ACTION: Final

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5101:3-2-07.2 **Classification of hospitals.**

For purposes of setting rates and making payments under the "Diagnosis Related Group" (DRG) prospective payment system, the department classifies most hospitals into mutually exclusive peer groups.

(A) Definitions.

(1) "Teaching hospitals" are hospitals with major teaching emphasis that meet one of the following definitions: the hospital, regardless of number of beds has an intern- and resident-to-bed ratio of at least .35 or the hospital has greater than five hundred beds and has an intern- and resident-to-bed ratio of .25. For purposes of this paragraph, the intern- and resident-to-bed ratio for Ohio hospitals is that recognized by the hospital's medicare fiscal intermediary for the hospital's cost-reporting period described in paragraph (D) of rule 5101:3-2-07.4 of the Administrative Code. For non-Ohio hospitals, the intern- and resident-to-bed ratio used to make this determination is derived from the medicare cost report for the cost-reporting period used in setting rates for rate period beginning July 1, 1990.

(2) "Children's hospitals" are those hospitals that primarily serve patients eighteen years of age and younger and that are excluded from medicare prospective payment in accordance with 42 C.F.R.~~CFR~~ 412.23(d) effective October 1, 2006.

(3) "Rural referral center hospitals" are those hospitals located in non-~~MSA~~ metropolitan statistical areas (MSAs)~~areas~~ that~~which~~ are recognized by medicare as rural referral centers in accordance with 42 C.F.R.~~CFR~~ 412.96 effective October 1, 2006.

(4) "MSA-~~area~~ hospitals" are those hospitals not defined in this rule as children's or teaching hospitals that are located in ~~metropolitan statistical areas (~~MSAs~~)~~ as those areas are established by the federal office of management and budget.

(5) "Non-MSA ~~area~~ hospitals" are those hospitals not defined in this rule as teaching, children's, or rural referral centers that are not located in ~~metropolitan statistical areas (~~MSAs~~)~~ as those areas are established by the federal office of management and budget.

(6) "Cancer hospitals" are hospitals recognized by medicare ~~which~~ that primarily treat neoplastic disease in accordance with 42 C.F.R.~~CFR~~ 412.23(f) effective October 1, 2006.

(7) For the purposes of this rule, the "number of beds" is the total number of beds

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reported in the December, 1986 "Directory of Registered Hospitals" published by the Ohio department of health.

(B) Ohio hospital prospective payment peer groups.

(1) For each Ohio children's hospital, a prospective rate will be determined in accordance with rule 5101:3-2-07.4 of the Administrative Code using data ~~which is~~ specific to each hospital.

(2) Rural referral center hospitals are grouped together and a peer group average cost per discharge is developed in accordance with rule 5101:3-2-07.4 of the Administrative Code using data from these hospitals.

(3) Teaching hospitals are grouped together and a peer group average cost per discharge is developed in accordance with rule 5101:3-2-07.4 of the Administrative Code using data from these hospitals.

(4) Non-MSA ~~area~~ hospitals with less than one hundred beds are grouped together and a peer group average cost per discharge is developed in accordance with rule 5101:3-2-07.4 of the Administrative Code using data from these hospitals.

(5) Non-MSA ~~area~~ hospitals with one hundred beds or more are grouped together and a peer group average cost per discharge is developed in accordance with rule 5101:3-2-07.4 of the Administrative Code using data from these hospitals.

(6) MSA ~~area~~ hospitals are peer grouped on the basis of wage index categories. MSA ~~area~~ hospitals that have adjusted gross wage index categories in their area, as published in the March 1985 "Report on Hospital Wage Index" required by section 2316(a) of Public Law 98-369 within .01 (rounded values) of each other are grouped together for payment purposes. For each of the groups formed, a peer group average cost per discharge is developed in accordance with rule 5101:3-2-07.4 of the Administrative Code using data from hospitals in the group.

(C) Non-Ohio prospective payment peer groups.

(1) For discharges on or after July 1, 1990, non-Ohio teaching hospitals will be reimbursed on the basis of a rate developed using data from Ohio teaching hospitals. The calculations used to develop this rate are described in paragraphs (C)(1)(a) to (C)(1)(b) of this rule.

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(a) For each Ohio teaching hospital a fully adjusted, inflated peer group average cost per discharge is calculated as described in paragraphs (D) to (G)(3)(a) of rule 5101:3-2-07.4 of the Administrative Code except that the adjustment described in paragraphs (D)(9) to (D)(9)(b) of rule 5101:3-2-07.4 of the Administrative Code is not made.

