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State/Territory Name: Oregon

State Plan Amendment (SPA) #: 24-0025

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S3-14-28
Baltimore, Maryland 21244-1850

Financial Management Group

July 9, 2025

Emma Sandoe, PhD
Medicaid Director, Oregon Health Authority
500 Summer Street Northeast, E-15
Salem, Oregon 97301-1079

RE: TN 24-0025

Dear Dr. Sandoe:

The Centers for Medicare & Medicaid Services (CMS) has reviewed the proposed Oregon state plan amendment (SPA) to Attachment 4.19-A OR 24-0025, which was submitted to CMS on December 23, 2024. This plan amendment updates reimbursement for inpatient hospital psychiatric services delivered by DRG hospitals.

We reviewed your SPA submission for compliance with statutory requirements, including in sections 1902(a)(2), 1902(a)(13), 1902(a)(30), 1903 as it relates to the identification of an adequate source for the non-federal share of expenditures under the plan, as required by 1902(a)(2) of the Social Security Act and the applicable implementing Federal regulations.

Based upon the information provided by the state, we have approved the amendment with an effective date of January 1, 2025. We are enclosing the approved CMS-179 and a copy of the new state plan pages.

If you have any additional questions or need further assistance, please contact Diana Dinh at 670-290-885 or via email at Diana.Dinh@cms.hhs.gov.

Sincerely,

[redacted]

Rory Howe
Director
Financial Management Group

Enclosures

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB No. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 24 — 0025

2. STATE: OR

3. PROGRAM IDENTIFICATION: TITLE OF THE SOCIAL SECURITY ACT: (●) XIX ( ) XXI

TO: CENTER DIRECTOR
CENTERS FOR MEDICAID & CHIP SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
1/1/25

5. FEDERAL STATUTE/REGULATION CITATION
1905(a)(1), 42 CFR 440.10

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)
a. FFY 2025 $ 618,039
b. FFY 2026 $ 823,303

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
Attachment 4.19-A, pages 7-12, 12a-NEW, 13-16, 16a-NEW, and 21A-1A, 21A-2

8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
Attachment 4.19-A, pages 7-12, 13-16, and 21A-1A, 21A-2

9. SUBJECT OF AMENDMENT
This transmittal is being submitted to revise hospital inpatient psych payment methods.

10. GOVERNOR'S REVIEW *(Check One)*
( ) GOVERNOR'S OFFICE REPORTED NO COMMENT
( ) COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
( ) NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
(●) OTHER, AS SPECIFIED:

11. SIGNATURE OF STATE AGENCY OFFICIAL
[redacted]

12. TYPED NAME
Emma Sandoe, PhD

13. TITLE
Medicaid Director

14. DATE SUBMITTED
12/23/24

15. RETURN TO
Oregon Health Authority
Medical Assistance Programs
500 Summer Street NE E-65
Salem, OR 97301

ATTN: Jesse Anderson, State Plan Manager

FOR CMS USE ONLY

16. DATE RECEIVED
December 23, 2024

17. DATE APPROVED
July 9, 2025

PLAN APPROVED - ONE COPY ATTACHED

18. EFFECTIVE DATE OF APPROVED MATERIAL

[redacted]VING OFFICIAL

20. TYPED NAME OF APPROVING OFFICIAL
Rory Howe

21. TITLE OF APPROVING OFFICIAL
Director, FMG

22. REMARKS

FORM CMS-179 (09/24)

Instructions on Back

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

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, 10th Revision, Clinical Modification (ICD-10-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.

OHA 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. OHA may modify the logic of the grouper program. OHA will work with representatives of hospitals which may be affected by grouper logic changes in reaching a cooperative decision regarding changes.

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

MEDICARE GROUPER (Cont)

The psychiatric adult and pediatric methodology will apply to the most recent MS-DRGs in MDC-19 and MDC-20 published by Medicare IPPS final rule.

