

## I. Classification for Eligible Providers of Hospital Services

All hospitals are subject to the provisions set forth in subsections (A) and (B) of this section.

### (A) Eligible Providers

- (1) All hospitals, except those excluded in subsections (A)(1) and (A)(2) of this section, that meet Medicare (Title XVIII) conditions of participation as described in 42 CFR 482 effective as of October 1, 2016, are eligible to participate in the Ohio Medicaid (Title XIX) program upon execution of a provider agreement. Also considered to be eligible is a hospital that is currently determined to meet the requirements for Title XVIII participation and has in effect a hospital utilization review plan applicable to all patients who receive medical assistance under Title XIX. The following hospitals are excluded from participation:
  - (a) Tuberculosis hospitals; and
  - (b) Hospitals that have 50% or more of their beds registered with the State of Ohio as alcohol and/or drug abuse rehabilitation beds, and have no beds licensed as psychiatric beds with the State of Ohio.
- (2) Freestanding psychiatric hospitals with more than 16 beds may provide inpatient psychiatric services in accordance with subsection (A)(2) of this section:
  - (a) For recipients age 65 or older, hospitals shall operate pursuant to the provisions of 42 CFR 441 subpart C effective as of October 1, 2016.
  - (b) For recipients under age 21, hospitals shall operate pursuant to the provisions of 42 CFR 441 subpart D effective as of October 1, 2016.
  - (c) For recipients age 21 or older, but under age 65, hospitals shall operate pursuant to the provisions of 42 CFR 482 subpart E effective as of October 1, 2016.
  - (d) In the case of a recipient under age 22, the hospital shall provide services before the recipient reaches age 21 or, if the recipient was receiving services immediately before he or she reached age 21, before the earlier of the following:
    - (i) The date he or she no longer requires the services; or
    - (ii) The date he or she reaches age 22.

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- (3) Ohio Medicaid will not reimburse freestanding psychiatric hospitals with more than 16 beds for inpatient psychiatric services rendered to recipients age 21 or older, but under age 65, except in accordance with the provisions of 42 CFR 438.6(e) effective as of October 1, 2016.
- (4) Freestanding psychiatric hospitals with 16 or fewer beds may provide inpatient psychiatric services to recipients of any age and shall operate pursuant to the provisions of 42 CFR 482 subpart E effective as of October 1, 2016.

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**(B) Classification of Hospitals**

Hospitals shall be classified into mutually exclusive peer groups for purposes of setting rates and making payments under both the inpatient and outpatient prospective payment systems, or to those hospitals excluded from the prospective payment systems.

**(1) Definitions**

- (a) "Critical access hospitals" (CAH) are those hospitals that are certified as a critical access hospital by the Centers for Medicare and Medicaid Services (CMS) and excluded from Medicare prospective payment in accordance with 42 CFR 400.202 effective October 1, 2017.
- (b) "Rural hospitals" are those hospitals located in Ohio counties that are not classified into core based statistical areas (CBSA) as designated in the inpatient prospective payment system (IPPS) case-mix and wage index table as published by CMS for the federal fiscal year beginning in the calendar year immediately preceding the effective date of the hospital rates.
- (c) "Children's hospitals" are those hospitals that primarily serve patients 18 years of age and younger and that are excluded from Medicare prospective payment in accordance with 42 CFR 412.23(d) effective October 1, 2017 or are registered with the Ohio Department of Health.
- (d) "Teaching hospitals" are those hospitals with a major teaching emphasis that have at least two hundred beds and have an intern-and-resident-to-bed ratio of at least .35. For non-Ohio hospitals, only those hospitals classified by the Ohio Department of Medicaid (ODM) as teaching hospitals as of June 30, 2016 will be considered non-Ohio teaching hospitals.
- (e) "Urban hospitals" are those hospitals located in Ohio counties that are classified into CBSAs as designated in the IPPS case-mix and wage index table as published by CMS for the federal fiscal year beginning in the calendar year immediately preceding the effective date of the hospital rates, and not otherwise defined in subsections (B)(1)(a) to (B)(1)(d) of this section.
- (f) "Cancer hospitals" are those hospitals recognized by Medicare that primarily treat neoplastic disease in accordance with 42 CFR 412.23(f) effective October 1, 2017.
- (g) "Freestanding rehabilitation hospitals" are those hospitals in which the Department of Health and Human Services has determined to be excluded from Medicare prospective payment in accordance with 42 CFR 412.23(b) effective October 1, 2017.
- (h) "Freestanding long-term acute care hospitals" are those hospitals in which the Department of Health and Human Services has determined to be excluded from Medicare prospective payment in accordance with 42 CFR 412.23(e) effective October 1, 2017.

