

410-125-0141 DRG Rate Methodology

(1) Diagnosis Related Groups:

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

(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 Division of Medical Assistance Programs (Division) 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, the Division may modify the logic of the grouper program. The Division will work with representatives of hospitals that may be affected by grouper logic changes in reaching a cooperative decision regarding changes. The Division's DRG weight tables can be found on the Division web site.

(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 Division establishes a relative weight based on federal Medicare DRG weights. For State-specific rehabilitation, neonate, and adolescent psychiatric DRGs, Oregon Title XIX fee-for-service claims history is used. To determine whether enough claims exist to establish a reasonable weight for each state-specific rehabilitation, neonate, and adolescent psychiatric DRG, the Division uses the following methodology: Using the formula $N = Z \cdot S / R$ where $Z = 1.15$ (a 75% confidence level), S is the standard deviation and $R = 10\%$ of the mean. The Division determines the minimum number of claims required to set a stable weight for each DRG (N must be at least 5). For State-specific rehabilitation, neonate, and

adolescent psychiatric DRGs lacking sufficient volume, the Division sets a relative weight using:

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

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

(c) When a test shows at the 90% confidence level that an externally derived weight is not representative of the average cost of services provided to the Division's Title XIX population in that DRG, the weight derived from the Division's 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, will be established when changes are made to the DRG Grouper logic. State specific relative weights shall be adjusted, as needed, as determined by the Division. When relative weights are recalculated, the overall Case Mix Index (CMI) will be kept constant. Re-weighting of DRGs or the addition or modification of the grouper 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: Hospitals larger than fifty (50) beds are reimbursed using the DRG as described in (2) above. Effective for services on or after:

(a) August 15, 2005, the operating unit payment is 100% of 2004 Medicare and related data published in Federal Register/Vol. 68, No. 148, August 1, 2003. The unit value is also referred to as the operating unit per discharge.

(b) May 1, 2009, the operating unit payment is 108.5% of the 2004 Medicare and related data published in Federal Register/Vol. 68, No. 148, August 1, 2003. The unit value is also referred to as the operating unit per discharge.

(c) Effective October 1, 2009 the operating unit payment is 100% of the most recent version of the Medicare base payment rates. The Division will

revise the base payment rates each year in October when Medicare posts the rates.

(6) DRG Payment: The DRG payment to each Oregon DRG 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).

(7) 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;

(b) For dates of service on and after March 1, 2004 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% 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% of the DRG or \$25,000 (whichever is greater), equals;

(v) Outlier costs, multiplied by;

(vi) Cost outlier percentage, (cost outlier percentage is 50%), equals;

(vii) Cost outlier payment;

(E) Third party reimbursements are deducted from the Division calculation of the payable amount;

(F) When hospital cost reports are audited during the cost settlement process, 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 DMAP 42, adjusted to reflect the Medicaid mix of services.

(8) 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 Division uses the Medicare definition and calculation of capital costs. These costs are taken from the Hospital Statement of Reimbursable Cost (Medicare Report);

(b) For the dates of service on and after March 1, 2004 the Capital cost per discharge is one hundred (100) percent of the published Medicare capital rate for fiscal year 2004, see (5). The capital cost is added to the Unit Value and paid per discharge.

(c) Effective October 1, 2009 the Capital cost per discharge is one hundred (100) percent of the current year Medicare capital rate and updated every October thereafter, see (5) above. The capital cost is added to the Unit Value and paid per discharge.

(9) 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. Division 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%. Payment is made within thirty days of the end of the quarter;

(B) The direct medical education payment per discharge will be adjusted at an inflation factor determined by the Division in consideration of inflationary trends, hospital productivity and other relevant factors(C) notwithstanding subsection (9) of this rule, this subsection becomes effective for dates of service:

(i) On July 1, 2006 and thereafter direct medical education payments will not be made to hospitals; and

(ii) On July 1, 2008 and thereafter direct medical education payments will be made to hospitals, but will not be operative as the basis for payments until the Division determines all necessary federal approvals have been obtained.

(10) 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 Division's 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 (5)(c) above, 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 will be made within thirty days of the end of the quarter.

(g) Notwithstanding subsection (10) of this rule, this subsection becomes effective for dates of service:

(i) On July 1, 2006 and thereafter indirect medical education payment will not be made to hospitals; and

(ii) On July 1, 2008 and thereafter indirect medical education payments will be made to hospitals, but will not be operative as the basis for payments

until the Division determines all necessary federal approvals have been obtained.

[Publications: Publications referenced are available from the agency.]

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.065

10-1-09

7-1-10 (Hk and Stats)

3-1-11 (Hk)