5160-2-75 **Outpatient hospital reimbursement.**

~~Effective for dates of service on or after the effective date~~For purposes of this rule, eligible providers of hospital services as defined in rule 5160-2-01 of the Administrative Code and assigned to prospective payment peer group as described in rule 5160-2-05 of the Administrative Code are subject to the enhanced ambulatory patient grouping system (EAPG) prospective payment methodology utilized by the Ohio department of medicaid (ODM) as described in this rule.

(A) Definitions.

(1) "Enhanced ambulatory patient grouping (EAPG)" is a group of outpatient procedures, encounters, or ancillary services, which reflect similar patient characteristics and resource utilization, and which incorporate the use of international classification of diseases (ICD) diagnosis codes, current procedural terminology (CPT) code set and healthcare common procedure coding system (HCPCS) procedure codes.

(2) "EAPG grouper" is the software provided by 3M health information systems to group outpatient claims based on services performed and resource intensity.

(3) "Default EAPG settings" are the default EAPG grouper options in 3M's core grouping software for each EAPG grouper version.

(4) "Discounting factor" is a factor applicable for multiple significant procedures or repeated ancillary services designated by default EAPG settings or both. The appropriate percentage (fifty or one hundred per cent) will be applied to the highest weighted of the multiple procedures or ancillary services payment group.

(a) "Full payment" is the EAPG payment with no applicable discounting factor.

(b) "Consolidation factor" is a factor of zero per cent applicable for services designated with a same procedure consolidation flag or clinical procedure consolidation flag by the EAPG grouper under default EAPG settings.

(c) "Packaging factor" is a factor of zero per cent applicable for services designated with a packaging flag by the EAPG grouper under default EAPG settings.

(5) "EAPG base rate" is the dollar value that ~~shall~~will be multiplied by the final EAPG weight for each EAPG on a claim to determine the total allowable medicaid payment for a visit.

(6) "Hospital peer groups" are for the purposes of setting rates and making payments under the EAPG or prospective payment system. ~~The department~~ODM classifies all hospitals not excluded in rule 5160-2-05 of the Administrative Code into one of the mutually exclusive peer groups defined in this paragraph.

(a) Critical access hospitals as defined in rule 5160-2-05 of the Administrative Code.

(b) Rural hospitals as defined in rule 5160-2-05 of the Administrative Code.

(c) Children's hospitals as defined in rule 5160-2-05 of the Administrative Code.

(d) Teaching hospitals as defined in rule 5160-2-05 of the Administrative Code.

(e) Urban hospitals as defined in rule 5160-2-05 of the Administrative Code.

(f) All other hospitals not located in Ohio that are not classified in paragraphs (A)(6)(a) to (A)(6)(e) of this rule.

~~(7) "Interim period" is the initial time after EAPG implementation when data collection will occur to determine EAPG relative weights for services not currently paid under the EAPG system implemented on the effective date of this rule. The interim period will begin on the effective date of this rule and will last at least six months.~~

~~(8) "Transitional period" is the initial time after EAPG implementation and prior to the department's next EAPG rebasing, wherein EAPG relative weights and peer group base rates are recalculated.~~

~~(9)~~(7) "Outpatient claim" encompasses the outpatient services rendered to one eligible medicaid recipient on one date of service.

~~(10)~~(8) "Outpatient invoice" is a bill submitted in accordance with Chapter 5160-1 of the Administrative Code, to ~~the department~~ODM for services rendered to one eligible medicaid recipient on one or more date(s) of service. For an invoice encompassing more than one date of service, each date will be processed separately as an individual claim. An invoice should be limited to thirty calendar days.

~~(11)~~(9) "Procedure code" is a CPT or HCPCS code as identified in rule 5160-1-19 of the Administrative Code. A list of covered procedure codes is published on ~~the department~~ODM's website, http://medicaid.ohio.gov/.

~~(12)~~(10) "Relative weight" is a factor specific to each EAPG that represents that EAPG's relative cost compared to an average case. The relative weights for all EAPGs are calculated as described in paragraph (F) of this rule.

~~(13)~~(11) "Revenue center codes" are those in effect on the date of service and are listed in ~~the department~~ODM's hospital billing guidelines as published on ~~the department~~ODM's ~~web site~~website, http://medicaid.ohio.gov/.

(B) EAPG payment formula.

~~For dates of service during the interim period,~~The total EAPG payment is the product of the following for each detail line:

(1) ~~Hospital-specific~~Peer group base rate in paragraph (D)(2) of this rule or base rate as adjusted ~~for payment neutrality as described~~ in paragraph ~~(I)~~(E) of this rule; multiplied by

(2) EAPG relative weight for which the service was assigned by the EAPG grouper, rounded to the nearest whole cent;

(3) Multiply the product of paragraph (B)(1) and (B)(2) of this rule by the applicable discounting factor(s) as defined in paragraph (A)(4) of this rule;

(a) Laboratory services ~~billed with valid HCPCS code(s) 36415, 36416, 78267, 78268 or 80000-89999 shall~~ will be reimbursed the lesser of charges or the assigned EAPG payment.

