5160-2-65 **Inpatient hospital reimbursement.**

Effective for dates of discharge on or after July 1, 2013, hospitals defined as eligible providers of hospital services in rule 5160-2-01 of the Administrative Code and not defined in paragraph (A) of this rule are subject to the all patient refined diagnosis related groups (APR-DRG) and prospective payment methodology utilized by the Ohio department of medicaid as described in this rule.

Unless otherwise referenced in this rule, rules 5160-2-07.1, 5160-2-07.3, 5160-2-07.4, 5160-2-07.8, 5160-2-07.9 and 5160-2-07.11 of the Administrative Code apply only to inpatient hospital claims for discharges occurring on or before June 30, 2013.

(A) Excluded hospitals. Services provided by the following institutions are not subject to the APR-DRG reimbursement system:

(1) "Freestanding rehabilitation hospitals" excluded from medicare prospective payment in accordance with 42 CFR 412.23(b) effective October 1, 2003;

(2) "Freestanding long-term hospitals" excluded from medicare prospective payment in accordance with 42 CFR 412.23(e) effective October 1, 2003;

(3) Hospitals that are excluded from medicare prospective payment due to providing services, in total, which are excluded due to a combination of the provisions of paragraphs (A)(1) and (A)(2) of this rule;

(4) Cancer hospitals as defined in rule 5160-2-07.2 of the Administrative Code for discharges on and after July 1, 1992.

(B) Hospital peer groups. For purposes of setting rates and making payments under the APR-DRG prospective payment system, the department classifies all hospitals not defined in paragraph (A) of this rule into one of the mutually exclusive peer groups defined in this paragraph.

(1) Teaching hospitals as defined in rule 5160-2-07.2 of the Administrative Code that are located in Ohio.

(2) Teaching hospitals as defined in rule 5160-2-07.2 of the Administrative Code that are not located in Ohio.

(3) Children's hospitals as defined in rule 5160-2-07.2 of the Administrative Code that are located in Ohio.

(4) Children's hospitals as defined in rule 5160-2-07.2 of the Administrative Code

that are not located in Ohio.

(5) Rural referral center hospitals as defined in rule 5160-2-07.2 of the Administrative Code that are located in Ohio.

(6) Metropolitan statistical area (MSA) hospitals as defined in rule 5160-2-07.2 of the Administrative Code that are located in Ohio.

(7) Non-MSA hospitals as defined in rule 5160-2-07.2 of the Administrative Code that are located in Ohio.

(8) Hospitals that are not located in Ohio that are not classified in paragraph (B)(2) or (B)(4) of this rule.

(9) Notwithstanding paragraph (B)(6) of this rule, hospitals located in rural counties as designated on the fiscal year (FY) 2016 inpatient prospective payment system (IPPS) case-mix and wage index table as published by the center for medicare and medicaid services (CMS), effective October 1, 2015, shall be recognized as a rural hospital for rate setting and payment purposes. A copy of the medicare FY 2016 IPPS case-mix and wage index table by CMS certification number (CCN) is available on the department's website at medicaid.ohio.gov.

(C) Classification procedures are as described in rule 5160:2-07.2 of the Administrative Code.

(D) DRG/severity of illness assignment.

(1) Each discharge on or after July 1, 2013 is assigned a DRG and one of four severity of illness (SOI) factors based upon the date of discharge.

(2) If a claim submitted by a hospital is deemed ungroupable because it does not contain valid values for one or more of the variables required by the APR-DRG grouper, then the claim will be denied payment by the department.

(E) Payment formula.

(1) The formula used in the APR-DRG prospective payment system effective for dates of discharge on or after July 1, 2013 is as follows: total payment, rounded to the nearest whole penny, equals (a) base payment plus (b) capital allowance plus (c) medical education allowance (if hospital is eligible) plus (d) outlier payment (if applicable) plus (e) other payments for organ

transplants where;

(a) Base payment equals the hospital base rate as described in paragraph (H) of this rule multiplied by the corresponding relative weight for the DRG/SOI as described in paragraph (I) of this rule.

(b) Capital allowance equals the per case add-on as described in paragraph (K) of this rule.

(c) Medical education allowance equals the per case add-on, case mix adjusted, as described in paragraph (L) of this rule.

