Other Implemented: ORS 414.025 & 414.065
History:
MHD 12-1990, f. & cert. ef. 10-15-90
MHD 6-1989, f. & cert. ef. 11-17-89

309-015-0023 Interim Rate Setting

Rate establishment process. At least annually, the Medicaid ~~i~~Intermediary will establish an interim Medicaid per diem rate for each participating psychiatric hospital, separate cost entity, or distinct program within a hospital.~~:~~

(1) A hospital may request an interim per diem rate or rates. If a review of the hospital's prior year Medicaid cost report (adjusted for inflation, changes in patient populations and programs, and other relevant factors) does not justify the requested rate(s), the Medicaid Intermediary may establish different interim rate(s).~~:~~

(a) Actual expenditures for the most recent fiscal period available will be used to determine salary and wage and total expense distribution for each cost center included in the total expenditures. Any other directly relevant event, such as facility restructuring, will be considered as well;

(b) The Division will apply the proportions from subsection (a) of this section to total anticipated expenditures for the new period to determine salary and wage expense distribution for each cost center during the new period;

(c) The Division will establish and apply capital allowances and other adjustments to total anticipated expenditures for the new period from subsection (b) of this section;

(d) If the hospital has separate cost entities or distinct programs, the hospital will provide estimates to the Division of a weighted average interim rate. The average will be developed by multiplying each proposed interim rate by estimated Medicaid patient days for that rate, summing all of the products, and dividing that sum by the total annual estimated Medicaid patient days for the hospital;

(e) The interim or weighted average interim per diem rate may not exceed the maximum allowable rate unless the hospital meets the criteria for reimbursement above the maximum allowable rate as a disproportionate share hospital (see OAR 309-015-0035(5)). In that case, the interim or average interim Disproportionate Share adjusted Medicaid Rate (DSR) may include estimated costs up to 135 percent of the maximum allowable Medicaid rate, except for hospitals meeting criteria set forth in ~~the following paragraph~~section (1)(f);

(f) If a psychiatric hospital has a low-income rate of 60 percent and also receives 60 percent or more of its service revenue from any combination of the following:

(A) Public funds, excluding Medicare and Medicaid;

(B) Bad debts; or

(C) Free care;~~.~~

~~(g)~~ 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, subject to a disproportionate share allotment established for Oregon by the Health Care Financing Administration;

(gh) 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~~ must not exceed actual costs.

(2) If a hospital does not request an interim rate, the Medicaid Intermediary will establish an interim rate based on the hospital's prior year cost report using the same factors listed in section (1) of this rule.

Statutory/Other Authority: ORS 413.042
Statutes/Other Implemented: ORS 414.025 & 414.065
History:
MHD 2-1994, f. & cert. ef. 2-24-94
MHD 12-1990, f. & cert. ef. 10-15-90
MHD 6-1989, f. & cert. ef. 11-17-89
MHD 7-1987, f. & ef. 12-30-87, Renumbered from 309-015-0015
Reverted to MHD 21-1983, f. & ef. 12-5-83
MHD 12-1985(Temp), f. & ef. 7-1-85
MHD 21-1983, f. & ef. 12-5-83
MHD 17-1983(Temp), f. 9-30-83, ef. 10-1-83

309-015-0025 Retrospective Settlement Rate Setting (Year-~~-~~End and Final)

(1) Year-end settlement process. ~~The year-end settlement process will be as follows:~~

(a) Upon receipt of an audited Medicaid cost report from the Supervisor of the Division Audit Section, the Revenue and Rates Manager of the Institutional Revenue Section will determine a retrospective year-end settlement rate for each participating hospital, separate cost entity, or distinct program within a hospital on the basis of Division review of actual allowable Medicaid costs reported in the hospital's cost statement for the previous year;

(b) The year-end settlement rate for a non-disproportionate-~~-~~share hospital will be calculated by using the following procedure:

(A) Divide the applicable Title XIX allowable costs for each participating hospital, separate cost entity, or distinct program by the applicable number of Title XIX patient days, including therapeutic leave days;

