5160-2-65 Inpatient hospital reimbursement on or after July 1, 2013.

Effective for dates of discharge on or after July 1, 2013, hospitals defined as eligible providers of hospital services in section 5101:3-2-01 of the Appendix to Attachment 4.19-A and not defined in paragraph (A) of this section are subject to the all patient refined diagnosis related groups (APR-DRG) and prospective payment methodology utilized by the Ohio department of Medicaid as described in this section.

(A) Excluded hospitals. Services provided by the following institutions are not subject to the APR-DRG reimbursement system:

(1) "Freestanding rehabilitation hospitals" excluded from Medicare prospective payment in accordance with 42 CFR 412.23(b) effective October 1, 2003;

(2) "Freestanding long-term hospitals" excluded from Medicare prospective payment in accordance with 42 CFR 412.23(e) effective October 1, 2003;

(3) Hospitals that are excluded from Medicare prospective payment due to providing services, in total, which are excluded due to a combination of the provisions of paragraphs (A)(1) and (A)(2) of this section;

(4) Cancer hospitals as recognized by Medicare that primarily treat neoplastic disease in accordance with 42 CFR 412.23(f) for discharges on and after July 1, 1992.

(B) Hospital peer groups. For purposes of setting rates and making payments under the APR-DRG prospective payment system, the department classifies all hospitals not defined in paragraph (A) of this section into one of the mutually exclusive peer groups defined below.

(1) Teaching hospitals as defined in section 5101:3-2-07.2 of the Appendix to Attachment 4.19-A.

(2) Children's hospitals are those hospitals that primarily serve patients eighteen years of age or younger and that are excluded from Medicare prospective payment in accordance with 42 CFR 412.96 effective October 1, 2006.

(3) Rural referral center hospitals are those hospitals located in non-metropolitan statistical areas (MSAs) that are recognized by Medicare as rural referral centers in accordance with 42 CFR 412.96 effective October 1, 2006.

(4) MSA hospitals, that are located in Ohio, are those hospitals not defined in this section as children's or teaching hospitals that are located in MSAs as those areas are established by the Federal Office of Management and Budget.

(5) Non-MSA hospitals, that are located in Ohio, are those hospitals not defined in this section as teaching, children's, or rural referral centers that are not located in MSAs as those areas are established by the Federal Office of Management and Budget.

(6) Hospitals that are not located in Ohio that are not classified in paragraph (B)(1) or (B)(2) of this section.

(7) Notwithstanding paragraph (B)(4) of this section, hospitals located in rural counties as designated on the federal fiscal year (FFY) 2016 inpatient prospective payment system (IPPS) case-mix and wage index table as published by the center for Medicare and Medicaid services

(CMS), effective October 1, 2015, shall be recognized as a rural hospital for rate setting and payment purposes.

(C) Classification procedures are as described in section 5101:3-2-07.2 of the Appendix to Attachment 4.19-A.

(D) DRG/severity of illness assignment.

(1) Each discharge on or after July 1, 2013 is assigned a DRG and one of four severity of illness (SOI) factors based upon the date of discharge.

(2) If a claim submitted by a hospital is deemed ungroupable because it does not contain valid values for one or more of the variables required by the APR-DRG grouper, then the claim will be denied payment by the department.

(E) Payment formula.

(1) The formula used in the APR-DRG prospective payment system effective for dates of discharge on or after July 1, 2013 is as follows: total payment, rounded to the nearest whole penny, equals (a) base payment plus (b) capital allowance plus (c) medical education allowance (if hospital is eligible) plus (d) outlier payment (if applicable) plus (e) other payments for organ transplants where;

(a) Base payment equals the hospital base rate as described in paragraph (H) of this section multiplied by the corresponding relative weight for the DRG/SOI as described in paragraph (I) of this section.

(b) Capital allowance equals the per case add-on as described in paragraph (K) of this section.

(c) Medical education allowance equals the per case add-on, case mix adjusted, as described in paragraph (L) of this section.

(d) Outlier payment equals the eligible outlier costs multiplied by the outlier payment percentage as described in paragraph (J) of this section.

(e) Other payments for transplant related services as described in paragraph (M) of this section.

