LEGAL NOTICE
STATE OF OHIO
OHIO DEPARTMENT OF MEDICAID
COLUMBUS, OHIO

DATE:	**November 16, 2015**
TIME:	**11:00 a.m.**
LOCATION:	**Room A501, Lazarus Building**
	50 W. Town St., Columbus, Ohio 43215

Pursuant to section 5164.02 and Chapter 119 of the Ohio Revised Code and 42 CFR 447.205 and section 1902(a)(13)(A) of the Social Security Act, the Director of the Ohio Department of Medicaid (Department) gives notice of the Department's intent to adopt, amend or rescind the rules identified below and of a public hearing thereon. These rules are being amended to modify the provisions relating to the reimbursement of outpatient hospital services under the Ohio Medicaid program. These modifications result from recommendations by the Department and the General Assembly to build appropriations established in Am. Sub. H.B. 64 of the 131st General Assembly and from five year rule review.

Rule 5160-2-02, entitled General provisions: hospital services, provides information about the general provisions for covering hospital services. This rule is being proposed for amendment to update the rule body to reflect updates to the Department's reimbursement methodologies that contributed to the building of the appropriation established in Am. Sub. H.B. 64. The Department proposes to modify the definition of inpatient services to include all outpatient services rendered to a patient within three calendar days prior to the date of an inpatient admission in hospitals described in OAC rule 5160-2-01. This change would be effective for inpatient admissions that begin on or after on January 1, 2016. The Department estimates that including outpatient hospital services provided within three calendar days prior to an inpatient admission as inpatient services will decrease expenditures by $8.34 million on an annual aggregate basis.

Rule 5160-2-21, entitled Reimbursement for services provided in an outpatient hospital setting, describes the outpatient payment policies and rates for outpatient services delivered by hospitals that are subject to prospective payment based on diagnosis related groups (DRG). This rule is being proposed for amendment to update the rule body and its appendices to reflect updates to the Department's reimbursement methodologies that contributed to the building of the appropriation established in Am. Sub. H.B. 64. The Department will reform its outpatient hospital reimbursement policy for pharmaceuticals billed with revenue center code (RCC) 025X and/or 0636 with a provider-administered pharmaceutical HCPCS J-code or Q-code. When applicable for additional payment based on the provisions in OAC rule 5160-2-21, any line item that contains RCC 025X and/or 0636 with a provider-administered pharmaceutical HCPCS J-code or Q-code as listed on the Department's Provider-Administered Pharmaceuticals fee schedule, will be paid in accordance with paragraph (E) of rule 5160-4-12 of the Administrative Code at the rate in effect on the date of service. If a HCPCS J-code or Q-code is listed on the Provider-

Administered Pharmaceuticals fee schedule as "by report," charges on that detail line will pay sixty percent of the hospital's specific cost-to-charge ratio. Charges on detail lines that carry RCC 025X and/or 0636 without a provider-administered pharmaceutical HCPCS J-code or Q-code when an applicable J-code or Q-code does not exist for the provider-administered pharmaceutical for the date of service will also pay sixty percent of the hospital's specific outpatient cost-to-charge ratio. The rule will also allow the five percent rate increase for outpatient hospital services, except for children's hospitals, authorized in Am. Sub. H.B. 1 of the 128th General Assembly to expire on December 31, 2015. The appendices to this rule will be updated to reflect the expiration of the five percent rate increase that was implemented on January 1, 2010. Appendix H to this rule, which provides reimbursement rates for laboratory services will be eliminated; laboratory services will pay in accordance to Appendix DD to OAC rule 5160-1-60, at the same rate as eliminated Appendix H. These changes would take effect on January 1, 2016.

Language regarding payment for claims that carry a surgical procedure code but do not group to an outpatient surgical code group will be removed; and outdated language will also be removed. The intellectual disability diagnosis codes that pertains to unlisted dental surgery payments will be updated to include International Classification of Diseases (ICD) -10 diagnosis codes. The Department estimates that eliminating the five percent increase for outpatient hospital services will decrease expenditures by $107.5 million annually. Reforming reimbursement logic for pharmaceuticals will result in $44.3 million in savings annually.

The Department estimates that all of these reimbursement changes will decrease expenditures by $233.1 million on an annual aggregate basis.

A public hearing on the proposed rule will be held at the date, time, and location listed at the top of this notice. Both written and 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.

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/. In addition, a copy of the proposed rules are available for public review at each County Department of Job and Family Services.

Requests for a copy of the proposed rule and testimony on the rule should be submitted by mail to the Ohio Department of Medicaid Rule Administrator, Office of Chief Legal Counsel, 50 W. Town Street, Suite 400, Columbus, Ohio 43215-3414, by fax at (614) 752-8298, or by e-mail at Rules@Medicaid.Ohio.gov. Testimony received may be reviewed at this address.