LEGAL NOTICE
STATE OF OHIO
OHIO DEPARTMENT OF MEDICAID

Pursuant to section 1902(a)(13)(A) of the Social Security Act, the director of the Ohio Department of Medicaid (Department) gives final notice of the Department's action to modify provisions relating to the inpatient hospital reimbursement methodology for hospitals participating in the Medicaid program. The Department amended the Cost Coverage Payment Methodology to continue to ensure adequate access for Medicaid recipients to inpatient hospital services.

An initial notice was issued on April 29, 2020 to inform the public of the Department's intent to modify provisions relating to the inpatient hospital reimbursement methodology for hospitals participating in the Medicaid program. This final notice reflects the result of the public and legislative processes.

The cost coverage add-on, which is case-mix adjusted, is added to a hospital's base rates for each inpatient discharge for those hospitals paid under the "All Patient Refined-Diagnosis Related Group" (APR-DRG) inpatient prospective payment system. For those hospitals excluded from the prospective payment systems, the cost coverage add-on is a percentage increase to their prospective cost-to-charge ratio for discharges.

The Department will no longer require less than 400 Medicaid discharges in order for private, free-standing psychiatric hospitals to receive money from the private free-standing psychiatric allocation pool. All private, free-standing psychiatric hospitals are now eligible to receive money from the private free-standing psychiatric allocation pool. Additionally, the Department has updated the calculation for hospitals excluded from the prospective payment system to multiply the inpatient cost-to-charge ratio, calculated from cost report data, by the inpatient charges reported on the hospital's cost report rather than using the payments reported on the hospital cost report since the new method will result in a more accurate cost coverage reimbursement.

The cost coverage add-on amount is allocated from five policy pools based on appropriated funds each state fiscal year. The first allocation pool is the inpatient cost coverage standard pool, which allocates the lesser of $259,229,112.31 or 36.38% of the appropriated funds. The second allocation pool is the outpatient cost coverage standard pool, which is the lesser of $168,054,601.29 or 23.59% of the appropriated funds. The third allocation pool is the cost coverage sustainability pool, which is the sum of the lesser of $233,000,000.00 or 32.70% of the appropriated funds and the greater of 7.33% or the balance of the appropriated funds. The fourth allocation pool is for privately-owned psychiatric hospitals. The fourth allocation pool allocates 1.86% of the greater of 7.33% portion of the cost coverage sustainability pool or the balance of the appropriated funds. The fifth allocation pool is for hospitals with a dedicated psychiatric emergency department established prior to October 1, 2019, located in a general acute care hospital, which do not participate in the Care Innovation and Community Improvement Program (CICIP). These hospitals will be allocated $9,500,000.00. This methodology does not apply to the Medicaid maximum allowed amount calculation.

If, as an interested party, you need further information regarding the rates for a specific hospital under these methodologies, you may email a request to the Hospital Section of the Bureau of Policy and Health Plan Services at: hospital_policy@medicaid.ohio.gov.