(B) If the hospital has more than one distinct program, divide the applicable Medicaid allowable costs by the applicable number of Medicaid patient days, including therapeutic leave days, for each program. Then determine the weighted average Medicaid settlement rate for the entire hospital. This is accomplished by multiplying each proposed year-end settlement rate by the number of Medicaid patient days for that rate, adding the products together, and dividing the resulting sum by total Medicaid patient days for the hospital;

(C) If these calculations produce a year-end Medicaid settlement rate or ~~the~~ average year-end Medicaid settlement rate ~~from above~~ that is less than the maximum allowable Medicaid rate for psychiatric hospitals during the current fiscal year, use the lower rate. If the calculated rate~~;~~

~~(D) If the year-end Medicaid settlement rate or the average year-end settlement rate from above~~ exceeds the maximum allowable rate ~~established for psychiatric hospitals during the current fiscal year~~, use the maximum allowable rate as the retrospective year-end settlement rate for the hospital.

(c) The year-end settlement rate may exceed the maximum allowable rate if the Division determines the hospital meets the criteria listed in OAR 309-015-0035(5) as a disproportionate share hospital. ~~;~~

~~(d) In that case, t~~The disproportionate share adjusted year-end settlement rate will be calculated as follows:

(A) Actual costs up to 135 percent of the maximum allowable rate; or

(B) Actual costs up to 100 percent of the cost of uncompensated care during the facility's previous fiscal year, subject to a disproportionate share allotment established yearly by the Health Care Financing Administration, if the psychiatric hospital has a low-income rate of 60 percent and also receives 60 percent or more of its service revenue from any combination of the following:

(i) Public funds, excluding Medicare and Medicaid;

(ii) Bad debts; or

(iii) Free care.

(de) The year-end settlement will be determined by:

(A) ~~m~~Multiplying the settlement ~~"~~rate~~"~~ determined under section (1)(b)~~calculated above~~ by the total number of Medicaid patient days, including therapeutic leave days; or, for disproportionate share hospitals, multiplying the disproportionate share adjusted rate by the total number of Medicaid patient days, including therapeutic leave days.

(B) Comparing ~~T~~the result ~~will be compared~~ to the amount of reimbursement paid to the hospital during the fiscal period. If the result favors the hospital, the Division will pay the difference to the hospital. If the result favors the Division, the hospital will pay the difference to the Division. In either case, payments shall be made within 30 days approval of the year-end Medicaid cost report by the Medicaid Intermediary.

(2) Final settlement process. ~~The final settlement process will be as follows:~~

(a) Upon receipt of the final Medicare ~~C~~cost ~~R~~report from the Medicare Intermediary, the hospital provider will prepare the final Medicaid cost report. The Medicaid report will reflect all relevant adjustments made to the Medicare cost report;

(b) Using the final Medicaid cost report developed in subsection (a) of this section, 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 subsections (1)(a) through (c~~d~~) of this rule.

(3) Upon completion of each settlement, both year-end and final, the Division will review the disproportionate share costs and make any necessary adjustments to quarterly disproportionate share payments. The Division will review all factors relevant to the disproportionate share payments, including actual costs of services, amounts already paid, and charges reimbursed from other sources during the time period included in the Medicaid cost settlement.

Statutory/Other Authority: ORS 413.042
Statutes/Other Implemented: ORS 414.025 & 414.065
History:
MHD 2-1994, f. & cert. ef. 2-24-94
MHD 12-1990, f. & cert. ef. 10-15-90
MHD 6-1989, f. & cert. ef. 11-17-89
MHD 7-1987, f. & ef. 12-30-87
MHD 21-1983, f. & ef. 12-5-83
MHD 17-1983(Temp), f. 9-30-83, ef. 10-1-83

309-015-0030 Billing Requirements

(1) Bill submission time limits. Bills shall be submitted to the Division ~~through the Division of Medical Assistance Programs,~~ on forms designated by the Medicaid Intermediary~~,~~ as soon as possible after the date service is rendered. Payment shall not be made for services which were provided more than 12 months prior to presentation of the claim unless the hospital shows that the delay was caused by factors outside its control.

(2) Billing charge limits. Billings to the Division shall in no case exceed the customary charges to private patients for any like item or service charged by the hospital.

