Public notice

Notice of intent – OHA will amend the Medicaid State Plan to use an in-state wage index to calculate rates for all Oregon hospitals.

Date: June 27, 2025

Contact: Jesse Anderson, State Plan manager

Comments due: 5 p.m. Friday, July 18, 2025

Oregon Health Authority (OHA) intends to submit a State Plan Amendment (SPA) to the Centers for Medicare & Medicaid Services (CMS). The SPA will amend the Medicaid State Plan to apply an in-state wage index when calculating inpatient and outpatient rates for all Oregon hospitals.

Background

To calculate hospital rates, OHA uses the wage index published in the annual CMS final rules for the Hospital Inpatient and Hospital Outpatient Prospective Payment Systems. The index maps three Southern Oregon hospitals to a California wage index. This update would allow OHA to use the wage index of the hospitals' physical location.

The Oregon wage index for these hospitals currently results in a lower rate than the California wage index. To ensure no fiscal impact to these hospitals, OHA will continue to reimburse at Federal Fiscal Year 2025 reimbursement rates until those rates are lower than rates calculated using the current year Oregon wage index.

There is no fiscal impact to hospitals or the agency to make this change.

Obtaining SPA language

The following pages show edits to existing State Plan language in the proposed SPA. You can also view the full State Plan, approved SPAs and proposed SPAs on the OHA website.

How to comment:

OHA welcomes public review and input. Please send written comments by 5 p.m. Friday, July 18, 2025, to jesse.anderson@oha.oregon.gov.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State/Territory: OREGON

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.

Effective for services on or after October 1, 2025, for calculating the DRG unit values in situations where the Agency generally uses the most recent Medicare wage and geographic index from the CMS final rule, in cases where an out-of-state wage and geographic index is published for an in-state hospital the Agency will instead use the county of the physical location of the hospital to determine the hospital's wage and geographic index. Notwithstanding this provision, the Agency will grandfather the Federal Fiscal Year 2025 reimbursement rates for hospitals that are impacted by this provision until such time as those rates are lower than rates calculated using the current year county-based wage and geographic index.

The Unit Value plus the Capital amount multiplied by the claim assigned DRG relative weight is the hospital's Operational Payment.

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

UNIT VALUE(Cont)

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

2.a. OUTPATIENT HOSPITAL SERVICES

A. Type A, Type B and Critical Access Hospitals:

Oregon Type A, Type B and Critical Access hospitals are reimbursed for outpatient hospital services under a cost-based methodology. Interim payment is made by applying the cost-to-charge ratio, derived from the Medicare cost report, to billed charges for outpatient hospital services. A cost settlement based on the Medicare cost report, as finalized by the fiscal intermediary for purposes of Medicare reimbursement for the respective cost reporting period. The final reimbursement for Type A, Type B and Critical Access hospitals is at 100% of costs.

B. DRG reimbursed Hospitals:

Hospitals that are not a Type A, Type B or Critical Access hospitals are referred to as DRG hospitals. These are reimbursed for outpatient hospital services based on the most recent Medicare payment methodology established by the Centers for Medicare and Medicaid Services under the Outpatient Prospective Payment System using the Ambulatory Payment Classification (APC) methodology.

Effective for services on or after January 1, 2026, for calculating APC reimbursement in situations where the Agency generally uses the most recent Medicare wage and geographic index from the CMS final rule, in cases where an out-of-state wage and geographic index is published for an in-state hospital the Agency will instead use the county of the physical location of the hospital to determine the hospital's wage and geographic index. Notwithstanding this provision, the Agency will grandfather the calendar year 2025 reimbursement rates for hospitals that are impacted by this provision until such time as those rates are lower than rates calculated using the current year county-based wage index.

The APC methodology does not apply to clinical laboratory services. The interim payment for clinical laboratory is the lesser of billed charges or the OHA fee schedule as authorized in Attachment 4.19-B, section 3. "Other Lab and X-ray" of this state plan.

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

2.a. OUTPATIENT HOSPITAL SERVICES (Cont)

C. Supplemental payment to DRG hospitals:
In addition, supplemental payments are made to DRG hospitals in an amount equal to the available gap under the applicable upper payment limit. In no instance will these payments exceed the available applicable gap. For private hospitals, payments will be limited to the total available private hospital upper payment limit gap calculated in the following section. The distribution of payments will be determined by first calculating a percentage as follows: one quarter of the upper payment limit gap divided by the total private DRG hospital outpatient Medicaid fee-for-service payments from the quarter preceding the month of payment. This percentage will then be applied to each private DRG hospital's outpatient Medicaid fee-for-service payments from the quarter preceding the month of payment to determine the individual private DRG hospital outpatient supplemental payments. This process will be repeated, and payments will be made quarterly.

D. Non-state government owned hospitals:
Payments will be limited to the total available non-state government owned hospital upper payment limit gap calculated in the following section. The distribution of payments will be determined by first calculating a percentage as follows: one quarter of the upper payment limit gap divided by the total non-state government owned DRG hospital outpatient Medicaid fee-for-service payments from the quarter preceding the month of payment. This percentage will then be applied to each non-state government owned DRG hospital's outpatient Medicaid fee-for-service payments from the quarter preceding the month of payment to determine the individual non-state government owned DRG hospital outpatient supplemental payments. This process will be repeated, and payments will be made quarterly.

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

2.a. OUTPATIENT HOSPITAL SERVICES (Cont)

E. Out-of-State hospitals:
Out-of-state contiguous and non-contiguous hospitals are reimbursed at an APC methodology as outlined in 2.a.(2), for outpatient services except for clinical laboratory which are reimbursed at the lesser of billed charges or the OHA fee schedule. There is no cost settlement. The reimbursement for out-of-state contiguous and non-contiguous hospital's will be 80% of Medicare. The Agency will grandfather a reimbursement rate of 50% of the 2024 hospital specific charge master if requested by the hospital. Supporting documentation will be required for this process.

F. Highly specialized out-of-state outpatient hospital services:
Provided by written agreement or contract between OHA and the provider. The rate is negotiated on a provider-by-provider basis and is a discounted rate.

Outpatient reimbursement does not exceed applicable Federal upper payment limits.