(d) Outlier payment equals the eligible outlier costs multiplied by the outlier payment percentage as described in paragraph (J) of this rule.

(e) Other payments for transplant related services as described in paragraph (M) of this rule.

(F) Payments under the prospective payment system are made on the basis of a prospectively determined rate as provided in this rule. No year-end retrospective adjustment is made for prospective payment except as provided in rule 5160-2-24 of the Administrative Code. Except as provided in rules 5160-2-24, 5160-2-07.13, and 5160-2-40 of the Administrative Code, a hospital may keep the difference between its prospective payment rate and costs incurred in furnishing inpatient services and is at risk for costs which exceed the prospective payment amounts.

(G) Sources for inputs in the payment formula.

(1) The dataset used as inputs in the payment formula and determination of relative weights established for discharges on or after July 1, 2013 consists of:

(a) Inpatient hospital claims with dates of discharge from October 1, 2008 through September 30, 2010;

(b) Cost reports submitted by hospitals to the department on its medicaid cost report for the hospital years that end in state fiscal years 2009 (JFS 02930 rev. 4/2009), 2010 (JFS 02930 rev. 4/2010) and 2011 (JFS 02930 rev. 4/2011); and

(c) Inflation factors computed for Ohio by a nationally-recognized research firm that computes similar factors for the medicare program.

(2) The inflation factors were used to apply an inflationary value to the total cost computed for each case inflating it to September 30, 2013.

(H) Computation of hospital base rate.

(1) Except as described in paragraph (H)(4) of this rule, the base rate for each Ohio children's hospital is equal to:

(a) Ninety-nine and five hundredths per cent of the total inflated costs for the cases assigned to a children's hospital divided by the number of cases assigned to the children's hospital; divided by

(b) The peer group case mix score as calculated in paragraph (H)(3) of this rule.

(2) Except as described in paragraph (H)(4) of this rule, the base rate for hospitals in Ohio peer groups other than Ohio children's hospitals is equal to:

(a) Sixty-four and five hundredths per cent of the total inflated costs for the cases assigned to a peer group; divided by the number of cases in the peer group; divided by

(b) The peer group case mix score as calculated in paragraph (H)(3) of this rule.

(c) For dates of service on or after January 1, 2014, the amount will be equal to ninety-five per cent of the amount calculated in paragraphs (H)(2)(a) and (H)(2)(b) of this rule.

(3) The peer group case mix score is equal to:

(a) The sum of the relative weight values across all cases assigned to a peer group; divided by

(b) The number of cases in the peer group.

(4) For non-Ohio hospital peer groups, the peer group base rate is equal to the value assigned to the peer group effective January 1, 2013. For dates of service on or after January 1, 2014, the amount will be equal to ninety-five per cent of the base rate in effect on January 1, 2013.

(5) Peer group risk corridors.

Effective for discharges on or after July 1, 2013 and on or before ~~June 30, 2016~~December 31, 2016, the department will apply the following:

(a) If a hospital is in a non-MSA peer group, in the rural referral center peer group, or is in a MSA peer group but has a medicare designation as a critical access hospital, then the hospital’s base rate is equal to the greater of:

(i) The peer group base rate; or

(ii) Seventy per cent of the computed costs of the hospital’s cases.

(b) If a hospital is in a MSA peer group and is not a medicare designated critical access hospital, then the hospital's base rate is equal to:

(i) The peer group base calculated in paragraph (H)(2) of this rule, if the peer group base rate does not result in more than a three per cent reduction or gain in payments compared to the DRG prospective payment system in effect prior to July 1, 2013; or

(ii) A hospital-specific base rate established to ensure the new peer group base rate does not result in more than a three per cent reduction or gain in payments compared to the prior DRG prospective payment system.

(iii) For discharges on or after July 1, 2014 the risk corridor shall be adjusted to be no more than a five per cent reduction or gain.

(iv) For discharges on or after July 1, 2015 the risk corridor shall be adjusted to be no more than an eight per cent reduction or gain.

(c) If the hospital is in the teaching hospital peer group, then the hospital's base rate is equal to:

(i) The peer group base rate unless it was found that the new peer group base rate would result in a reduction or more than a three per cent gain in payments from the prior DRG prospective payment system; or

(ii) A hospital-specific base rate established to ensure that the new peer group base rate does not result in a reduction or more than a three per cent gain in payments compared to the prior DRG prospective payment system.

