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NOTICE OF PROPOSED RULEMAKING
INCLUDING STATEMENT OF NEED & FISCAL IMPACT

FILED
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ARCHIVES DIVISION
SECRETARY OF STATE

CHAPTER 410
OREGON HEALTH AUTHORITY
HEALTH SYSTEMS DIVISION: MEDICAL ASSISTANCE PROGRAMS

FILING CAPTION: Reference Update for Inpatient Hospital Psychiatric DRG Base Rates for Oregon DRG Hospitals

LAST DAY AND TIME TO OFFER COMMENT TO AGENCY: 11/21/2024 5:00 PM

The Agency requests public comment on whether other options should be considered for achieving the rule's substantive goals while reducing negative economic impact of the rule on business.

A public rulemaking hearing may be requested in writing by 10 or more people, or by a group with 10 or more members, within 21 days following the publication of the Notice of Proposed Rulemaking in the Oregon Bulletin or 28 days from the date the Notice was sent to people on the agency mailing list, whichever is later. If sufficient hearing requests are received, the notice of the date and time of the rulemaking hearing must be published in the Oregon Bulletin at least 14 days before the hearing.

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NEED FOR THE RULE(S)

410-120-1295 needs to be amended to include the new diagnosis-related group (DRG) base rates. As an initiative from the Governor's Office, Oregon Health Authority (OHA) conducted a review of the Medicaid reimbursement structure and payment levels for inpatient hospital DRG psychiatric services. The larger rule changes will be in the Chapter 410 Division 125 rules.

OHA selected to implement a tiered MS-DRG payment structure in which the DRG base rate varies by hospital and separately for adults and pediatrics. In addition, OHA decided to adopt a day outlier payment policy for inpatient psychiatric stays as follows. Upon state plan approval, the rules can become permanent on January 1, 2025

DOCUMENTS RELIED UPON, AND WHERE THEY ARE AVAILABLE

CMS issued the FY 2025 Inpatient Psychiatric Facilities (IPF) Prospective Payment System final rule to update IPF: https://www.cms.gov/medicare/payment/prospective-payment-systems/inpatient-psychiatric-facility

FY 2025 Final Rule, Correction Notice and Interim Final Action with Comment Period Tables: https://www.cms.gov/medicare/payment/prospective-payment-systems/acute-inpatient-pps/fy-2025-ipps-final-rule-home-page#Tables

STATEMENT IDENTIFYING HOW ADOPTION OF RULE(S) WILL AFFECT RACIAL EQUITY IN THIS STATE

These changes are expected to significantly increase overall reimbursement for eligible claims and therefore cover a greater portion of costs for eligible facilities. This increases services and availability to adversely impacted communities. This may encourage mor providers to participate in providing inpatient psychiatric stays.

FISCAL AND ECONOMIC IMPACT:

Increase in reimbursement to facilities for inpatient psychiatric stays

COST OF COMPLIANCE:

(1) Identify any state agencies, units of local government, and members of the public likely to be economically affected by the rule(s). (2) Effect on Small Businesses: (a) Estimate the number and type of small businesses subject to the rule(s); (b) Describe the expected reporting, recordkeeping and administrative activities and cost required to comply with the rule(s); (c) Estimate the cost of professional services, equipment supplies, labor and increased administration required to comply with the rule(s).

1. No impact

2.

(a) No cost on small businesses

(b) No changes or costs

(c) Not changes or costs

DESCRIBE HOW SMALL BUSINESSES WERE INVOLVED IN THE DEVELOPMENT OF THESE RULE(S):

Impacted small businesses were engaged by the Actuarial Team, the Hospital Team, and contractors, and invited to comment and participate in the RAC.

WAS AN ADMINISTRATIVE RULE ADVISORY COMMITTEE CONSULTED? NO IF NOT, WHY NOT?

For 6 months, the Office of Actuarial and Financial Analytics, the subject matter expert for Hospital Services (division 125) Angel Wynia, Operations and Policy Analyst, Medicaid, and several other staff members and contractors gathered input from interested parties. Additionally, OHA analyzed cost report data from 2020 to 2023 for 14 hospitals.

The comments, feedback, and community input is documented in 2 main reports. One report is for the conclusions and summaries from the meetings. The second report is solely for feedback from interested parties.