(3) Customary charge criteria. In determining the customary charges to a private patient for use in billings or calculating interim or settlement rates, the following criteria will be applied:

(a) The private patient billing rate must be for items and services comparable to the items and services included in the rate for Medicaid services;

(b) When private patient rates are based on the number of beds in a room, the Medicaid ~~i~~Intermediary considers the lowest room charge as the usual and customary charge for services;

(c) When ancillary charges are made to private patients in addition to a basic charge, then either:

(A) ~~t~~The Medicaid Intermediary considers the usual and customary charge to be the lowest basic room charge plus the average ancillary charge for those items included in the Medicaid rate. The average ancillary charge is determined by dividing the ancillary costs by the number of patient days; or

(B~~d~~) Where charges are based on the classification of the patient (i.e., Medicare, Medicaid, ~~and~~ or Private), the Medicaid Intermediary considers the usual and customary charge to be the rate for private patients exclusive of ancillary charges.

(4) Payment restrictions.

(a) Payment will be made only for those days a patient is actually in residence at the hospital in active treatment or when a patient is on therapeutic leave.

(b) For purposes of this rule, “in residence” means that the patient is in the facility at least 12 hours of each day, including the hours of sleep. The day of admission is exempt from this 12 hour rule; however, to be counted for residence purposes, the day of admission must extend through midnight (2,400 hours). The day of discharge is not counted.

(5) Payment credit. Any payment received by the hospital prior to the submission of an invoice to the Division ~~of Medical Assistance Programs~~ shall be indicated as a credit on the invoice.

(6) Post-payment receipt of funds. Any payments to the provider from any source subsequent to payment by the Division ~~of Medical Assistance Programs~~ shall be reported to ~~that~~ the Division on a~~n~~ Division-approved adjustment form ~~specified by the Division of Medical Assistance Programs~~, giving full particulars. Failure to report such payments will be considered concealment of material facts and is grounds for recovery and/or sanction (see OAR 309-015-0052).

Statutory/Other Authority: ORS 413.042
Statutes/Other Implemented: ORS 414.025 & 414.065
History:
MHD 2-1994, f. & cert. ef. 2-24-94
MHD 12-1990, f. & cert. ef. 10-15-90
MHD 6-1989, f. & cert. ef. 11-17-89
MHD 7-1987, f. & ef. 12-30-87
MHD 21-1983, f. & ef. 12-5-83
MHD 17-1983(Temp), f. 9-30-83, ef. 10-1-83

309-015-0035 Payments

(1) Timing. Payments to providers will be made following the month of service, based on the invoice submitted by the provider to the Division ~~of Medical Assistance Programs~~.

(2) Eligible services. Payments will be made for the provision of active psychiatric inpatient treatment services for persons eligible for such services under Medicaid.

(3) Non-eligible services.

(a) If review of a psychiatric hospital's Medicaid patient records by a Professional Standards Review Organization reveals that a patient received an inappropriate level of care, (i.e., less than active treatment), payment will not be allowed under these rules.

(b) Any payments to the provider for patients receiving an inappropriate level of care shall be recovered by the Division.

(A) Such payments shall be reported to the Division ~~of Medical Assistance Programs~~ on a~~n~~ Division-approved adjustment form ~~specified by the Division of Medical Assistance Programs~~.

(B) Failure to report such payments will be considered concealment of material facts and is grounds for sanction (see OAR 309-015-0052).

(4) Payment to non-disproportionate ~~-~~share hospitals. The Division shall not pay more in total for psychiatric hospital inpatient services for hospitals which do not serve a disproportionate number of low-income patients with special needs than would be paid under the Medicare principles of reimbursement.

(5) 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 following criteria, as described in Section 1923(b)(3) of the Social Security Act.~~:~~

(a) The hospital must serve~~s~~ disproportionate numbers of low-income persons; i.e., has a low income utilization rate which exceeds 25 percent using the ~~following formula:~~sum of:

(A~~a~~) The total Medicaid in-patient revenues paid to the hospital, plus the amount of the cash subsidies received as payment for inpatient services directly from state and local governments in a cost reporting period, divided by the total amount of revenues of the hospital for in-patient psychiatric services (including the amount of such cash subsidies) in the same cost reporting period; and~~. The percentage derived in paragraph (a) of this subsection shall be added to the following percentage;~~

