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ARCHIVES DIVISION
STEPHANIE CLARK
DIRECTOR

800 SUMMER STREET NE
SALEM, OR 97310
503-373-0701

TEMPORARY ADMINISTRATIVE ORDER
INCLUDING STATEMENT OF NEED & JUSTIFICATION

DMAP 146-2024
CHAPTER 410
OREGON HEALTH AUTHORITY
HEALTH SYSTEMS DIVISION: MEDICAL ASSISTANCE PROGRAMS

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FILING CAPTION: New Impatient Psychiatric Adult and Pediatric Payment Methodologies. OOS Rule Update.

EFFECTIVE DATE: 01/01/2025 THROUGH 06/29/2025

AGENCY APPROVED DATE: 12/19/2024

CONTACT: Martha Martinez-Camacho
503-559-0830
hsd.rules@oha.oregon.gov

500 Summer Street NE
Salem,OR 97301

Filed By:
Martha Martinez-Camacho
Rules Coordinator

NEED FOR THE RULE(S):

Current inpatient psychiatric rates for adults and pediatrics have been deemed fiscally ineffective. A new rate structure and process, developed with input from the Governor's Office, the Oregon Health Authority (OHA), Oregon hospital providers, and Mercer, will be adopted on 1/1/2025. This update will affect managed care and fee-for-service (FFS) reimbursement levels for Medicaid inpatient psychiatric adult and pediatric services at DRG hospitals in Oregon. OHA will implement a tiered MS-DRG payment structure, with base rates varying by hospital, patient type (adult or pediatric), and length of stay. Additionally, a day outlier payment policy will be introduced effective 1/1/2025.

For contiguous and non-contiguous hospitals, as well as out-of-state (OOS) hospitals, OHA is adopting the APC methodology for out-of-state hospital reimbursement. Reimbursement calculations will be modified using the wage index and outlier parameters set at the 50th percentile of Oregon hospitals. OHA will grandfather the reimbursement language at 50% of the 2024 hospital-specific charge master, if requested by a hospital.

JUSTIFICATION OF TEMPORARY FILING:

(1) Low DRG inpatient hospital psychiatric adult and pediatric rates and reimbursements have burdened Oregon hospitals, limited care opportunities and have led to health inequities.

(2) The groups that would suffer if these rules were not immediately filed are hospital providers, CCO brokerages, FFS brokerages and FFS OHP members.

(3) Oregon providers are bearing the financial burden of outdated inpatient psychiatric rates for adults and pediatrics, as treatment costs often exceed DRG payments. This situation has led to operational reductions and limited access to services. Additionally, the rising cost of care, combined with outdated reimbursement rates, is financially impacting Coordinated Care Organizations (CCOs) that represent members near the Oregon borders who seek or require care in out-of-state (OOS) hospitals.

(4) The temporary action aims to mitigate consequences by immediately implementing new inpatient psychiatric adult and pediatric rates. This change is designed to significantly enhance the financial stability of psychiatric providers for inpatient psychiatric adult and pediatric services provided, thereby reducing disparities in treatment plans and the cost of care.
Adopting the proposed OOS language will enable CCOs to contract with both contiguous and non-contiguous hospitals.

DOCUMENTS RELIED UPON, AND WHERE THEY ARE AVAILABLE:

Mercer rate calculations, hospital providers and CCOs.

RULES:
410-125-0121, 410-125-0141, 410-125-0181

AMEND: 410-125-0121

RULE TITLE: Contiguous Area Out-of-State Hospitals — Effective for services rendered on or after October 1, 2003

RULE SUMMARY: Inpatient Psychiatric adult and pediatric service methodology update, OOS payment and rate changes

RULE TEXT:
Contiguous area hospitals are out-of-state hospitals located less than 75 miles outside the Oregon border. Unless such hospitals have an agreement or contract with the Agency of Medical Assistance Programs (Agency) for specialized services, contiguous area out-of-state hospitals shall receive DRG reimbursement or billed charges whichever is less. The unit value for contiguous out-of-state hospitals shall be set at the final unit value for the 50th percentile of Oregon hospitals (see Inpatient Rate Calculations for Other Hospitals, DRG Rate Methodology OAR 410-125-0141 for the methodology). Contiguous area out-of-state hospitals are also eligible for cost outlier payments. No capital or medical education payments shall be made. The hospital shall receive a disproportionate share reimbursement if eligible (see OAR 410-125-0150).

