5101:3-2-07.9 Payment for outliers.

This rule defines cost and day outliers and exceptional outliers, and describes the reimbursement methodology that will be used ~~in paying~~ to pay for all types of outliers for inpatient hospitals subject to the prospective payment system. The payment policies contained in this rule are effective for dates of discharge on or after ~~January 1, 2006~~October 1, 2011.

(A) The Ohio department of job and family services ("ODJFS") will provide for an additional payment to a hospital for covered inpatient hospital services to a medicaid recipient that ~~exceeds~~exceed the thresholds as described in paragraphs (A)(1) to (A)(6) of this rule.

(1) For diagnostic related groups (DRGs) 1 to 384; 391 to 468; 471 to 503: The total allowed charges for an inpatient stay exceeds the statewide arithmetic mean charge, as described in rule 5101:3-2-07.3 of Attachment 4.19-A, for the appropriate DRG by two standard deviations.

(2) For DRGs 385; 388 to 390; 892 to 898: The total allowed charges for the inpatient stay exceeds the statewide arithmetic mean charge, as described in rule 5101:3-2-07.3 of Attachment 4.19-A, for the applicable DRG by one standard deviation.

(3) For DRGs 1 to 384; 391 to 468; 471 to 503: The recipient's covered length of stay exceeds the statewide geometric mean length of stay for the applicable DRG by two standard deviations.

(4) For DRGs 388 to 390 and 892 to 898: The recipient's covered length of stay exceeds the statewide geometric mean length of stay for the applicable DRG by one standard deviation.

(5) If a hospital that does not meet the criteria described in paragraphs (E)(1) and (E)(2) of this rule has a discharge that qualified for both a cost and a day outlier payment, then the hospital receives payment for the case as a cost outlier only.

(6) Effective August 1, 2002, if the cost for a case determined by multiplying the allowed charges from the claim by the hospital-specific cost-to-charge ratio, determined in accordance with the provisions of paragraph (B)(2) of rule 5101:3-2-22 of Attachment 4.19-A, exceeds four hundred forty-three thousand, four hundred sixty-three dollars, then payment will be as described in paragraph (D) of this rule. This threshold amount will be inflated on an annual basis on January first of each year by using the inflation factor described in paragraph (G)(1) of rule 5101:3-2-07.4 of Attachment 4.19-A, that has been supplied to the department by three months prior to the beginning of the rate year.

5101:3-2-07.9 Payment for outliers.

(B) Payment for extended length of stay (day outliers).

(1) If the hospital stay reflected by a discharge includes covered days of care beyond the threshold as described in paragraphs (A)(3) and (A)(4) of this rule, an additional payment shall be made.

(2) Any case that qualifies for a day outlier payment is subject to review as described in rule 5101:3-2-07.13 of Attachment 4.19-A.

(3) For ~~discharges in~~ DRGs 1 to 384; 391 to 468; 471 to 503: Except as provided in paragraph (B)(5) of this rule, the per diem payment will be based on sixty per cent of the per diem rate, except that for hospitals meeting the criteria described in paragraphs (E)(1) and (E)(2) of this rule, per diem payment will be eighty per cent of the per diem rate. The per diem rate is calculated by dividing the hospital's final prospective rate for that DRG as described in ~~paragraph (I) of~~ rule 5101:3-2-07.4 of Attachment 4.19-A, less capital and teaching allowance for the applicable DRG by the statewide geometric mean length of stay, calculated excluding outliers, for that DRG.

The total day outlier payment is then determined by multiplying the number of covered days beyond the day threshold times the per diem payment amount. The total payment is the final prospective payment rate as described in ~~paragraph (I) of~~ rule 5101:3-2-07.4 of Attachment 4.19-A, plus the outlier payment. If the total payment exceeds allowable charges, reimbursement is limited to allowable charges.

(4) For DRGs 388 to 390 and 892 to 898: The per diem payment will be based on eighty per cent of the per diem rate determined by dividing the hospital's final prospective payment rate for that DRG as described in paragraph (I) of rule 5101:3-2-07.4 of Attachment 4.19-A, less capital and teaching allowance for the applicable DRG by the statewide geometric mean length of stay, calculated excluding outliers, for that DRG. The total day outlier payment is then determined by multiplying the number of covered days beyond the day threshold times the per diem payment amount. The total payment is the final prospective payment rate as described in ~~paragraph (I) of~~ rule 5101:3-2-07.4 of Attachment 4.19-A, plus the outlier payment. If the total payment exceeds allowable charges, reimbursement is limited to allowable charges.

