Ohio | Common Sense Initiative

Mike DeWine, Governor
Jon Husted, Lt. Governor

Carrie Kuruc, Director

Business Impact Analysis

Agency, Board, or Commission Name: Ohio Department of Medicaid

Rule Contact Name and Contact Information:

Tommi Potter- Rules@Medicaid.Ohio.gov

Regulation/Package Title (a general description of the rules' substantive content):

Hospital Cost Coverage Add-On

Rule Number(s): 5160-2-60

Date of Submission for CSI Review: 3/3/2021

Public Comment Period End Date: 3/10/2021

Rule Type/Number of Rules:

New/___ rules

No Change/____ rules (FYR? ___)

Amended/__X__ rules (FYR? ___)

Rescinded/____ rules (FYR? ___)

The Common Sense Initiative is established in R.C. 107.61 to eliminate excessive and duplicative rules and regulations that stand in the way of job creation. Under the Common Sense Initiative, agencies must balance the critical objectives of regulations that have an adverse impact on business with the costs of compliance by the regulated parties. Agencies should promote transparency, responsiveness, predictability, and flexibility while developing regulations that are fair and easy to follow. Agencies should prioritize compliance over punishment, and to that end, should utilize plain language in the development of regulations.

77 SOUTH HIGH STREET | 30TH FLOOR | COLUMBUS, OHIO 43215-6117

CSIPublicComments@governor.ohio.gov

Reason for Submission

1. **R.C. 106.03 and 106.031 require agencies, when reviewing a rule, to determine whether the rule has an adverse impact on businesses as defined by R.C. 107.52. If the agency determines that it does, it must complete a business impact analysis and submit the rule for CSI review.**

   Which adverse impact(s) to businesses has the agency determined the rule(s) create?

   The rule(s):

   a. ☐ **Requires a license, permit, or any other prior authorization to engage in or operate a line of business.**

   b. ☐ **Imposes a criminal penalty, a civil penalty, or another sanction, or creates a cause of action for failure to comply with its terms.**

   c. ☐ **Requires specific expenditures or the report of information as a condition of compliance.**

   d. ☒ **Is likely to directly reduce the revenue or increase the expenses of the lines of business to which it will apply or applies.**

Regulatory Intent

2. **Please briefly describe the draft regulation in plain language.**
   Please include the key provisions of the regulation as well as any proposed amendments.

   This rule sets forth an additional payment methodology in the form of a Cost Coverage Add-on (CCA). This additional payment methodology will ensure adequate access for Medicaid recipients to inpatient and outpatient hospital services. This cost coverage add-on, which is case-mix adjusted, is added to a hospital's base rates for each inpatient discharge or outpatient service on or after the effective date of the rule for those hospitals paid under the "All Patient Refined-Diagnosis Related Group" (APR-DRG) inpatient prospective payment system and the "Enhanced Ambulatory Patient Grouping" (EAPG) outpatient prospective payment system. For those hospitals excluded from the prospective payment systems, the cost coverage add-on will be a percentage adjustment to their prospective inpatient and outpatient cost-to-charge ratios for discharges or services on or after the effective date of the rule. The methodology in this rule does not apply to the Medicaid maximum allowed amount calculation described in OAC 5160-2-25.

   The amendments to the rule include the addition of paragraph (J) to add language from the emergency rule filed October 30, 2020, to allow the Department to make short term

adjustments, either increases or decreases, to hospital-specific CCA rates with the approval of the Medicaid Director. The goal of these adjustments will be to maintain budget neutrality and ensure that hospital payments are aligned with the proposed projections. Additionally, the proposed rule adds the definition of Outpatient Hospital Behavioral Health (OPHBH) visits and clarifies that OPHBH visits are not included in the calculations of the outpatient CCA rates. Only outpatient visits derived from the EAPG payment methodology are included.

3. **Please list the Ohio statute(s) that authorize the agency, board or commission to adopt the rule(s) and the statute(s) that amplify that authority.**

   5164.02.