(b) The fully adjusted, inflated peer group average cost per discharge described in paragraph (C)(1)(a) of this rule is multiplied by each hospital's medicaid discharges as described in paragraph (D)(11)(a) of rule 5101:3-2-07.4 of the Administrative Code. The results of these computations are summed for all Ohio teaching hospitals, and then divided by the sum of medicaid discharges for all Ohio teaching hospitals. The result of this computation is rounded to the nearest whole penny.

(2) For discharges on or after July 1, 1990, non-Ohio children's hospitals will be reimbursed on the basis of a rate developed using data from Ohio childrens hospitals. The calculations used to develop this rate are described in paragraph (C)(2)(a) to (C)(2)(b) of this rule.

(a) For each Ohio children's hospital a fully adjusted, inflated peer group average cost per discharge is calculated as described in paragraphs (D) to (G)(3)(b) of rule 5101:3-2-07.4 of the Administrative Code except that the adjustment described in paragraphs (D)(9) to (D)(9)(b) of rule 5101:3-2-07.4 of the Administrative Code is not made and except that the value of .12 is substituted for the value calculated in paragraph (F)(2)(e)(ii) of rule 5101:3-2-07.4 of the Administrative Code.

(b) The fully adjusted, inflated peer group average cost per discharge described in paragraph (C)(2)(a) of this rule is multiplied by each hospital's medicaid discharges as described in paragraph (D)(11)(a) of rule 5101:3-2-07.4 of the Administrative Code. The results of these computations are summed for all Ohio children's hospitals, and then divided by the sum of medicaid discharges for all Ohio children's hospitals. The result of this computation is rounded to the nearest whole penny.

(3) For discharges on or after July 1, 1990, non-Ohio hospitals that are not teaching or children's hospitals will be reimbursed on the basis of a rate developed using data from Ohio nonteaching and nonchildren's hospitals. The calculations used to develop this rate are described in paragraphs (C)(3)(a) to (C)(3)(b) of this rule.

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(a) For each Ohio nonchildren's and nonteaching hospital, a fully adjusted, inflated peer group average cost per discharge is calculated as described in paragraphs (D) to (G)(3)(a) of rule 5101:3-2-07.4 of the Administrative Code except that the adjustment described in paragraphs (D)(9) to (D)(9)(b) of rule 5101:3-2-07.4 of the Administrative Code is not made.

(b) The fully adjusted, inflated peer group average cost per discharge described in paragraph (C)(3)(a) of this rule is multiplied by each hospital's medicaid discharges as described in paragraph (D)(11)(a) of rule 5101:3-2-07.4 of the Administrative Code. The results of these computations are summed for all Ohio nonteaching and nonchildrens hospitals, and then divided by the sum of medicaid discharges for all Ohio nonteaching and nonchildrens hospitals. The result of this computation is rounded to the nearest whole penny.

(D) Classification procedures.

(1) A hospital is classified into a peer group at the beginning of each rate year based upon the data available to the department sixty days prior to the rate year. Once established, the classification of a hospital into a peer group remains in effect throughout the rate year unless the hospital is designated by medicare during the rate year to be a rural referral center hospital. In this instance the hospital must submit all documentation to the department that it has been designated as a rural referral center. After such documentation is received, the hospital will be reclassified into the rural referral center peer group effective for discharges occurring on or after the beginning of the rate year or the effective date of the designation, whichever is later.

(2) When an existing hospital is deleted or added to a peer group at a time other than when the department rebases the DRG system, the deletion or addition of a hospital from a peer group does not result in a redetermination of payment rates for the peer group except as otherwise provided in rule 5101:3-2-07.8 of the Administrative Code. If a new hospital is established at a time other than when the department rebases the DRG system, the department will assign that hospital to a peer group for payment purposes but will not recalculate any part of the prospective payment rate for that peer group.

(3) Facilities ~~which~~ that close at a time other than rebasing of the DRG system and that notify the department of closure thirty days prior to the beginning of a rate year are not included in the peer groups defined in this rule for the purpose of setting payment rates. Closure notifications received less than

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thirty days prior to a rate year do not result in a redetermination of peer group payment rates for that year.

(4) In the case of hospital mergers when all facilities involved in the merger retain separate provider numbers for the medicare program, each facility will be treated separately following the procedures outlined in this rule. In the case of hospital mergers when the merged facility retains only one medicare provider number, the department will either follow the determinations made by the medicare program with regard to treatment of the merged facilities or will make a separate determination. Such separate determinations will be made, on a case by case basis, in instances when medicare's determination would be appropriate in the context of medicare pricing and classification methods but inappropriate in the context of medicaid pricing methods and peer grouping logic as described in this rule.

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CERTIFIED ELECTRONICALLY

Certification

12/12/2007

Date

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