(5) For DRG 488, DRG 489 and DRG 490: The per diem payment for hospitals meeting the criteria described in paragraph (G) of this rule ~~If a hospital meeting the criteria described in paragraph (G) of this rule has a discharge that groups into DRG 488, DRG 489, or DRG 490, the per diem payments made under paragraph (A)(1) of this rule~~ will be based on eighty per cent of the per diem rate. The per diem rate is calculated by dividing the hospital's final prospective rate for that DRG as described in ~~paragraph (I) of~~ rule 5101:3-2-07.4 of Attachment 4.19-A, less capital and teaching allowance for the applicable DRG by the statewide geometric mean length of stay, calculated excluding outliers, for that DRG. The total day outlier payment

is then determined by multiplying the number of covered days beyond the day threshold times the per diem payment amount. The total payment is the final prospective payment rate as determined in ~~paragraph (I) of~~ rule 5101:3-2-07.4 of Attachment 4.19-A, plus the outlier payment. If the total payment exceeds allowable charges, reimbursement is limited to allowable charges.

(C) Payment for extraordinary high-charge cases (cost outliers).

(1) If the allowable charges ~~exceeds~~exceed the statewide charge threshold for the applicable DRG as described in paragraphs (A)(1) and (A)(2) of this rule, an additional payment shall be made. The threshold amount for each DRG will be inflated ~~on an annual basis on January first of each year~~ by using the cost outlier inflation factor described in ~~paragraph (G) of rule 5101:3-2-07.4 of the Administrative Code, that has been supplied to the department by three months prior to the beginning of the rate year~~ paragraphs (C)(1)(a) and (C)(1)(b) of this rule.

(a) For discharges on or after October 1, 2011 through December 31, 2011, the threshold amount for each DRG in effect on September 30, 2011 shall be inflated by 13.6 per cent.

(b) For discharges on or after January 1, 2012 through the implementation of the new DRGs established by section 309.30.30 of Amended Substitute House Bill 153 of the 129th General Assembly, the threshold amount for each DRG in effect on December 31, 2011 shall be inflated by 9.72 per cent.

(2) Any case that qualifies for a cost outlier payment is subject to review as described in rule 5101:3-2-07.13 of Attachment 4.19-A.

(3) For ~~discharges in~~ DRGs 1 to 384; 391 to 468; 471 to 503: Except as otherwise provided in paragraghs (C)(5) and (C)(6) of this rule, the difference determined by subtracting the statewide charge threshold, as described in paragraph (A)(1) of this rule from allowable charges, is multiplied by the hospital-specific cost to charge ratio to determine the additional payment to be made for the outlier portion. The total payment for cost outlier claims except those described in paragraphs (C)(5) and (C)(6) of this rule is the final prospective payment rate as described in ~~paragraph (I) of~~ rule 5101:3-2-07.4 of Attachment 4.19-A, plus the outlier amount.

Total reimbursement is limited to the lower of allowable claim charges or claim cost. Claim cost is calculated by multiplying allowable claim charges by the hospital specific, medicaid inpatient cost-to-charge ratio, as described in ~~paragraph (B)(2) of~~ rule 5101:3-2-22 of Attachment 4.19-A.

(4) For DRGs 385; 388 to 390; and 892 to 898: Except as otherwise provided in paragraph (C)(5) of this rule, the~~The~~ difference determined by subtracting the statewide charge threshold, as described in paragraph (A)(2) of this rule from the allowable charges, is multiplied by the hospital-specific cost to charge ratio to determine the additional payment to be made for the outlier portion ~~except as provided in paragraph (C)(5) of this rule~~. The total payment for cost outlier claims except those described in paragraph (C)(5) of this rule is the final prospective payment rate as described in ~~paragraph (I) of~~ rule 5101:3-2-07.4 of Attachment 4.19-A, plus the outlier amount. Total reimbursement is limited to the lower of allowable claim charges or claim cost. Claim cost is calculated by multiplying allowable claim charges by the hospital specific, medicaid inpatient cost-to-charge ratio, as described in ~~paragraph (B)(2) of~~ rule 5101:3-2-22 of Attachment 4.19-A.

5101:3-2-07.9 Payment for outliers.

(5) For hospitals meeting the criteria described in paragraphs (E)(1) and (E)(2) of this rule, payment for cost outlier claims will be eighty-five per cent of the product of allowed claim charges times the hospital-specific, medicaid inpatient cost-to-charge ratio as described in ~~paragraph (B)(2) of~~ rule 5101:3-2-22 of Attachment 4.19-A.