4. **Does the regulation implement a federal requirement? Is the proposed regulation being adopted or amended to enable the state to obtain or maintain approval to administer and enforce a federal law or to participate in a federal program?** ***If yes, please briefly explain the source and substance of the federal requirement.***

   No, the regulation does not implement a federal requirement.

5. **If the regulation includes provisions not specifically required by the federal government, please explain the rationale for exceeding the federal requirement.**

   The Department believes these regulations are needed to provide Ohio hospitals with additional funds to ensure adequate access for Medicaid recipients to hospital services.

6. **What is the public purpose for this regulation (i.e., why does the Agency feel that there needs to be any regulation in this area at all)?**

   This regulation provides hospitals an additional payment methodology in the form of a cost coverage add-on to ensure adequate access for Medicaid recipients to inpatient and outpatient hospital services. This cost coverage add-on is added to each hospital's base rate or cost-to-charge ratio for each inpatient discharge or outpatient service to ensure access to hospital services for Ohio Medicaid recipients.

7. **How will the Agency measure the success of this regulation in terms of outputs and/or outcomes?**

   The success of this regulation will be measured by payment of the cost coverage add-on and is intended to ensure access to medical and behavioral health services for Ohio Medicaid recipients.

8. **Are any of the proposed rules contained in this rule package being submitted pursuant to R.C. 101.352, 101.353, 106.032, 121.93, or 121.931?**

If yes, please specify the rule number(s), the specific R.C. section requiring this submission, and a detailed explanation.
Not applicable.

Development of the Regulation

9. Please list the stakeholders included by the Agency in the development or initial review of the draft regulation.
If applicable, please include the date and medium by which the stakeholders were initially contacted.

The Ohio Hospital Association (OHA) took part in the development of these regulations.

10. What input was provided by the stakeholders, and how did that input affect the draft regulation being proposed by the Agency?

On January 5, 2020, the Department shared the drafted version of the rule with OHA. OHA reviewed the rule and agreed with the Department's proposal to remove Outpatient Hospital Behavioral Health (OPHBH) visits from total Medicaid visits, since OPHBH is not reimbursed under EAPG. OHA was also in agreement to add the provision to adjust the CCA rate, either increase or decrease, to ensure budget neutrality.

11. What scientific data was used to develop the rule or the measurable outcomes of the rule? How does this data support the regulation being proposed?

Financial data reported by hospitals to the Department of Medicaid on the Hospital Cost Report (ODM 02930) is used to develop the CCA rates.

12. What alternative regulations (or specific provisions within the regulation) did the Agency consider, and why did it determine that these alternatives were not appropriate? If none, why didn't the Agency consider regulatory alternatives?

The Department has worked closely with the hospital industry to develop this program. Together, we have determined that this regulation was the best avenue to achieve the desired results.

13. Did the Agency specifically consider a performance-based regulation? Please explain.
Performance-based regulations define the required outcome, but don't dictate the process the regulated stakeholders must use to achieve compliance.

No, the agency did not specifically consider a performance-based regulation for this program. This program was developed with the hospital industry to ensure access to Ohio Medicaid recipients for hospital services.

14. What measures did the Agency take to ensure that this regulation does not duplicate an existing Ohio regulation?

This rule was developed specifically for the cost coverage add-on program and was reviewed by the Bureau of Health Plan Policy, and ODM Legal Services to ensure that duplication does not exist. In addition, OHA staff reviewed the proposed regulation.

15. Please describe the Agency's plan for implementation of the regulation, including any measures to ensure that the regulation is applied consistently and predictably for the regulated community.

The Department has implemented the cost coverage add-on for all hospitals in Ohio, effective January 2, 2020. Depending on the type of hospital, for each inpatient discharge or outpatient service that occurred on or after January 1, 2020, the CCA is added to either a hospital's base rates or their cost-to-charge ratios. The financial model used to determine CCA rates is examined in great detail for accuracy by the Department, its actuary and OHA to ensure the regulation is applied consistently and predictably for hospitals. The results of this financial modeling and analysis are used to make decisions about the performance of this regulation and any necessary adjustments are made in accordance with the amended language of this rule.

