PUBLIC HEARING NOTICE
OHIO DEPARTMENT OF MEDICAID

DATE:	**July 9, 2018**
TIME:	**11:00AM**
LOCATION:	**Lazarus Building, Room A501** **50 W. Town St., Columbus, Ohio 43215-3414**

Pursuant to section 5164.02 and Chapter 119. of the Ohio Revised Code, the director of the Ohio Department of Medicaid (department) gives notice of the department's intent to adopt, amend, or rescind the rules as identified below and of a public hearing thereon.

Rule 5160-2-05, entitled Classification of hospitals, sets forth the methodology in which hospitals, paid under the "All Patient Refined-Diagnosis Related Group" (APR-DRG) inpatient prospective payment system, the "Enhanced Ambulatory Patient Grouping" (EAPG) outpatient prospective payment system or those hospitals excluded from the prospective payment systems, are classified into mutually exclusive peer groups. This rule also defines what the payment peer groups for Ohio hospitals are and how they are paid. The proposed amendments to this rule are intended to continue the reform and modernization of the hospital reimbursement methodology.

This rule is being amended to clarify that rural and urban hospitals refer to hospitals located in an Ohio county; updating the reclassification provision so that beginning on or after January 1, 2019, any hospital geographically located in an Ohio county that has been newly included or newly excluded from a Core Based Statistical Area (CBSA), as designated in the inpatient prospective payment system (IPPS) case-mix and wage index table as published by the Centers for Medicare and Medicaid Services (CMS), shall be placed into either the rural peer group or, based on the geographical location of the hospital, the urban peer group for the new classification. The hospital's new base rate shall be the average cost per discharge of the new peer group without any consideration for hospital-specific risk provisions of either the new or previous peer group.

Additionally, a new paragraph is being added to describe how rates are determined for new, acquired, merged and replacement hospitals. For hospitals newly enrolled in Medicaid and paid on a prospective payment basis, the base rate shall be the base rate of the peer group in which they are classified, without any consideration for hospital-specific risk provisions, and they shall receive the statewide average for capital allowance and the statewide average for both inpatient and outpatient cost-to-charge ratios until a cost report is filed by the new owner and hospital-specific rates are calculated. For hospitals newly enrolled in Medicaid and paid on reasonable cost basis, rates shall be ninety percent of the statewide average for both inpatient and outpatient cost-to-charge ratios until a cost report is filed by the new owner and hospital-specific rates are calculated based on the cost report. For acquired and replacement hospitals, rates shall be equal to the prior owner's rates until a cost report is filed by the new owner and hospital-specific rates are calculated based on the cost report. For hospitals that have merged, rates from the surviving Medicaid provider number shall be used until a cost report is filed and hospital-specific rates are calculated based on the

cost report. Additional changes to this rule include updating date references to the Code of Federal Regulations that are referenced in this rule and removing the provision regarding OAC rule 5160-2-07.2 which has been rescinded. This rule is anticipated to be effective for inpatient discharges and outpatient services on or after the effective date of this rule.

OAC rule 5160-2-65, entitled Inpatient hospital reimbursement, is being proposed for amendment. This rule sets forth the Medicaid inpatient hospital reimbursement methodology for hospitals subject to APR-DRG prospective payment. The proposed amendments to this rule are intended to continue the reform and modernization of the inpatient hospital reimbursement methodology. The proposed rule will clarify the separate inputs, hospital base rate and relative weight, in the payment formula. The hospital base rates used in the inpatient payment calculation will not change. The proposed rule will update the diagnosis related groups (DRG) relative weight component used to calculate inpatient payments by using more recent hospital claims data and hospital cost report data and inflate to December 31, 2018 the inflation factors used to apply an inflationary value to the total cost computed. The formula used to calculate inpatient payments will not change. This rule is also being amended to include the psychiatric DRGs 750-759 in the relative weights computation. Additionally, the relative weight adjustment for Long Term Reversible Contraceptives (LARCs) is being adjusted to three and eight hundredths percent from three and thirteen hundredths percent. Lastly, the coding adjustment implemented to correct for increased coding specificity as a result of the implementation of the International Classification Of Diseases, Tenth Revision (ICD-10) shall be removed as the inpatient hospital claims used in the updated dataset for the computation of the DRG relative weights fully incorporate ICD-10 coding.

OAC rule 5160-2-75, entitled Outpatient hospital reimbursement, is being proposed for amendment. This rule sets forth the Medicaid outpatient hospital reimbursement methodology for hospitals subject to the enhanced ambulatory patient grouping system prospective payment methodology. The proposed amendments to this rule are intended to continue the reform and modernization of the outpatient hospital reimbursement methodology. The Department is proposing to amend the rule to clarify that revenue center codes, 025X and 636, apply to reimbursement for outpatient hospital pharmaceuticals when applicable and to add the payment formula for pharmaceuticals that carry revenue center code 025X or 636 with a provider-administered pharmaceutical HCPCS J-code, except HCPCS J-code J0714, that are not listed on the provider-administered pharmaceutical fee schedule or are listed as “by report”. Payment shall be the product, for each detail line, of allowed charges multiplied by the hospital’s specific medicaid outpatient cost-to-charge ratio, rounded to the nearest whole cent, multiplied by sixty percent, rounded to the nearest whole cent. The Department proposes to remove the discounting factor applicable to observation services. Lastly, the Department proposes to add payment for acupuncture services limited to the treatment of low back pain and migraine headache.

A copy of the proposed rules is available, without charge, to any person at the address listed below. The rules are also available on the internet at http://www.registerofohio.state.oh.us/.

A public hearing on the proposed rules 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.

Requests for a copy of the proposed rules and testimony on the rules 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) 995-1301, or by e-mail at Rules@Medicaid.Ohio.gov. Testimony received may be reviewed at this address.