(F) Payments under the prospective payment system are made on the basis of a prospectively determined rate as provided in this section. No year-end retrospective adjustment is made for prospective payment except as provided in 5101:3-2-24 of the Appendix to Attachment 4.19-A. Except as provided in sections 5101:3-2-24, 5101:3-2-07.13, and 5101:3-2-40 of the Appendix to Attachment 4.19-A, a hospital may keep the difference between its prospective payment rate and costs incurred in furnishing inpatient services and is at risk for costs which exceed the prospective payment amounts.

(G) Sources for inputs in the payment formula.

(1) The dataset used as inputs in the payment formula and determination of relative weights established for discharges on or after July 1, 2013 consists of:

(a) Inpatient hospital claims with dates of discharge from October 1, 2008 through September

30, 2010;

(b) Cost reports submitted by hospitals to the department on its Medicaid cost report for the hospital years that end in state fiscal years 2009, 2010 and 2011; and

(c) Inflation factors computed for Ohio by a nationally-recognized research firm that computes similar factors for the Medicare program.

(2) The inflation factors were used to apply an inflationary value to the total cost computed for each case inflating it to September 30, 2013.

(H) Computation of hospital base rate.

(1) Except as described in paragraph (H)(4) of this section, the base rate for each Ohio children's hospital is equal to:

(a) Ninety-nine and five hundredths percent of the total inflated costs for the cases assigned to a children's hospital divided by the number of cases assigned to the children's hospital; divided by

(b) The peer group case mix score as calculated in paragraph (H)(3) of this section.

(2) Except as described in paragraph (H)(4) of this section, the base rate for hospitals in Ohio peer groups other than Ohio children's hospitals is equal to:

(a) Sixty-four and five hundredths percent of the total inflated costs for the cases assigned to a peer group; divided by the number of cases in the peer group; divided by

(b) The peer group case mix score as calculated in paragraph (H)(3) of this section.

(c) For dates of service on or after January 1, 2014, the amount will be equal to ninety-five percent of the amount calculated in paragraph (H)(2)(a) and (H)(2)(b) of this rule.

(3) The peer group case mix score is equal to:

(a) The sum of the relative weight values across all cases assigned to a peer group; divided by

(b) The number of cases in the peer group.

(4) For non-Ohio hospital peer groups, the peer group base rate is equal to the value assigned to the peer group effective January 1, 2013. For dates of service on or after January 1, 2014, the amount will be equal to ninety-five percent of the base rate in effect on January 1, 2013.

(5) Peer group risk corridors.

Effective for discharges on or after July 1, 2013 and on or before July 5, 2017, the department will apply the following:

(a) If a hospital is in a non-MSA peer group, in the rural referral center peer group, or is in a MSA peer group but has a Medicare designation as a critical access hospital, then the hospital's base rate is equal to the greater of:

(i) The peer group base rate; or

(ii) Seventy percent of the computed costs of the hospital's cases.

(b) If a hospital is in a MSA peer group and is not a Medicare designated critical access hospital, then the hospital's base rate is equal to:

(i) The peer group base calculated in paragraph (H)(2) of this section, if the peer group base rate does not result in more than a three percent reduction or gain in payments compared to the DRG prospective payment system in effect prior to July 1, 2013; or

(ii) A hospital-specific base rate established to ensure the new peer group base rate does not result in more than a three percent reduction or gain in payments compared to the prior DRG prospective payment system.

(iii) For discharges on or after July 1, 2014 the risk corridor shall be adjusted to be no more than a five percent reduction or gain.

(iv) For discharges on or after July 1, 2015 the risk corridor shall be adjusted to be no more than an eight percent reduction or gain.

(c) If the hospital is in the teaching hospital peer group, then the hospital's base rate is equal to:

(i) The peer group base rate unless it was found that the new peer group base rate would result in a reduction or more than a three percent gain in payments from the prior DRG prospective payment system; or

(ii) A hospital-specific base rate established to ensure that the new peer group base rate does not result in a reduction or more than a three percent gain in payments compared to the prior DRG prospective payment system.

(d) If the hospital is in a children's hospital peer group, then the hospital's base rate is equal to:

(i) The hospital base rate calculated in paragraph (H)(1) of this section, if the base rate does not result in more than a five percent reduction or gain in payments compared to the prior DRG prospective payment system; or

(ii) A hospital-specific base rate established to ensure the new peer group base rate does not result in more than a five percent reduction or gain in payments compared to the prior DRG prospective payment system.