Adverse Impact to Business

16. Provide a summary of the estimated cost of compliance with the rule. Specifically, please do the following:

a. Identify the scope of the impacted business community; and

All Ohio Hospitals.

b. Identify the nature of all adverse impact (e.g., fees, fines, employer time for compliance,); and

The hospital-specific CCA amounts are developed using historical cost report information. As such, it is possible that real-time claims information differs from the historical data used on the CCA calculations. As a result, ~~that~~ in order to spend within our appropriation authority, it may be necessary to adjust the hospital-specific CCA amounts. In some cases, this may be a negative adjustment, which would appear to be an adverse impact.

c. Quantify the expected adverse impact from the regulation.

The adverse impact can be quantified in terms of dollars, hours to comply, or other factors; and may be estimated for the entire regulated population or for a "representative business." Please include the source for your information/estimated impact.

The amount of the adverse impact cannot be quantified. The cost coverage add-on payment policy pools are based upon authorized appropriations for each SFY. Adjustments to the policy pools are then made based on those total authorized appropriations. Therefore, any adjustment to the appropriations that would result in a decrease to the payment policy pools would potentially cause a decease to a hospital's cost coverage add on rates.

17. Why did the Agency determine that the regulatory intent justifies the adverse impact to the regulated business community?

While this regulation provides additional funding to Ohio hospitals through the cost coverage add-on, it is also important for the Department to ensure that we remain within our appropriated budget. This regulation gives the Department the flexibility to make mid-year adjustments to the CCA which for some hospitals may result in lower CCA rate for a period of time.

Regulatory Flexibility

18. Does the regulation provide any exemptions or alternative means of compliance for small businesses? Please explain.

Not applicable.

19. How will the agency apply Ohio Revised Code section 119.14 (waiver of fines and penalties for paperwork violations and first-time offenders) into implementation of the regulation?

Not applicable.

20. What resources are available to assist small businesses with compliance of the regulation?

Questions may be directed to the Hospital Services Section (Hospital_Policy@medicaid.ohio.gov) of ODM.

5160-2-60 **Hospital cost coverage add-on.**

Effective for services or discharges on or after the effective date of this rule, payments made to Ohio hospitals under the prospective payment systems or non-diagnostic related groups (DRG) prospective payment system will receive a cost coverage add-on. The provisions of this rule do not apply to the medicaid maximum allowed amount calculation described in rule 5160-2-25 of the Administrative Code.

(A) Definitions.

(1) "Inpatient case mix" means the sum of the relative weight values for all discharges during the calendar year preceding the calendar year that precedes the state fiscal year (SFY) of the cost coverage add-on divided by the total number of discharges during the same calendar year.

(2) "Freestanding psychiatric hospital" means a privately-owned psychiatric hospital with more than sixteen beds that is eligible to provide medicaid services as described in rule 5160-2-01 of the Administrative Code.

(3) "Outpatient case mix" means the sum of the relative weight values for each enhanced ambulatory patient grouping (EAPG) detail line paid with a relative weight during the calendar year preceding the calendar year that precedes the state fiscal year of the cost coverage add-on divided by the total number of EAPG detail lines paid with a relative weight during the same calendar year.

(4) "Psychiatric Emergency Department (PED)" means a dedicated psychiatric emergency department established prior to October 1, 2019 that is located in a general acute care hospital that does not participate in the care innovation and community improvement program (CICIP).

(5) "Total medicaid inpatient discharges" for each hospital means the sum of medicaid fee for service (FFS) discharges reported on "Ohio Medicaid Hospital Cost Report" ODM 02930, schedule C-1, section I, columns 2 and 3, line 54 for the applicable SFY and medicaid managed care plan (MCP) discharges reported on ODM 02930, schedule C-1, section I, columns 7 and 8, line 54.