AMEND: 410-120-1295

RULE SUMMARY: OHA selected to implement a tiered MS-DRG payment structure in which the DRG base rate varies by hospital and separately for adults and pediatrics. In addition, OHA decided to adopt a day outlier payment policy for inpatient psychiatric stays as follows.

CHANGES TO RULE:

410-120-1295
Non-Participating Provider ¶

(1) For purposes of this rule, a provider enrolled with the Health Systems Division (Division) that does not have a contract with a Division-contracted Managed Care Entity (MCE) is referred to as a non-participating provider.¶
(2) For services covered by the CCO or PHP, a non-participating provider, other than a hospital governed by (3) of this rule, must accept from the Division-contracted MCE, as payment in full, the amount that the provider would be paid from the Division if the client was fee-for-service (FFS).¶
(3) For covered services provided on and after October 1, 2011, the Division-contracted MCE that does not have a contract with a hospital, is required to reimburse, and hospitals are required to accept as payment in full, the following reimbursement:¶
(a) Non-participating Type A and Type B hospital: The MCE shall reimburse a non-participating Type A and Type B hospital fully for the cost of covered services based on the cost-to-charge ratio used for each hospital in setting the global payments to the MCE for the contract period;¶
(b) Hospitals (not designated as a rural access or Type A and Type B hospital) including Child/Adolescent Psychiatric units in a hospital: As specified in ORS 414.743, the MCE shall reimburse inpatient and outpatient services using a Medicare payment methodology at a specified percentage point less than the percentage of Medicare costs used by the Oregon Health Authority (Authority) when calculating the base hospital capitation

payment to the MCE excluding any supplemental payments.¶
(A) Effective for services on or after October 1, 2011, for a hospital providing 10 percent or more of the hospital admissions and outpatient hospital services to enrollees of the plan, the percentage of the Medicare reimbursement shall be equal to 64 percent;¶
(B) Effective for services on or after October 1, 2011, for a hospital providing less than 10 percent of the hospital admissions and outpatient hospital services to enrollees of the plan, the percentage of the Medicare reimbursement shall be equal to 66 percent.¶
(C) Effective for services on or after January 1, 2020 for a hospital providing 10 percent or more of the hospital admissions and outpatient hospital services to enrollees of the plan, the percentage of the Medicare reimbursement shall be equal to 76 percent.¶
(D) Effective for services on or after January 1, 2020 for a hospital providing less than 10 percent of the hospital admissions and outpatient hospital services to enrollees of the plan, the percentage of the Medicare reimbursement shall be equal to 78 percent.¶
(E) Effective for services on or after January 1, 2023 but before January 1, 2024,¶
(i) For a hospital providing 10 percent or more of the hospital admissions and outpatient hospital services to enrollees of the plan, the percentage of the Medicare reimbursement shall be equal to 81 percent; and¶
(ii) For a hospital providing less than 10 percent of the hospital admissions and outpatient hospital services to enrollees of the plan, the percentage of the Medicare reimbursement shall be equal to 83 percent.¶
(4) A non-participating hospital must notify the MCE within two (2) business days of an MCE patient admission when the MCE is the primary payer. Failure to notify does not, in and of itself, result in denial for payment. The CCO or FCHP is required to review the hospital claim for:¶
(a) Medical appropriateness;¶
(b) Compliance with emergency admission or prior authorization policies;¶
(c) Member's benefit package;¶
(d) The MCE contract and the Division's administrative rules.¶
(5) After notification from the non-participating hospital, the MCE may:¶
(a) Arrange for a transfer to a contracted facility, if the patient is medically stable and the MCE has secured another facility to accept the patient;¶
(b) Perform concurrent review; and/or¶
(c) Perform case management activities.¶
(6) In the event of a disagreement between the MCE and hospital, the provider may appeal the decision by asking for an administrative review as specified in OAR 410-120-1580.¶
(7) Effective for services on or after January 1, 2025, Calendar Year (CY) 25 Inpatient Hospital Psychiatric diagnosis-related group (DRG) Base Rates for Oregon DRG Hospitals, published by the Centers for Medicare & Medicaid Services (CMS) published Inpatient Prospective Payment System (IPPS) factors for federal fiscal year (FFY) 2025 available as of August 1, 2024. See Chapter 410 Division 125 administrative rules.
Statutory/Other Authority: ORS 413.042
Statutes/Other Implemented: ORS 414.065, 414.025, 414.743