(e) If the hospital is a psychiatric hospital owned and operated by the state of Ohio, regardless of peer group, then the hospital's base rate is equal to;

(i) The hospital base rate calculated in paragraph (H)(1) of this section, if the peer group base rate does not result in a reduction in payments compared to the prior DRG prospective payment system; or

(ii) A hospital-specific base rate established to ensure the new peer group base rate does not result in a reduction.

(I) Computation of relative weights. The relative weight is equal to:

(1) The average inflated cost per case within the DRG/SOI; divided by

(2) The average inflated cost per case across all DRG/SOIs.

(J) Computation of outlier payments.

(1) If a discharge is eligible for an outlier payment, then the payment is equal to ninety-five percent of the value of eligible outlier costs. For dates of service on or after January 1, 2014, the payment will be equal to ninety percent of the value of eligible outlier costs.

(2) Eligible outlier costs are equal to the cost of the case minus an outlier threshold.

(a) When discharges are submitted for payment by hospitals, the cost of the case is computed as the product of covered billed charges and a hospital-specific Medicaid inpatient cost-to-charge ratio. The inpatient cost-to-charge ratio is computed by dividing the Medicaid inpatient costs as reported on the Medicaid cost report by the Medicaid inpatient charges as reported on the Medicaid cost report.

(b) The outlier threshold is equal to the base payment as described in paragraph (E)(1)(a) of this section plus a fixed outlier threshold as described in paragraph (J)(2)(c) of this section.

(c) The fixed outlier threshold varies and can be either DRG specific or peer group specific. The fixed outlier threshold for neonate and tracheostomy DRGs is forty-two thousand nine hundred dollars. The fixed outlier threshold for DRGs other than neonate and tracheostomy DRGs billed by hospitals in a children's peer group or the teaching peer group is fifty-four thousand four hundred dollars. The fixed outlier threshold for cases other than neonate and tracheostomy billed by hospitals among other peer groups is sixty-eight thousand dollars.

(3) For any claim that qualifies for an outlier payment, the final claim payment shall be limited to the lessor of covered billed charges or the total payment calculated in paragraph (E)(1) of this section.

(K) Computation of capital payments.

(1) For Ohio hospitals, a capital allowance will be paid as described on page 12b of Attachment 4.19-A.

(2) For non-Ohio hospitals a capital allowance will be paid as described on page 12b of Attachment 4.19-A.

(3) Hospitals serving recipients enrolled in a Medicaid managed care plan shall be paid a capital allowance that it is determined based on a hospital's Medicaid managed care service experience as published by the department. Non-Ohio hospitals shall be paid a capital allowance using the published statewide average managed care capital rate.

(L) Computation of medical education payments.

Ohio hospitals that have an approved medical education program as defined in 42 CFR 405.421 effective September 1, 1983, qualify for an allowance for medical education. The medical education allowance amount is described in section 5101:3-2-07.7 of the Appendix to Attachment 4.19-A adjusted to ensure payment neutrality for medical education with the adoption of the APR-DRG payment system described in this section. For dates of service on or after January 1, 2014,

the medical education payments for all hospitals except Ohio children's hospitals will be equal to ninety-five percent of the amount described in this paragraph.

(1) If a hospital had modeled medical education payments that were less than the medical education payments received for the same discharges upon initial payment, then the hospital's medical education allowance was adjusted upward so that, when multiplied by the new relative weights, the payments yielded payment neutrality on the medical education payment component alone.

(2) If a hospital had modeled medical education payments that were more than the medical education payments received for the same discharges upon initial payment, then no adjustment was made to the medical education allowance rate for the hospital.

(M) Other payments for transplant related services.

(1) Reimbursement for all organ transplant services, except for kidney transplants, is contingent upon review and recommendation by the "Ohio Solid Organ Transplant Consortium" based on criteria established by Ohio organ transplant surgeons and authorization from the department.