(6) "Total medicaid inpatient charges" for each hospital means the sum of FFS medicaid inpatient charges reported on ODM 02930, schedule H, column 1, line 8 and MCP inpatient charges reported on ODM 02930, schedule I, column 2, line 202.

(7) "Total medicaid outpatient charges" for each hospital means the sum of FFS medicaid outpatient charges reported on ODM 02930, schedule H, column 1, line 16 and MCP outpatient charges reported on ODM 02930, schedule I, column 4, line 202.

(8) "Total medicaid inpatient costs" for each hospital means the sum of FFS medicaid inpatient costs reported on ODM 02930, schedule H, column 1, line 1 and MCP inpatient costs reported on ODM 02930, schedule I, column 3, line 202.

(9) "Total medicaid outpatient costs" for each hospital means the sum of FFS medicaid outpatient costs reported on ODM 02930, schedule H, column 1, line 10 and MCP outpatient costs reported on ODM 02930, schedule I, column 5, line 202.

(10) "Total medicaid outpatient visits" for each hospital means the sum of medicaid FFS visits reported on ODM 02930, schedule C-1, section I, columns 2 and 3, line 56 and medicaid MCP visits reported on ODM 02930, schedule I, column 4, line 205, less the visits described in paragraph (A)(11) of this rule.

(11) "Total Outpatient Hospital Behavioral Health (OPHBH) visits" for each hospital means the sum of FFS OPHBH visits reported on ODM 02930, schedule K, column 1, line 18 and MCP OPHBH visits reported on ODM 02930, schedule K, column 5, line 18.

(B) Source data for calculations

The calculations described in this rule will be based on cost-reporting data described in rule 5160-2-23 of the Administrative Code, which reflects the interim settled Ohio medicaid hospital cost report (ODM 02930) for each hospital's cost reporting period ending in the SFY prior to the SFY that ends immediately preceding the SFY to which the cost coverage add-on will apply. The data policies described in rules 5160-2-08 and 5160-2-09 of the Administrative Code that use the same cost report data described in this paragraph will apply to the data used for the cost coverage add-on, except for hospitals that have closed or are known to be closing.

(C) The appropriations authorized by the general assembly for each SFY will be divided into the following policy pools:

(1) Inpatient cost coverage standard pool, which is the lesser of 259,229,112.31 dollars or 36.38 per cent of the appropriated funds.

(2) Outpatient cost coverage standard pool, which is the lesser of 168,054,601.29 dollars or 23.59 per cent of the appropriated funds.

(3) Cost coverage sustainability pool is the sum of:

(a) The lesser of 233,000,000.00 dollars or 32.70 per cent of the appropriated funds; and

(b) The greater of 7.33 per cent or the balance of the appropriated funds.

(4) Freestanding psychiatric hospitals as described in paragraph (A)(2) of this rule will receive 1.86 per cent of the amount described in paragraph (C)(3)(b) of this rule.

(5) Hospitals that meet the definition of a PED as described in paragraph (A)(4) of this rule will receive 9,500,000.00 dollars.

(D) Inpatient cost coverage.

(1) Cost coverage standard pool.

(a) From the amount specified in paragraph (C)(1) of this rule, 15,939,479.00 dollars will be allocated to children’s hospitals, as defined in rule 5160-2-05 of the Administrative Code, based on the payments made to each children's hospital from funds specifically appropriated by Am. Sub. HB 49 of the 132nd General Assembly.

(b) Each hospital will be allocated from paragraph (C)(1) of this rule, an amount equal to the inpatient non-claims specific lump sum payments not resulting from an alternative payment model or the hospital care assurance program (HCAP) as described in rule 5160-1-70 or 5160-2-09 of the Administrative Code, less the amount allocated in paragraph (D)(1)(a) of this rule.

(c) Any amounts in paragraph (D)(1)(b) of this rule allocated to a closed hospital are reallocated to the remaining hospitals based on the ratio of each hospital's allocation in paragraph (D)(1)(b) of this rule to the sum of the allocation for all remaining hospitals.