(b) Radiology services ~~billed with valid CPT code 36251-36254, 62302-62305 or 70000-79999 shall~~ will be reimbursed the lesser of charges or the assigned EAPG payment.

(4) Rounded to the nearest whole cent.

(C) Sources for inputs in the payment formula.

The dataset used as inputs in the payment formula and determination of relative weights established for dates of service on or after the effective date of this rule consists of:

(1) All outpatient hospital claims with dates of service from ~~October 1, 2015~~January 1, 2017, through ~~September 30, 2018~~June 30, 2021;

(2) Cost reports submitted by hospitals to ~~the department~~ODM on its Ohio medicaid hospital cost report for the hospital years that end in state fiscal years ~~2016~~

~~(ODM 02930 rev. 4/2016) and~~ 2017 (ODM 02930 rev. 4/2017) through 2021 (ODM 02930 rev. 5/2021); and

(3) Inflation factors computed for Ohio by a nationally recognized research firm that computes similar factors for the medicare program. The inflation factors were used to inflate the total cost computed for each case inflating it to ~~June 30, 2020~~June 30, 2024.

(D) Computation of case mix adjusted average cost per case (base rate).

(1) For each Ohio peer group, sum the total inflated cost for all ~~case~~cases; divided by

(2) The number of cases assigned to each peer group; and multiply the result below ~~by seventy-one and nine-tenths per cent.~~:

(a) For teaching hospitals, seventy per cent;

(b) For southeast hospitals, sixty-eight per cent;

(c) For southwest hospitals, sixty-three per cent; and

(d) For all other peer groups, sixty-two per cent.

(3) For each Ohio peer group, sum the relative weight values for all cases assigned to the peer group; divided by

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

(5) For each Ohio peer group, ~~Multiply~~multiply the amount described in paragraph (D)(2) of this rule by the ~~product~~ result of paragraphs (D)(3) and (D)(4) of this rule.

(6) For non-Ohio peer groups, the peer group base rate is ~~seventy~~sixty-four per cent of the statewide average.

(E) Risk corridors.

Effective for ~~discharges~~dates of service on or after the effective date of this rule, ~~the department~~ODM will apply the following to Ohio hospital peer groups except those defined in paragraphs (A)(6)(a) and (A)(6)(b) of this rule:

(1) If the peer group base rate calculated in paragraph (D) of this rule results in the fiscal impact at the individual hospital level that results in the reduction of payments from current levels, the individual hospital base rate is adjusted to a zero per cent reduction in payments~~The peer group base rate calculated in~~

~~paragraph (D) of this rule if the peer group base rate does not result in more than a zero per cent reduction or five per cent gain in payments compared to the prospective payment system in effect prior to the effective date of this rule~~; or

(2) If the peer group base rate calculated in paragraph (D) of this rule results in the fiscal impact at the individual hospital level that results in the increase of payments from current levels that is greater than ten per cent, the individual hospital base rate is adjusted to a ten per cent increase in payments. ~~A hospital-specific base rate established to ensure the new peer group base rate does not result in more than a zero per cent reduction or five per cent gain in payments compared to the prior prospective payment system.~~

(F) Computation of relative weights.

The relative weight is equal to:

(1) The average inflated cost per case within each EAPG; divided by

(2) The average inflated cost per case across all EAPGs.

~~(3) A budget neutrality factor is applied to all EAPGs in each EAPG type:~~

~~(a) Significant procedures are increased by 1.517;~~

~~(b) Physical therapy and rehabilitation procedures are increased by 1.221;~~

~~(c) Mental health and counseling procedures are increased by 1.138;~~

~~(d) Radiologic procedures are increased by 0.886;~~

~~(e) Diagnostic significant procedures are increased by 1.092;~~

~~(f) Medical visits are increased by 1.187;~~

~~(g) Ancillary services are increased by 1.532; and~~

~~(h) Dental procedures, incidental services, drugs, durable medical equipment (DME), and unassigned services are increased by 1.254.~~

(G) Items conditionally payable outside of EAPG.

(1) Pharmaceuticals.

(a) When applicable, reimbursement for provider-administered pharmaceuticals HCPCS J-code or Q-code billed with revenue center

code 25X or 636 ~~shall~~ will be the lesser of charges or the payment amounts in the provider-administered pharmaceutical fee schedule as published on ~~the department~~ODM's ~~web site~~website, http://medicaid.ohio.gov/.

(b) Additional payments for pharmaceuticals will be made in accordance with the discounting factors as determined by the EAPG grouper.

(c) Pharmaceutical line items without a "National Drug Code" will be denied payment by ~~the department~~ODM.

(d) Charges listed in line items that carry revenue center code 025X or 636 with a provider-administered pharmaceutical HCPCS J-code or Q-code that are not listed on the provider-administered pharmaceutical fee schedule or listed as "by report" will pay in accordance ~~to~~with paragraph ~~(G)(1)(c)(ii)(d)~~(G)(3)(b)(iv) of this rule.