(B~~b~~) The total amount of the hospital's charges for in-patient 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 in-patient services received directly from state and local governments described in ~~paragraph~~ section (5)(a)(A) ~~of this subsection~~ in the period attributable to in-patient hospital services, divided by the total amount of the hospital's charges for in-patient psychiatric services in the hospital in the same period. The total in-patient 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).~~;~~

~~(c) The sum of percentages derived in paragraphs (a) and (b) of this subsection shall exceed 25 percent in order to qualify as a disproportionate share hospital; and~~

(b~~d~~) The hospital ~~is~~ must be efficiently and economically operated and is in compliance with treatment and program standards for psychiatric inpatient services as required by the state and federal statutes and regulations.

Statutory/Other Authority: ORS 413.042
Statutes/Other Implemented: ORS 414.025 & 414.065
History:
MHD 2-1994, f. & cert. ef. 2-24-94
MHD 12-1990, f. & cert. ef. 10-15-90
MHD 6-1989, f. & cert. ef. 11-17-89
MHD 7-1987, f. & ef. 12-30-87
MHD 21-1983, f. & ef. 12-5-83
MHD 17-1983(Temp), f. 9-30-83, ef. 10-1-83

309-015-0040 Accounting and Record Keeping

(1) Records retention.

(a) The provider shall maintain, for a period of not less than three years following the date of submission of the annual Medicaid cost report to the Medicaid Intermediary, financial and statistical records of the period covered by such statement ~~which~~ that are accurate and in sufficient detail to substantiate the cost data reported.

(b) In the event of any ~~f there are~~ audit activity ~~issues~~, the records shall be maintained for three years after the final audit settlement.

(c) The records shall be maintained in a condition that can be audited for compliance with generally accepted accounting principles and provisions of these rules. Failure to maintain records in such condition shall result in disallowance of costs.

(2) Documentation of allowable costs. Expenses reported as allowable costs must be adequately documented in the financial records of the provider or they shall be disallowed.

Statutory/Other Authority: ORS 413.042
Statutes/Other Implemented: ORS 414.025 & 414.065
History:
MHD 6-1989, f. & cert. ef. 11-17-89
MHD 7-1987, f. & ef. 12-30-87
MHD 21-1983, f. & ef. 12-5-83
MHD 17-1983(Temp), f. 9-30-83, ef. 10-1-83

309-015-0045 Filing of Annual Medicaid Cost Report

(1) Timing of report. The provider shall file annually with the Medicaid Intermediary, an annual Medicaid cost report covering actual costs based on the latest fiscal period of operation of the facility. If the provider has separate cost entities or distinct programs, an annual Medicaid cost report shall be filed for each entity.

(a) A Medicaid cost report will be filed for less than an annual period only when necessitated by facilities terminating their agreement with the Division, or by a change in ownership, or by a change in fiscal period.

(b) The provider ~~is to~~ shall use the same fiscal period for the Medicaid cost report as that used for the Medicare cost report and the federal tax return.

(c) The Medicaid cost report is due within 90 days of the end of the normal fiscal period, change of ownership, or withdrawal from the program except when Medicare grants an extension of the Medicare cost report (upon which the Medicaid cost report relies). In that case, the due date for the Medicaid cost report may be extended by the Medicaid Intermediary for the same number of days as the due date for the Medicare cost report.

(2) Contents of report. The annual Medicaid cost report is a uniform cost report containing an itemized list of allowable costs to be used by all providers. It shall report the hospital's actual financial data and be completed in accordance with instructions provided by the Medicaid ~~i~~Intermediary.

(3) Application of Medicare principles of reimbursement. Providers filing annual Medicaid cost reports with the Medicaid Intermediary shall apply Medicare principles of reimbursement.

(4) Signature. Each required annual Medicaid cost report shall be signed by the individual who normally signs the provider's federal income tax return or other reports. If the report is prepared by someone other than an employee of the provider, the individual preparing the report shall also sign and indicate his or her status with the provider.

(5) Improperly completed reports. The Medicaid Intermediary shall return improperly completed or incomplete annual Medicaid cost reports to the provider for proper completion. All providers shall return corrected or completed reports to the Division within 30 days or become subject to the same penalty as for failure to submit the cost statement.

