PUBLIC HEARING NOTICE
OHIO DEPARTMENT OF MEDICAID

DATE: August 14, 2013
TIME: 10:00 a.m.
LOCATION: Room 3110B, Rhodes State Office Tower
30 East Broad Street, Columbus, Ohio

Pursuant to section 5111.01, and Chapter 119 of the Ohio Revised Code, the director of the Ohio Department of Medicaid gives notice of the department's intent to adopt rule 5101:3-2-65 on a permanent basis to implement the New Hospital Inpatient Reimbursement methodology by adopting a new diagnostic related Grouper and updating hospital inpatient payment rates, effective July 1, 2013 as required by Am. Sub. H.B. No. 153 of the 129th General Assembly. This rule was adopted on an emergency basis on July 1, 2013

Pursuant to section 1902(a)(13)(A) of the Social Security Act, the Medicaid Director announced the commencement of the inpatient hospital payment methodology change project. Included was a public process to solicit comments on the proposal development which began on March 20, 2012 and included bi-weekly meetings with the Ohio Hospital Association and the Ohio Children's Hospital Association. There were also less frequent meetings with the Ohio Association of Health Plans and it's member Medicaid Managed Care Organizations. These hospital industry meetings totaled 30 stakeholder meetings over the course of March 2012 to April 2013. On August 7, 2012, the department issued a Federal Medicaid and public hearing notice for an industry-wide webinar held on August 13, 2012 – this webinar was attended by over 140 hospital representatives. In addition, the department held three webinars for all hospitals, four meetings with the Ohio Hospital Association (OHA) DRG workgroup and three meetings with the OMA's contracted managed Care Plans (MCPs)

Policy development:
Currently, payments for inpatient hospital services are based upon diagnostic related groups (DRGs), using a grouper that is mostly based off of the original CMS grouper-version 15 but with Ohio-specific modifications. The department will move to 3M's All Patient Refined grouper (APR-DRG) effective July 1, 2013.

Concurrent with this change, the department evaluated all other inpatient payment methodology components. The department used a recent two year database (dates of discharge from 10/1/2008 to 9/30/2010) of fee-for-service claims, health plan encounters, and related Medicaid hospital cost reports in this reimbursement methodology development. Areas considered for updates or change in methodology included, but were not limited to, the following:

- The number and composition of hospital peer groups (used to set base rates and other payment features);
- Inclusion of hospitals currently exempt from the DRG payment methodology, under the prospective payment system;
- Add-on payments such as outliers, capital, direct medical education and indirect medical education;

- Payments for select services such as psychiatric care, detox services, rehabilitation and nursery; and
- Treatment of transfer cases, readmissions and short stays

New items that will be considered in the methodology include:
- The treatment of hospital acquired conditions and never events and
- Quality-based incentives

Following the department's engagement with the hospital industry and providers through meetings throughout 2012 and 2013 to review the status of studies conducted related to the proposed methodology, and the concurrent review of the fiscal impacts of these studies, the department is proposing to adopt and implement the joint recommendations that resulted.

The results of the extensive public input process are the adoption of the following hospital inpatient reimbursement methodology:

- Adoption of 3M's All Patient Refined grouper (APR-DRG), new hospital base rates and relative weights;
- Adoption of hospital specific base rates that incorporated the negotiated hospital impact stop loss/stop gain provisions designed to prevent large swings in hospital reimbursements;
- Retention of the current number and composition of hospital peer groups;
- Continued exclusion of hospitals currently exempt from the DRG payment methodology, under the prospective payment system;
- Adoption of a Medicare-like outlier reimbursement methodology, with the retention of add-on payments such as capital, and direct and indirect medical education with a minor modification to the medical education allowance to prevent provider loss of medical education payments due to the downward revision of imputed case mix scores;
- Retention of the current concepts for the payments for select services such as inpatient psychiatric care, detox services, rehabilitation, nursery, transfer cases, readmissions and short stays.

The department estimates that these changes will result in an aggregate payment increase of $84.2 million annually.

A copy of the proposed rule is available, without charge, to any person affected by the rule at the address listed below. The rule is also available on the internet at http://www.registerofohio.state.oh.us/. A public hearing on the proposed rule(s) will be held at the date, time, and location listed at the top of this notice. Either written or oral testimony will be taken at the public hearing. Additionally, written comments submitted or postmarked no later than the date of the public hearing will be treated as testimony.

Requests for a copy of the proposed rule or comments on the rule should be submitted by mail to the Office of Medical Assistance c/o Ohio Department of Job and Family Services, Office of Legal and Acquisition Services, 30 East Broad Street, 31st Floor, Columbus, Ohio 43215-3414, by fax at (614) 752-8298, or by e-mail at rules@jfs.ohio.gov.