STATUTORY/OTHER AUTHORITY: ORS 413.042

STATUTES/OTHER IMPLEMENTED: ORS 414.065

AMEND: 410-125-0141

RULE TITLE: DRG Rate Methodology

RULE SUMMARY: Inpatient Psychiatric adult and pediatric service methodology update, OOS payment and rate changes

RULE TEXT:

(1) Diagnosis Related Groups, (DRG):

(a) The DRG is a system of classification of diagnoses and procedures based on the International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM);

(b) 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 an individual claim to a DRG category. Medicare revises the Grouper program each year in October. The Agency uses the Medicare Grouper program in the assignment of inpatient hospital claims. The most recent version of the Medicare grouper shall be installed each year within ninety (90) days of the date it is implemented by Medicare. Where better assignment of claims is achieved through changes to the grouper logic, the Agency may modify the logic of the grouper program. The Agency shall work with representatives of hospitals that may be affected by grouper logic changes in reaching a cooperative decision regarding changes. The Agency DRG weight tables can be found on the Agency web site:

(a) Acute Care Hospitals larger than fifty (50) beds are considered DRG hospitals and reimbursed using Medicare's MS-DRG grouper;

(b) Hospitals enrolled as long-term acute care (LTAC) are reimbursed using Medicare's MS-LTC DRG grouper.

(c) Inpatient psychiatric adult and pediatric services are reimbursed using the most recent Medical Severity Diagnosis Related Groups, (MS-DRG), in Major Diagnosis Category, (MDC), MDC-19 and MDC-20 published by Medicare in the latest inpatient Prospective Payment System, (IPPS) final rule.

(3) DRG Relative Weights:

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

(b) For most DRGs, the Agency establishes a relative weight based on federal Medicare DRG weights. For state-specific Rehabilitation, and Neonate, Oregon Title XIX fee-for-service claims history is used. The Agency employs the following methodology to determine whether enough claims exist to establish a reasonable weight for each state-specific Rehabilitation, and Neonate, the Agency uses the following methodology: Using the formula $N = ((Z * S)/ R)^2$, where Z=1.15(a 75 percent confidence level), S is the standard deviation, and R = 10 percent of the mean. The Agency 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, and Neonate, lacking sufficient volume, the Agency sets a relative weight using:

(A) Agency non-Title XIX claims data; or

(B) Data from other sources expected to reflect a population similar to the Agency Title XIX caseload;

(c) When a test shows at the 90 percent confidence level that an externally derived weight is not representative of the average cost of services provided to the Agency Title XIX population in that DRG, the weight derived from the Agency Title XIX claims history is used instead of the externally derived weight for that DRG;

(d) Those relative weights based on Federal Medicare DRG weights shall be established when changes are made to the DRG Grouper logic. State-specific relative weights shall be adjusted, as needed, as determined by the Agency. When relative weights are recalculated, the overall Case Mix Index (CMI) shall be kept constant. Reweighing of DRGs or the addition or modification of the grouper logic shall 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: Hospitals larger than fifty beds or enrolled as a long-term acute care (LTAC) hospital are reimbursed using the DRG as described in section (2). Effective for services on or after:

(a) Effective October 1, 2009 the operating unit payment is 100 percent of the most recent version of the Medicare base payment rates. The Agency shall revise the base payment rates each year in October when Medicare posts the rates.
(b) DRG Payment: The DRG payment to each Oregon DRG hospital or LTAC hospital is calculated by adding the unit value to the capital amount, then multiplied by the claim assigned DRG relative weight (out-of-state hospitals do not receive the capital amount).
(c) Effective January 1, 2025; the Agency shall establish separate unit values for inpatient psychiatric adult and pediatric services. The unit values shall apply to the DRGs published in the most recent Major Diagnostic Category (MDC) group 19 and 20 and be multiplied by the claim-assigned DRG relative weight. The adult and pediatric psychiatric unit values for each hospital have been established as a percentage of the estimated Medicaid costs for inpatient hospital psychiatric services based on calendar year 2021 and 2022 Oregon inpatient hospital claims and the applicable Medicare cost reports.
(6) The unit values for inpatient psychiatric adult and pediatric services are adjusted for the location of the hospital. The calculated labor portion of unit values are multiplied by the wage index as identified in the Medicare Inpatient Prospective Payment System Final Rule (IPPS Final Rule) to determine the location adjusted labor portion and the capital portion of the unit values are multiplied by the geographic adjustment factor as outlined in the IPPS Final Rule. The total unit value for each hospital equals the sum of the wage-adjusted labor portion, the non-labor portion and geographic-adjusted capital portion shall be rebased every two (2) years or at the discretion of the Agency. During non-rebase years, the adult and pediatric psychiatric unit values shall be updated using the Medicare increases in the Medicare market basket increases from the IPPS Final Rule effective October 1st of the non-rebase year.
(7) DRG Hospital Cost Outlier Payments:
(a) Cost outlier payments are an additional payment made to in-state and contiguous hospitals for exceptionally costly services or exceptionally long lengths of stay provided to Title XIX and SF (State Facility) clients. As of January 1, 2025, outlier payments for inpatient hospital psychiatric services follow the methodology outlines in Section (10);
(b) The calculation to determine the cost outlier payment for Oregon DRG hospitals is as follows:
(A) Non-covered services (such as ambulance charges) are deducted from billed charges;
(B) 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 caseload;
(C) 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;
(D) Costs which exceed the threshold ($25,000 or 270 percent of the DRG payment, whichever is greater) are reimbursed using the following formula:
(i) Billed charges less non-covered charges, multiplied by;
(ii) Hospital-specific cost-to-charge ratio equals;
(iii) Net Costs, minus;
(iv) 270 percent of the DRG or $25,000 (whichever is greater), equals;
(v) Outlier Costs, multiplied by;
(vi) Cost Outlier Percentage, (cost outlier percentage is 50 percent), equals;
(vii) Cost Outlier Payment;
(E) Third party reimbursements are deducted from the Agency calculation of the payable amount;
(F) When hospital cost reports are audited during the cost settlement process, an adjustment shall 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 shall be determined from the audited Medicare Cost Report and cost statement template, adjusted to reflect the Medicaid mix of services.
(8) LTAC Short Stay Outliers: Occurs when a covered length of stay is between one day and up to and including 5/6ths of the average length of stay for the LTC-DRG grouping. The Short Stay Outlier payment for the hospital shall be the lesser of:

(a) Per Diem for Short Stay Outlier Calculation:
(A) MS-LTC DRG payment, divided by;
(B) Geometric Length of Stay (GLOS,) multiplied by;
(C) Actual length of stay, multiplied by;
(D) 120 percent equals;
(E) Per Diem payment;
(b) Full MS-LTC DRG payment.
(9) LTAC High Cost Outliers: Are an additional payment when the estimated cost of a claim exceeds the outlier threshold (LTC DRG payment plus a fixed loss amount):
(a) The fixed loss amount is published annually by Medicare;
(b) If the estimated cost of a claim is greater than the outlier threshold, an additional payment is added to the LTC DRG payment;
(c) The outlier payment is 80 percent of the difference between the estimated cost of the claim and the outlier threshold (LTC DRG payment plus the fixed loss amount);
(d) The estimated cost of the claim is calculated by multiplying the Agency's allowable charge on the claim by the hospital's cost-to-charge ratio.
(10) Inpatient psychiatric adult and pediatric services day outlier payment:
(a) Effective for services on or after January 1, 2025; a day outlier shall be applied to inpatient psychiatric adult and pediatric services when the outlier threshold is met. The outlier threshold is a sliding scale starting at a length of stay thirty (30) days. The sliding scale determines the adjustment percentage for the calculation.
(b) Adjustment percentage sliding scale effective on or after January 1, 2025:
(A) Percentage scale for days of service 30-89 is 70 percent
(B) Percentage scale for days of service 90 plus is 50 percent
(11) Day outlier formula calculation effective on or after January 1, 2025:
(a) Unit value As defined in (5)(c);
(b) Multiplied by the DRG weight equals DRG base payment;
(c) Divide DRG base payment by the arithmetic length of stay (ALOS), equals DRG per diem;
(d) DRG per diem multiplied by days over the 30-day threshold, equals DRG outlier;
(e) DRG day outlier times the DRG Day Outlier Percentage equals allowable DRG outlier.
(f) Formula, unit value (70 percent of Medicare) X DRG weight=DRG base payment/ DRG ALOS= DRG per diem X days over 30-day threshold= DRG outlier X DRG day outlier percentage= allowable DRG outlier.
(12) Capital:
(a) The capital payment is a reimbursement to in-state hospitals for capital costs associated with the delivery of services to Title XIX, non-Medicare persons. The Agency uses the Medicare definition and calculation of capital costs. These costs are taken from the Hospital Statement of Reimbursable Cost (Medicare Report); capital cost per discharge is calculated as follows:
(b) The Capital cost per discharge is 100 percent of the current year Medicare capital rate for non-psychiatric services and updated every October thereafter, see section (5) of this rule. The capital cost is added to the Unit Value and paid per discharge for non-psychiatric services.
(c) There is no separate cost reimbursement for capital cost for adult and pediatric inpatient psychiatric services as it is captured in the unit value per section (5)(c).
(13) Direct Medical Education:
(a) 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 Agency uses the Medicare definition and calculation of direct medical education costs. These costs are taken from the Hospital Statement of Reimbursable Cost (Medicare Report);
(b) Direct medical education cost per discharge is calculated as follows:

(A) 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, are divided by the number of Title XIX non-Medicare discharges. This is the Title XIX direct medical education cost per discharge;
(B) The Title XIX direct medical education cost per discharge for this period is inflated forward to January 1, 1992, using the compounded HCFA-DRI market basket adjustment;
(c) Direct medical education payment per discharge:
(A) 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 percent. Payment is made within thirty days of the end of the quarter;
(B) The Direct Medical Education Payment per Discharge shall be adjusted at an inflation factor determined by the Department in consideration of inflationary trends, hospital productivity, and other relevant factors.
(C) Notwithstanding section (9) of this rule, this subsection becomes effective for dates of service:
(i) On July 1, 2006, and thereafter direct medical education payments shall not be made to hospitals; and
(ii) On July 1, 2008, and thereafter direct medical education payments shall be made to hospitals, but shall not be operative as the basis for payments until the Agency determines all necessary federal approvals have been obtained.
(14) Indirect Medical Education:
(a) 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;
(b) Indirect medical education costs are those indirect costs identified by Medicare as resulting from the effect of teaching activity on operating costs;
(c) 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 Agency indirect medical education factor. This factor is used for the entire Oregon Fiscal Year;
(d) For dates of service on and after March 1, 2004, the calculation for the Indirect Medical Education quarterly payment is as follows: Total paid discharges during the quarter multiplied by the Case Mix Index, multiplied by the hospital-specific February 29, 2004, Unit Value, multiplied by the Indirect Factor, equals the Indirect Medical Education Payment;
(e) Effective October 1, 2009, the calculation of the Indirect Medical Education quarterly payment is as follows: Total paid discharges during the quarter multiplied by the Case Mix Index, multiplied by the hospital unit value, see section (5)(c) of this rule, multiplied by the indirect factor, equals the Indirect Medical Education Payment;
(f) This determines the current quarter's Indirect Medical Education Payment. Indirect medical education payments are made quarterly to each eligible hospital. Payment for indirect medical education costs shall be made within thirty (30) days of the end of the quarter;
(g) Notwithstanding section (10) of this rule, this subsection becomes effective for dates of service:
(A) On July 1, 2006, and thereafter Indirect Medical Education payment shall not be made to hospitals; and
(B) On July 1, 2008, and thereafter Indirect Medical Education payments shall be made to hospitals, but shall not be operative as the basis for payments until the Agency determines all necessary federal approvals have been obtained.
[Publications: Publications referenced are available from the agency.]

STATUTORY/OTHER AUTHORITY: ORS 413.042

STATUTES/OTHER IMPLEMENTED: ORS 414.065

AMEND: 410-125-0181

RULE TITLE: Non-Contiguous and Contiguous Area Out-of-State Hospitals — Outpatient Services

RULE SUMMARY: Inpatient Psychiatric adult and pediatric service methodology update, OOS payment and rate changes

RULE TEXT:

Non-contiguous area hospitals are out-of-state hospitals located more than 75 miles outside the Oregon border. Contiguous area hospitals are out-of-state hospitals located less than 75 miles outside the Oregon border. Unless such hospitals have an agreement with the Agency of Medical Assistance Programs (Agency) regarding reimbursement for specialized services, these hospitals shall be reimbursed as follows:

(1) Laboratory, diagnostic and therapeutic radiology, nuclear medicine, CT scans, MRI services, other imaging services, and maternity case management services shall be reimbursed under a Agency fee schedule.

(2) All other outpatient services shall be reimbursed at 50 percent of billed charges. There is no cost settlement.

(3) Notwithstanding subsection (2) of this rule, this subsection becomes effective for dates of service on and after January 1, 2025, but shall not be operative as the basis for payments until Agency determines all necessary federal approvals have been obtained. Unless such hospitals have an agreement with the Agency regarding reimbursement for specialized services, these hospitals shall be reimbursed as follows:

(a) Out-of-state contiguous and non-contiguous hospitals are reimbursed at an APC methodology as outlined in 3(b)-(e)

(b) Out-of-state contiguous and non-contiguous reimbursement methodology for hospitals shall be calculated using the wage index and outlier parameters set at the 50th percentile of Oregon hospitals.

(c) The Agency shall grandfather a reimbursement of 50 percent of the 2024 hospital-specific charge master in lieu of the calculation in section 3(b) of this rule, if such payment is requested by the hospital. Supporting documentation shall be required for this process.

(d) Clinical laboratory services shall be reimbursed under an Agency fee schedule;

(e) There shall be no cost settlement for out-of-state contiguous and non-contiguous outpatient services.

(4) The National Drug Code (NDC) must be included on the electronic (837I) and paper (UB 04) claims for physician administered drug codes required by the Deficit Reduction Act of 2005.

STATUTORY/OTHER AUTHORITY: ORS 413.042

STATUTES/OTHER IMPLEMENTED: ORS 414.065