(6) Reduction of interim per diem rate — Late reports. If the original submission of the Medicaid cost report is not made within the required 90-day time period or extended period (see section (1) of this rule), the interim per diem rate then in effect will be reduced to 80 percent of the hospital's current interim per diem rate or the rate established from the last audited or desk reviewed cost statement, whichever is lower. This rate will remain in effect until submission of the Medicaid cost report.

(7) Late-billed services. If a hospital bills for services provided during a fiscal period for which the hospital has submitted an annual Medicaid cost report, the days which are late-billed may be included in the hospital's next fiscal period.

(8) False reports. If a provider knowingly, or with reason to know, files a report containing false information, such action constitutes cause for termination of its agreement with the Division. Providers filing false reports may be referred for prosecution under applicable statutes (see OAR 309-015-0052).

(9) Maintenance of report. The Medicaid Intermediary shall maintain each required annual Medicaid cost report submitted by a provider for three years following the date of submission. In the event there are audit questions, the cost statement shall be maintained for three years after the final audit settlement.

Statutory/Other Authority: ORS 413.042
Statutes/Other Implemented: ORS 414.025 & 414.065
History:
MHD 6-1989, f. & cert. ef. 11-17-89
MHD 7-1987, f. & ef. 12-30-87
MHD 21-1983, f. & ef. 12-5-83
MHD 17-1983(Temp), f. 9-30-83, ef. 10-1-83

309-015-0050 Auditing

(1) Desk review of annual Medicaid cost report. The Medicaid intermediary will analyze by desk review each annual Medicaid cost report after it has been properly completed and filed.

(2) Scope of desk review. The scope of the desk review will verify, to the extent possible:

(a) That the provider has properly included its allowable costs on the annual Medicaid cost report on the basis of generally accepted accounting principles and the provisions of these rules;

(b) That the provider has properly applied the cost finding method specified by the Medicaid Intermediary to its allowable costs determined in subsection (a) of this section; and

(c) Whether or not the analysis indicates that further auditing of the provider's financial and statistical records is needed.

(3) Allowable costs. The costs considered allowable may include part or all of the following (worksheet form numbers are correct as of the effective date of this rule):

(a) The costs stated as final values on Worksheet B, HCFA-2552, Cost Allocation for General Services Costs;

(b) Physician costs as determined by completing Worksheet A-8-2, HCFA-2552;

(c) Return on equity as determined by completing the applicable portions of Worksheet F, HCFA-2552.

(4) Ownership changes. Payments to providers shall not be increased, solely as a result of a change of ownership, in excess of the increase which would result from applying Section 1861(v)(1)(O) of the Social Security Act as applied to owners of record on or after July 18, 1984.

(5) Field audit. All filed annual Medicaid cost reports are subject to a field audit.

(6) Scope of field audit. The scope of the field audit will, at a minimum, be sufficiently comprehensive to verify that in all material respects:

(a) Generally accepted accounting principles and the provisions of these rules have been adhered to;

(b) Reported data is in agreement with supporting records; and

(c) The report is reconcilable to the appropriate Medicare report, federal tax return, and payroll tax reports.

Statutory/Other Authority: ORS 413.042
Statutes/Other Implemented: ORS 414.025 & 414.065
History:
MHD 2-1994, f. & cert. ef. 2-24-94
MHD 6-1989, f. & cert. ef. 11-17-89
MHD 7-1987, f. & ef. 12-30-87

MHD 3-1985, f. & ef. 2-25-85
MHD 10-1984(Temp), f. & ef. 12-21-84
MHD 21-1983, f. & ef. 12-5-83
MHD 17-1983(Temp), f. 9-30-83, ef. 10-1-83

309-015-0052 Provider Sanctions

(1) Basis for sanctioning. The Division will adhere to the provider sanction standards ~~follow the Division of Medical Assistance Program rules~~ in OAR 410-120-0000 through 410-120-1980 and Section 1902 of the Social Security Act ~~for provider sanctions~~. The base~~i~~s for sanction~~s~~ing will include:

(a) Criminal convictions;

(b) Exclusion, by the Secretary of Health and Human Services, from participation in the Medicare program;

(c) Not meeting the federal regulatory requirements for services in an institution for mental diseases or a psychiatric hospital as set forth at 42 CFR 435.1009 and 42 CFR 441, Subparts C and D;

(d) Having deficiencies which immediately jeopardize, or may jeopardize, the health and safety of patients;

(e) Abuse and misutilization, as described in OAR 410-120-0000 through 410-120-1980;

(f) Termination:

(A) From another governmental health/medical program;

(B) For failure to repay identified overpayments; or

(C) Due to commission, by a provider formerly suspended by the Division, of additional abuse or misutilization.