(6) For DRG 488, DRG 489 and DRG 490: The payment for cost outlier claims for hospitals meeting the criteria described in paragraph (G) of this rule, ~~payment for cost outlier claims~~ will be eighty-five per cent of the product of allowed claim charges times the hospital-specific, medicaid inpatient cost-to-charge ratio as described in ~~paragraph (B)(2) of~~ rule 5101:3-2-22 of Attachment 4.19-A ~~for cases grouping into DRG 488, DRG 489, or DRG 490~~.

(D) Cases that meet the criteria described in paragraph (A)(6) of this rule will be paid the product of the hospital's allowable charges times the hospital-specific cost-to-charge ratio, as described in ~~paragraph (B)(2) of~~ rule 5101:3-2-22 of Attachment 4.19-A.

(E) Hospitals that meet the criteria described in paragraphs (E)(1) and (E)(2) of this rule are subject to the special outlier payment policies described in paragraphs (A)(6), and (C)(5) of this rule.

(1) The hospital-specific outlier per cent as described in paragraph (F)(2)(b) of rule 5101:3-2-07.4 of Attachment 4.19-A is greater than one standard deviation over the statewide mean outlier per cent as described in paragraph (F)(2)(c) of rule 5101:3-2-07.4 of Attachment 4.19-A.

(2) The hospital's ratio of medicaid, general assistance, and Title V inpatient days to total inpatient days as described in paragraph (F)(1)(b) of this rule is greater than one standard deviation above the statewide mean ratio of medicaid, general assistance, and Title V inpatient days to total inpatient days as described in paragraph (F)(2)(c) of this rule.

(F) The calculations described in paragraphs (F)(1) to (F)(2)(c) of this rule were performed using ODHS 2930 cost-report data submitted by hospitals as described in rule 5101:3-2-23 of Attachment 4.19-A. For hospitals with fiscal periods ending September thirtieth, October thirty-first, or December thirty-first, the 1985 cost-report is used. For hospitals with fiscal periods ending March thirty-first, May thirty-first, June thirtieth, or August thirty-first, the 1986 cost report is used.

(1) Determination of each hospital's ratio of medicaid, general assistance, and Title V inpatient days to total inpatient days.

(a) Sum the number of days shown on the ODHS 2930, schedule D, section 1, column 6, total, for medicaid, general assistance, and Title V schedules.

(b) Divide the sum derived from paragraph (F)(1)(a) of this rule by total inpatient days as reported on the ODHS 2930, schedule D, section 1, column 4, total. Round to six decimal places.

(2) Determination of one standard deviation above the statewide mean ratio of medicaid, general assistance, and Title V inpatient days to total inpatient days.

(a) Sum the ratios derived from paragraph (F)(1)(b) of this rule across all Ohio hospitals. Divide the resulting sum by the number of hospitals to determine the statewide mean ratio.

(b) Determine the value of one standard deviation above the statewide mean ratio. Round the ratio to six decimal places.

(c) Sum the values calculated as described in paragraphs (F)(2)(a) and (F)(2)(b) of this rule to determine the value of one standard deviation above the statewide mean ratio of medicaid, general assistance, and Title V inpatient days to total inpatient days.

(G) Hospitals whose total number of cases in the claim files used for setting relative weights in accordance with rule 5101:3-2-07.3 of Attachment 4.19-A that group into DRG 488, DRG 489, or DRG 490 is greater than two standard deviations above the statewide mean for all cases that fall into these DRGs, as described in paragraphs (G)(1)(a) to (G)(1)(c) of this rule, are subject to the special outlier payment policies described in paragraphs (B)(5) and (C)(6) of this rule.

(1) Determination of two standard deviations above the statewide mean total cases that group into DRG 488, DRG 489, or DRG 490.

(a) Sum the number of cases that group into DRG 488, DRG 489, and DRG 490 using the claim base described in paragraphs (C) to (C)(4)(b) of rule 5101:3-2-07.3 of Attachment 4.19-A. Divide the resulting sum by the number of hospitals that had any claim group into DRG 488, DRG 489, or DRG 490.

(b) Determine the value of two standard deviations above the statewide mean number of cases.

(c) Sum the values calculated as described in paragraphs (G)(1)(a) and (G)(1)(b) of this rule to determine the value of two standard deviations above the statewide mean total number of cases in DRG 488, DRG 489, and DRG 490.