(d) For each hospital, sum the amount allocated in paragraphs (D)(1)(a) to (D)(1)(c) of this rule.

(2) Divide ten per cent of the cost coverage sustainability pool described in paragraph (C)(3) of this rule by the total medicaid discharges for all hospitals, then multiply the resulting quotient by the number of total medicaid discharges for each hospital.

(3) For freestanding psychiatric hospitals, divide the amount described in paragraph (C)(4) of this rule by the total medicaid discharges for all freestanding psychiatric hospitals, then multiply the resulting quotient by the number of medicaid discharges for each freestanding psychiatric hospital.

(4) For all hospitals with a PED, divide fifty per cent of the amount described in paragraph (C)(5) of this rule by the total medicaid discharges for all hospitals with a PED, then multiply the resulting quotient by the number of medicaid discharges for each hospital with a PED.

(E) Outpatient cost coverage.

(1) Cost coverage standard pool.

(a) Each hospital will be allocated from paragraph (C)(2) of this rule an amount equal to the outpatient non-claims specific lump sum payments not resulting from an alternative payment model or HCAP as described in rule 5160-1-70 or 5160-2-09 of the Administrative Code.

(b) Any amounts in paragraph (E)(1)(a) of this rule allocated to a closed hospital are reallocated to the remaining hospitals based on the ratio of each hospital's allocation in paragraph (E)(1)(a) of this rule to the sum of the allocation for all remaining hospitals.

(c) For each hospital, sum the amount allocated in paragraph (E)(1)(a) of this rule and the amount calculated in paragraph (E)(1)(b) of this rule.

(2) Divide ninety per cent of the cost coverage sustainability pool described in paragraph (C)(3) of this rule less the amount described in paragraph (C)(4) of this rule by the total medicaid visits for all hospitals, then multiply the resulting quotient by the number of total medicaid visits for each hospital.

(3) For all hospitals with a PED, divide fifty per cent of the amount described in paragraph (C)(5) of this rule by the total medicaid visits for all hospitals with a PED, then multiply the resulting quotient by the number of medicaid visits for each hospital with a PED.

(F) Inpatient cost coverage add-on amount per discharge for hospitals paid in accordance with rule 5160-2-65 of the Administrative Code.

(1) For each hospital, divide the sum of paragraphs (F)(1)(a) to (F)(1)(b) of this rule by the total medicaid discharges used in the inpatient case-mix calculation as described in paragraph (A)(1) of this rule.

(a) The sum of paragraphs (D)(1) to (D)(4) of this rule.

(b) Any outpatient amounts allocated in paragraphs (E)(1) to (E)(3) of this rule to a freestanding psychiatric hospital.

(2) For each hospital, divide the results in paragraph (F)(1) of this rule by the inpatient case-mix as defined in paragraph (A)(1) of this rule.

(3) The cost coverage add-on per discharge amount is equal to the amount calculated in paragraph (F)(2) of this rule, rounded to two decimal places.

(4) The amount calculated in paragraph (F)(3) of this rule will be added to the hospital's inpatient base rate.

(G) Outpatient cost coverage add-on amount per detail for hospitals paid in accordance with rule 5160-2-75 of the Administrative Code.

(1) For each hospital, divide the sum of paragraphs (E)(1) to (E)(3) of this rule by the total EAPG detail lines used in the outpatient case-mix calculation as described in paragraph (A)(3) of this rule.

(2) For each hospital, divide the results in paragraph (G)(1) of this rule by the outpatient case-mix as defined in paragraph (A)(3) of this rule.

(3) The cost coverage add-on per detail amount is equal to the amount calculated in paragraph (G)(2) of this rule, rounded to two decimal places.

(4) The amount calculated in paragraph (G)(3) of this rule will be added to the hospital's outpatient base rate.

(H) Inpatient cost coverage add-on for hospitals paid in accordance with rule 5160-2-22 of the Administrative Code.

(1) For each hospital, calculate total inpatient payments by multiplying total medicaid inpatient charges as described in paragraph (A)(6) of this rule by the inpatient cost-to-charge ratio described in rule 5160-2-22 of the Administrative Code calculated from the source data described in paragraph (B) of this rule.