(2) Reimbursement for bone marrow transplant and hematopoietic stem cell transplant is contingent upon review and the recommendation by the "Ohio Hematopoietic Stem Cell Transplant Consortium" based on criteria established by Ohio experts in the field of bone marrow transplant and authorization from the department. Reimbursement is further contingent upon:

(a) Membership in the "Ohio Hematopoietic Stem Cell Transplant Consortium"; or

(b) Compliance with the performance standards prescribed by the Ohio Department of Health Code, and the performance of ten autologous or ten allogeneic bone marrow transplants, dependent on which volume criteria is appropriate for the transplant requested.

(3) Organ acquisition and transportation costs for heart, heart/lung, liver, pancreas, single/double lung, and liver/small bowel transplant services will be reimbursed at one hundred percent of billed charges.

(4) For harvesting costs for bone marrow transplant services, the prospective payment amount will be either:

(a) The DRG amount as described in this section if the donor is a Medicaid recipient or if the bone marrow transplant is autologous.

(b) The product of the covered billed charges times the hospital-specific, Medicaid inpatient cost-to-charge ratio as described in paragraph (J)(2) of this section , if the donor is not a Medicaid recipient.

(N) Other payment policies.

(1) In accordance with section 5101:3-2-03 of the Appendix to Attachment 4.19-A, no coverage is available for days of inpatient care which occur solely for the provision of rehabilitation services related to a chemical dependency.

(2) A claim for inpatient services qualifies for interim payment on the thirtieth day of a

consecutive inpatient stay and at thirty-day intervals thereafter. Under interim payment, hospitals will be paid on a percentage basis of charges. The percentage will represent the hospital-specific Medicaid inpatient cost-to-charge ratio as described in paragraph (J)(2) of this section. For those hospitals which are not required to file a cost report under the provisions of section 5101:3-2-23 of the Appendix to Attachment 4.19-A, the statewide average Medicaid inpatient cost-to-charge ratio will be used. The statewide average Medicaid inpatient cost-to-charge ratio is computed by dividing the sum of the Medicaid inpatient costs as reported on the Medicaid cost report for all Ohio hospitals by the sum of Medicaid inpatient charges as reported on the Medicaid cost report for all Ohio hospitals. Interim payments are made as a credit against final payment of the final discharge bill. Amounts of difference between interim payment made and the prospective payment described in paragraph (A) of this section for the final discharge will be reconciled when the final discharge bill is processed.

(3) Payments for transfers as defined in section 5101:3-2-02 of the Appendix to Attachment 4.19-A are subject to the following provisions. If a hospital paid under the prospective payment system transfers an inpatient to another hospital or receives an inpatient from another hospital and that transfer is appropriate as defined in section 5101:3-2-07.13 of the Appendix to Attachment 4.19-A, then each hospital is paid a per diem rate for each day of the patient's stay in that hospital, plus capital, medical education and outlier allowances, as applicable, not to exceed, for nonoutlier cases, the final prospective payment rate that would have been paid for the appropriate DRG/SOI as described in paragraph (E) of this section. When a patient is transferred, the department's payment is based on the DRG/SOI under which the patient was treated at each hospital.

The per diem rate is determined by dividing the product of the hospital's base rate multiplied by the DRG/SOI relative weight as described in this section by the statewide average length of stay calculated for the specific DRG/SOI into which the case falls.

(4) In instances when a recipient's eligibility begins after the date of admission to the hospital or is terminated during the course of a hospitalization, payment will be made on a per diem basis as described in paragraph (N)(3) of this section plus the allowance for capital, medical education and outliers, as applicable.

For inpatient services provided to patients who are discharged, within the same hospital, from an acute care bed and admitted to a bed in a psychiatric unit distinct part, payment will be made based on the DRG representing services provided in the acute care section and the services provided in the psychiatric unit distinct part.

(5) Readmissions are defined in section 5101:3-2-02 of the Appendix to Attachment 4.19-A. A readmission within one calendar day of discharge, to the same institution, is considered to be one discharge for payment purposes so that one DRG payment is made. If two claims are submitted, the second claim processed will be rejected. In order to receive payment for the entire period of hospitalization, the hospital will need to submit an adjustment claim reflecting services and charges for the entire hospitalization.

(6) In the case of deliveries, the department requires hospitals to submit separate claims based respectively on the mother's individual eligibility and the child's individual eligibility.