(2) Durable medical equipment (DME).

(a) Additional payments may be made for items grouping to a DME EAPG type.

(b) Reimbursement for outpatient hospital DME ~~shall~~will be the lesser of charges or the payment amounts in the medicaid durable medical equipment fee schedule as published on ~~the department~~ODM's website, http://medicaid.ohio.gov/.

(c) Additional payments for DME will be made in accordance with the discounting factors as determined by the EAPG grouper.

(3) Independently billed services for drugs or medical supplies and devices.

(a) To request independently billed payment under EAPG, hospitals ~~must~~will report all services provided on the date of service; and

(b) Report modifier UB with the primary procedure performed. Claims submitted with modifier UB are subject to the following payment methodology:

(i) Charges listed in line items that carry revenue center codes 025X or 0636 with a provider administered HCPCS J-code or Q-code will pay in accordance ~~to~~with the provider-administered pharmaceutical fee schedule.

(ii) Charges listed in line items that carry revenue center code 025X without a provider-administered pharmaceutical CPT/HCPCS code or revenue center code 027X with or without a DME HCPCS code will pay in accordance ~~to~~with paragraph ~~(G)(1)(c)(ii)(d)~~(G)(3)(b)(iv) of this rule.

(iii) Charges listed in line items that carry revenue center code 025X or 0636 with a provider-administered pharmaceutical HCPCS J-code or Q-code that are not listed on the provider-administered pharmaceutical fee schedule or listed as "by report" will pay in accordance ~~to~~with paragraph ~~(G)(1)(c)(ii)(d)~~(G)(3)(b)(iv) of this rule.

(iv) Payment for charges listed in paragraph ~~(G)(1)(c)(ii)(b)~~(G)(3)(b)(ii) or ~~(G)(1)(c)(ii)(c)~~(G)(3)(b)(iii) of this rule is the product of the following for each detail line:

(a) Allowed charges multiplied by the hospital's specific medicaid outpatient cost-to-charge ratio as described in paragraph (B)(2) of rule 5160-2-22 of the Administrative Code, rounded to the nearest whole cent.

(b) Multiply the product of ~~(G)(1)(c)(ii)(d)(i)~~(G)(3)(b)(iv)(a) of this rule by sixty per cent; rounded to the nearest whole cent.

(v) All other detail lines on the same date of service will be paid zero.

(4) Dental services.

Reimbursement for items assigned to a dental service EAPG type will be paid as follows:

(a) Children's hospitals, as defined in rule 5160-2-05 of the Administrative Code, will be paid one-thousand sixty-two dollars.

(b) All other hospitals will be paid one-thousand one-hundred ninety-two dollars.

(c) Payments ~~shall~~will be multiplied by any applicable discounting factor, rounded to the nearest whole cent.

(5) Vaccines for children (VFC).

(a) The administration of immunizations covered under the VFC program may be reimbursed for recipients eighteen years or younger.

(b) Reimbursement for the administration of immunizations covered under the VFC program will be ten dollars for individuals eighteen years of age or younger, contingent upon the EAPG grouper. However, no payment will be made for vaccines that can be obtained at no cost through the federal VFC program.

(c) Additional payments for designated free vaccines will be made in accordance with the discounting factors as determined by the EAPG grouper.

(6) Observation services.

(a) Payment for observation services HCPCS code G0378 will be made using an average rate. Payment will be made for the following types of observation services:

(i) Acute care related observation services; and

(ii) Behavioral health (BH) and/or substance use disorder (SUD) observation services.

(b) Payments for observation services will be limited to a maximum of two consecutive days, except as provided in paragraph ~~(G)(f)(iii)~~(G)(6)(c) of this rule.

(c) Payments for observation services reported with HCPCS code G0378 will be made for up to twenty-four units per day or forty-eight consecutive units (which could extend over a three-day period).

(d) Outpatient claims for observation services described in paragraph (G)(6)(a)(ii) of this rule will include:

(i) A BH/SUD primary diagnosis code; and

(ii) Modifier 'HE' at the detail level for the observation code.

(H) ~~Notwithstanding rule 5160-2-03 of the Administrative Code, payment~~Coverage for acupuncture services is limited to the treatment of ~~low back pain and migraine headaches~~the services defined in rule 5160-8-51 of the Administrative Code.

~~(I) Payment neutrality.~~

~~(1) Outpatient hospital services provided between October 1, 2017 and September 30, 2018 were priced using the hospital-specific base rates resulting from paragraph (E) of this rule to determine total hospital payments under EAPG version 3.9.~~

~~(2) To determine total hospital payments for outpatient hospital services under EAPG version 3.14 after the effective date of this rule, the hospital-specific base rates will be adjusted to achieve payment neutrality for each hospital.~~

~~(3) No adjustment will be made for non-Ohio peer groups.~~

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Five Year Review (FYR) Dates: 10/17/2023 and 01/01/2029

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