(2) For each hospital, divide the amount in paragraph (H)(1) of this rule by the total medicaid inpatient costs as described in paragraph (A)(8) of this rule.

(3) For each hospital, sum the inpatient payments calculated in paragraph (H)(1) of this rule and the amounts distributed in paragraphs (D)(1) to (D)(4) of this rule.

(4) For each hospital, divide the result in paragraph (H)(3) of this rule by the total medicaid inpatient costs as described in paragraph (A)(8) of this rule.

(5) For each hospital, calculate the inpatient cost coverage increase by subtracting the result in paragraph (H)(2) of this rule from the result in paragraph (H)(4) of this rule and dividing the result by paragraph (H)(2) of this rule, rounded to four decimal places.

(6) For each hospital, multiply the result in paragraph (H)(5) of this rule by the inpatient cost-to-charge ratio calculated in paragraph (H)(1) of this rule.

(7) Apply the amount calculated in paragraph (H)(6) of this rule as an increase to the hospital's inpatient cost-to-charge ratio as follows:

(a) For each July first, the hospital's inpatient cost-to-charge ratio calculated the previous January in accordance with rule 5160-2-22 of the Administrative Code.

(b) For each January first, the hospital's inpatient cost-to-charge ratio as calculated in rule 5160-2-22 of the Administrative Code.

(I) Outpatient cost coverage add-on for hospitals paid in accordance with rule 5160-2-22 of the Administrative Code.

(1) For each hospital, calculate total outpatient payments by multiplying total medicaid outpatient charges as described in paragraph (A)(7) of this rule by the outpatient cost-to-charge ratio described in rule 5160-2-22 of the Administrative Code calculated from the source data described in paragraph (B) of this rule.

(2) For each hospital, divide the amount in paragraph (I)(1) of this rule by the total medicaid outpatient costs as described in paragraph (A)(9) of this rule.

(3) For each hospital, sum the outpatient payments calculated in paragraph (I)(1) of this rule and the distribution pools in paragraphs (E)(1) to (E)(3) of this rule.

(4) For each hospital, divide the result in paragraph (I)(3) of this rule by the total medicaid outpatient costs as described in paragraph (A)(9) of this rule.

(5) For each hospital, calculate the outpatient cost coverage increase by subtracting the result in paragraph (I)(2) of this rule from the result in paragraph (I)(4) of this rule and dividing the result by paragraph (I)(2) of this rule, rounded to four decimal places.

(6) For each hospital, multiply the result in paragraph (I)(5) of this rule by the outpatient cost-to-charge ratio calculated in paragraph (I)(1) of this rule.

(7) Apply the amount calculated in paragraph (I)(6) of this rule as an increase to the hospital's outpatient cost-to-charge ratio as follows:

(a) For each July first, the hospital's outpatient cost-to-charge ratio calculated the previous January in accordance with rule 5160-2-22 of the Administrative Code.

(b) For each January first, the hospital's outpatient cost-to-charge ratio as calculated in rule 5160-2-22 of the Administrative Code.

(J) To ensure that funds appropriated for the cost coverage add-on are fully expended in support of the intended purpose, the department may make short term adjustments to increase or decrease hospital-specific rates. Such adjustments will be calculated in accordance with the cost coverage sustainability pool as described in paragraphs (D)(2) and (E)(2) of this rule. The number of discharges or visits used to establish a case-mix adjusted hospital-specific rate, may be adjusted to reflect the time period for which the rate will be in effect. Any such adjustments will be developed in consultation with the department’s actuary and approved by the medicaid director.

Effective:

Five Year Review (FYR) Dates: 1/2/2025

_____

Certification

_____

Date

Promulgated Under:	119.03
Statutory Authority:	5164.02
Rule Amplifies:	5162.03, 5164.02
Prior Effective Dates:	01/02/2020, 07/01/2020, 10/30/2020 (Emer.)