(d) If the hospital is in a children's hospital peer group, then the hospital's base rate is equal to:

(i) The hospital base rate calculated in paragraph (H)(1) of this rule, if the base rate does not result in more than a five per cent reduction or gain in payments compared to the prior DRG prospective payment system; or

(ii) A hospital-specific base rate established to ensure the new peer group base rate does not result in more than a five per cent reduction or gain in payments compared to the prior DRG prospective payment system.

(e) If the hospital is a psychiatric hospital owned and operated by the state of Ohio, regardless of peer group, then the hospital's base rate is equal to;

(i) The hospital base rate calculated in paragraph (H)(1) of this rule, if the peer group base rate does not result in a reduction in payments compared to the prior DRG prospective payment system; or

(ii) A hospital-specific base rate established to ensure the new peer group base rate does not result in a reduction.

(I) Computation of relative weights. The relative weight is equal to:

(1) The average inflated cost per case within the DRG/SOI; divided by

(2) The average inflated cost per case across all DRG/SOIs.

(J) Computation of outlier payments.

(1) If a discharge is eligible for an outlier payment, then the payment is equal to ninety-five per cent of the value of eligible outlier costs. For dates of service on or after January 1, 2014, the payment will be equal to ninety per cent of the value of eligible outlier costs.

(2) Eligible outlier costs are equal to the cost of the case minus an outlier threshold.

(a) When discharges are submitted for payment by hospitals, the cost of the case is computed as the product of covered billed charges and a hospital-specific medicaid inpatient cost-to-charge ratio as described in rule 5160-2-22 of the Administrative Code.

(b) The outlier threshold is equal to the base payment as described in paragraph (E)(1)(a) of this rule plus a fixed outlier threshold as described in paragraph (J)(2)(c) of this rule.

(c) The fixed outlier threshold varies and can be either DRG specific or peer group specific. The fixed outlier threshold for neonate and tracheostomy DRGs is forty-two thousand nine hundred dollars. The fixed outlier threshold for DRGs other than neonate and tracheostomy DRGs billed by hospitals in a children's peer group or the teaching peer group is fifty-four thousand four hundred dollars. The fixed outlier threshold for cases other than neonate and tracheostomy billed by hospitals among other peer groups is sixty-eight thousand dollars.

(3) For any claim that qualifies for an outlier payment, the final claim payment shall be limited to the lessor of covered billed charges or the total payment calculated in paragraph (E)(1) of this rule.

(K) Computation of capital payments.

(1) For Ohio hospitals, a capital allowance will be paid as described in rule 5160-2-07.6 of the Administrative Code.

(2) For non-Ohio hospitals a capital allowance will be paid as described in rule 5160-2-07.6 of the Administrative Code.

(3) Hospitals serving recipients enrolled in a medicaid managed care plan shall be paid a capital allowance that it is determined based on a hospital's medicaid managed care service experience as published by the department. Non-Ohio hospitals shall be paid a capital allowance using the published statewide average managed care capital rate.

(L) Computation of medical education payments.

For Ohio hospitals that have an approved medical education program as defined in

rule 5160-2-07.7 of the Administrative Code, an education allowance amount is added. The medical education allowance amount is described in rule 5160-2-07.7 of the Administrative Code adjusted to ensure payment neutrality for medical education with the adoption of the APR-DRG payment system described in this rule. For dates of service on or after January 1, 2014, the medical education payments for all hospitals except Ohio children's hospitals will be equal to ninety-five per cent of the amount described in this paragraph.

(1) If a hospital had modeled medical education payments that were less than the medical education payments received for the same discharges upon initial payment, then the hospital’s medical education allowance was adjusted upward so that, when multiplied by the new relative weights, the payments yielded payment neutrality on the medical education payment component alone.

(2) If a hospital had modeled medical education payments that were more than the medical education payments received for the same discharges upon initial payment, then no adjustment was made to the medical education allowance rate for the hospital.

(M) Other payments for transplant related services.