(2) Sanctions. ~~The following s~~Sanctions ~~may be~~ imposed on a provider by the Division~~, based on grounds specified in this rule and~~ may include:

(a) Termination from participation in Oregon's Medical Assistance Program ~~and possible initiation of appropriate civil or criminal proceedings~~;

(b) Suspension from participation in Oregon's Medicaid Assistance Program;

(c) Suspension or withholding of payments to a provider;

(d) Required attendance at provider education sessions~~;~~. and

(e) Initiation of appropriate civil or criminal proceedings.

(3) Notice to providers. The Division will notify a deficient provider of action the Division plans to take at least 15 days prior to commencement of the action.~~;~~ ~~t~~The notification will include an explanation of the provider's right to appeal the proposed action (see OAR 309-015-0055).

Statutory/Other Authority: ORS 413.042
Statutes/Other Implemented: ORS 414.025 & 414.065

History:
MHD 2-1994, f. & cert. ef. 2-24-94
MHD 12-1990, f. & cert. ef. 10-15-90
MHD 6-1989, f. & cert. ef. 11-17-89

309-015-0055 Appeals

(1) Providers may appeal Division decisions regarding interim per diem rates, year-end settlement rates, final settlement rates, monetary recovery, sanctions, or other issues.

(2~~1~~) ~~Rate appeals. A letter will be sent notifying the provider of the interim per diem rate, the year-end settlement rate, or the final settlement rate.~~ A provider ~~shall~~ must send written notice of the appeal to ~~notify~~ the Division ~~in writing~~ within 15 days of the provider's receiving notice of Division action that forms the basis for the appeal. ~~receipt of the letter if the provider wishes to appeal the rate.~~ Letters of appeal must be postmarked within the 15-day limit and addressed to the ~~Assistant Administrator, Administrative Services (the~~ Medicaid Intermediary~~)~~.

(3~~2~~) The Medicaid Intermediary will forward all rate appeals to the Manager of the Division's Audit Section for initial consideration. For all other types of appeals, and for rate appeals that are not resolved by the Audit Section~~If no resolution is forthcoming~~, the provider will be given an opportunity for administrative review or a contested case hearing as outlined in OAR 410-120-1400 through 410-120-1600, except that final orders shall be issued by the ~~Administrator of the Division~~Chief Officer.

~~(3) Monetary recovery, sanctions, or other appeals. A provider may appeal the Division's proposed action by letter within the same 15-day period as allowed for rate appeals above; address the letter to the Assistant Administrator, Administrative Services (the Medicaid Intermediary).~~

Statutory/Other Authority: ORS 413.042
Statutes/Other Implemented: ORS 414.025 & 414.065
History:
MHD 2-1994, f. & cert. ef. 2-24-94
MHD 12-1990, f. & cert. ef. 10-15-90
MHD 6-1989, f. & cert. ef. 11-17-89
MHD 7-1987, f. & ef. 12-30-87
MHD 21-1983, f. & ef. 12-5-83
MHD 17-1983(Temp), f. 9-30-83, ef. 10-1-83

309-015-0060 Emergency Services in Non-Participating Hospitals

Reimbursable services. Emergency services provided in licensed psychiatric hospitals not participating in Medicaid will be reimbursed if the Division determines they meet federal requirements for Medicare reimbursement of emergency services as outlined in 42 CFR Part 424, Subpart G~~, Part 424 of the Medicare regulations~~.

Statutory/Other Authority: ORS 413.042
Statutes/Other Implemented: ORS 414.025 & 414.065
History:
MHD 2-1994, f. & cert. ef. 2-24-94
MHD 6-1989, f. & cert. ef. 11-17-89
MHD 7-1987, f. & ef. 12-30-87