(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, OHA 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. OHA employs the following methodology to determine whether enough claims exist to establish a reasonable weight for each state-specific Rehabilitation, and Neonate 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, OHA 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 DRGs lacking sufficient volume, OHA sets a relative weight using:

- OHA 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 OHA Title XIX population in that DRG, the weight derived from OHA Title XIX claims history is used instead of the externally derived weight for that DRG.

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

DRG RELATIVE WEIGHTS (Cont)

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 OHA. 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 Oregon Health Authority, 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.

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

UNIT VALUE(Cont)

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. OHA, in accordance with 42 CFR 447.253 and 447.205, will make public notice of changes and amend the state plan whenever a Unit Value adjustment is made under the provision of this subsection.

Effective January 1, 2025; the Agency will establish separate unit values for inpatient psychiatric adult and pediatric services.

The unit values will 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 inpatient 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.

The unit values for inpatient psychiatric adult and pediatric services are adjusted based on the hospital's location. The labor value portion is factored by multiplying it with the wage index as identified in 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.

The inpatient psychiatric adult and pediatric unit values will be rebased every two years. During non-rebase years, the inpatient adult and pediatric psychiatric unit values will 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.

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

(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. As of January 1, 2025, outlier payments for inpatient hospital psychiatric services follow the methodology outlined in Section (8). 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.

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

Third party reimbursements are deducted from the OHA 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. OHA 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 OHA 42, adjusted to reflect the Medicaid mix of services.

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

(8) PSYCHIATRIC DAY OUTLIER PAYMENTS

Effective for services on or after January 1, 2025; a Day Outlier will be applied to psychiatric adult and pediatric services when the outlier threshold is met. The outlier threshold is a sliding scale starting at a length of stay of thirty days. The sliding scale also determines the adjustment percentage for the calculation.

Outlier Threshold and Adjustment Percentage sliding scale:

30-90 days – 70%
90+ days - 50%

Formula for Day Outlier calculation:

Unit Value (As Defined on Page 10)
X DRG Weight
= DRG Base Payment
÷ DRG ALOS
= DRG Per Diem
X Days Over 30-Day Threshold
= DRG Day Outlier
X DRG Day Adjustment Percentage
= Allowable DRG Outlier Payment

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

(9) 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 for non-psychiatric services.

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

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. Refer to Unit Value calculation in Section (5).

(10) 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 not included in the capitation rates paid to managed care plans under the Oregon Health Plan 1115 Demonstration Project.

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

(11) 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 not 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.

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

(12) 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 (10) Direct Medical Education and (11) 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 (10) Direct Medical Education or (11) 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.

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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.

(13) DISPROPORTIONATE SHARE

The disproportionate share hospital (DSH) payment is an additional reimbursement made to hospitals which serve a disproportionate number of low-income patients with special needs. To receive DSH payments under Criteria I and Criteria 2 described below, a hospital must have at least two obstetricians with staff privileges at the hospital who have agreed to provide non-emergency obstetrical services to Medicaid patients. For hospitals in a rural area (outside of a Metropolitan Statistical Area, as defined by the Executive Office of Management and Budget), the term "obstetrician" includes any physician with staff privileges at the hospital who performs non-emergency obstetric procedures. This requirement does not apply to a hospital in which a majority of inpatients are under 18 years of age, or a hospital which had discontinued or did not offer non-emergency obstetric services as of December 22, 1987.

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

DISPROPORTIONATE SHARE (Cont)

The Medicaid utilization rate is the ratio of total paid Medicaid (Title XIX, non-Medicare) days to total inpatient days. Newborn days, days in specialized wards, and administratively necessary days are included. Days attributable to individuals eligible for Medicaid in another state are also accounted for.

A hospital's eligibility for DSH payments is determined at the beginning of each State fiscal year. Hospitals which are not eligible under Criteria 1 may apply for eligibility at any time during the year under Criteria 2. A hospital may be determined eligible under Criteria 2 only after being determined ineligible under Criteria 1. Eligibility under Criteria 2 is effective from the beginning of the quarter in which eligibility is approved. Out-of-state hospitals are eligible for DSH payments if they have been designated by their state Title XIX Medicaid program as eligible for DSH payments within that state.

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

(14) 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

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

(15) 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.