(1) Reimbursement for all organ transplant services, except for kidney transplants, is contingent upon review and recommendation by the "Ohio Solid Organ Transplant Consortium" based on criteria established by Ohio organ transplant surgeons and authorization from the department.

(2) Reimbursement for bone marrow transplant and hematopoietic stem cell transplant is contingent upon review and the recommendation by the "Ohio Hematopoietic Stem Cell Transplant Consortium" based on criteria established by Ohio experts in the field of bone marrow transplant and authorization from the department. Reimbursement is further contingent upon:

(a) Membership in the "Ohio Hematopoietic Stem Cell Transplant Consortium"; or

(b) Compliance with the performance standards described in agency 3701 of the Administrative Code, and the performance of ten autologous or ten allogeneic bone marrow transplants, dependent on which volume criteria is appropriate for the transplant requested.

(3) Organ acquisition and transportation costs for heart, heart/lung, liver, pancreas, single/double lung, and liver/small bowel transplant services will be reimbursed at one hundred per cent of billed charges.

(4) For harvesting costs for bone marrow transplant services, the prospective payment amount will be either:

(a) The DRG amount as described in this rule if the donor is a medicaid recipient or if the bone marrow transplant is autologous.

(b) The product of the covered billed charges times the hospital-specific, medicaid inpatient cost-to-charge ratio as described in rule 5160-2-22 of the Administrative Code, if the donor is not a medicaid recipient.

(N) Other payment policies.

(1) In accordance with rule 5160-2-03 of the Administrative Code, no coverage is available for days of inpatient care which occur solely for the provision of rehabilitation services related to a chemical dependency.

(2) A claim for inpatient services qualifies for interim payment on the thirtieth day of a consecutive inpatient stay and at thirty-day intervals thereafter. Under interim payment, hospitals will be paid on a percentage basis of charges. The percentage will represent the hospital-specific medicaid inpatient cost-to-charge ratio as described in rule 5160-2-22 of the Administrative Code. For those hospitals which are not required to file a cost report under the provisions of rule 5160-2-23 of the Administrative Code, the statewide average medicaid inpatient cost-to-charge ratio as described in rule 5160-2-22 of the Administrative Code will be used. Interim payments are made as a credit against final payment of the final discharge bill. Amounts of difference between interim payment made and the prospective payment described in paragraph (A) of this rule for the final discharge will be reconciled when the final discharge bill is processed.

(3) Payments for transfers as defined in rule 5160-2-02 of the Administrative Code are subject to the following provisions. If a hospital paid under the prospective payment system transfers an inpatient to another hospital or receives an inpatient from another hospital and that transfer is appropriate as defined in rule 5160-2-07.13 of the Administrative Code, then each hospital is paid a per diem rate for each day of the patient's stay in that hospital, plus capital, medical education and outlier allowances, as applicable, not to exceed, for nonoutlier cases, the final prospective payment rate that would

have been paid for the appropriate DRG/SOI as described in paragraph (E) of this rule. When a patient is transferred, the department's payment is based on the DRG/SOI under which the patient was treated at each hospital.

The per diem rate is determined by dividing the product of the hospital's base rate multiplied by the DRG/SOI relative weight as described in this rule by the statewide average length of stay calculated for the specific DRG/SOI into which the case falls.

For inpatient services provided to patients who are discharged, within the same hospital, from an acute care bed and admitted to a bed in a psychiatric unit distinct part, payment will be made based on the DRG representing services provided in the acute care section and the services provided in the psychiatric unit distinct part.

(4) In instances when a recipient's eligibility begins after the date of admission to the hospital or is terminated during the course of a hospitalization, payment will be made on a per diem basis as described in paragraph (N)(3) of this rule plus the allowance for capital, medical education and outliers, as applicable.

(5) Readmissions are defined in rule 5160-2-02 of the Administrative Code. A readmission within one calendar day of discharge, to the same institution, is considered to be one discharge for payment purposes so that one DRG payment is made. If two claims are submitted, the second claim processed will be rejected. In order to receive payment for the entire period of hospitalization, the hospital will need to submit an adjustment claim reflecting services and charges for the entire hospitalization.

(6) In the case of deliveries, the department requires hospitals to submit separate claims based respectively on the mother's individual eligibility and the child's individual eligibility.

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Certification

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Date

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