- (i) "Freestanding psychiatric hospitals" are those hospitals that are eligible to provide Medicaid services and are grouped into their natural peer group as defined in subsections (B)(1)(a) through (B)(1)(e) of this section.
- (j) For the purposes of this section, the "number of beds" is the total number of beds reported on the hospital's state fiscal year (SFY) 2014 Ohio Medicaid hospital cost report (ODM 02930, rev. 06/14).
- (k) For the purposes of this section, "interns and residents" is the net number of interns and residents reported on the hospital's SFY 2014 Ohio Medicaid hospital cost report.

(2) Ohio hospital prospective payment peer groups.

Hospitals described in subsection (B)(2) of this section shall be paid on a prospective payment basis for inpatient and outpatient services:

- (a) Critical access hospitals;
- (b) Rural hospitals;
- (c) Children's hospitals located in Ohio;
- (d) Non-Ohio children's hospitals;
- (e) Teaching hospitals;
- (f) Non-Ohio teaching hospitals;
- (g) Urban hospitals, which are grouped based on geographical regions; and
- (h) Hospitals that are not located in Ohio that are not classified in subsections (B)(2)(d) or (B)(2)(f) of this section.

(3) Hospitals described in subsection (B)(3) of this section shall be paid in accordance with Attachment 4.19-A, Section II, subsection (B).

- (a) Cancer hospitals;
- (b) Rehabilitation hospitals; and
- (c) Long-term acute care hospitals

(4) Reassignment of hospitals among peer groups.

Beginning January 1 of each calendar year, any hospital geographically located in an Ohio county that has been newly included or newly excluded from a CBSA, as designated in the IPPS case-mix and wage

index table as published by CMS for the federal fiscal year beginning in the calendar year immediately preceding the effective date of the hospital rates, shall be placed into either the rural peer group as defined in subsection (B)(1)(b) of this section or, based on the geographical location of the hospital, an urban peer group as defined in subsection (B)(1)(e) of this section, 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 for inpatient or outpatient rates of either the new or previous peer group.

(5) Rates for new, acquired, replacement, and merged hospitals.

(a) Hospitals new to Medicaid.

- (i) Hospitals described in subsection (B)(2) of this section that are newly enrolled with Medicaid shall be classified into mutually exclusive peer groups as defined in subsection (B)(1) of this section. Until data is available to calculate hospital-specific rates, the hospital shall receive the inpatient and outpatient base rates of the peer group in which they are classified into, the statewide average for capital allowance, and the statewide average for both inpatient cost-to-charge ratio and outpatient cost-to-charge ratio.
- (ii) Hospitals described in subsection (B)(3) of this section that are newly enrolled with Medicaid, shall receive ninety percent of the statewide average for both inpatient cost-to-charge ratio and outpatient cost-to-charge ratio until data is available to calculate hospital-specific rates.

(b) Acquired hospitals.

Hospitals that have a change of ownership shall receive the prior owner's rates for reimbursement until a cost report is filed by the new owner and hospital-specific rates are calculated.

(c) Replacement hospitals.

If a new hospital facility is opened for the purpose of replacing an existing (original) hospital facility identifiable to a unique Medicaid provider number and the original facility closes, the rates from the original facility shall be used for reimbursement until a cost report is filed by the new facility and hospital-specific rates are calculated.

(d) Hospital mergers.

When hospitals identifiable by a unique Medicaid provider number are involved in a merger, the rates for the surviving Medicaid provider number shall be used for reimbursement until a cost report is filed and hospital-specific rates are calculated.

## II. Methods and Standards for Establishing Payment Rates Inpatient Hospital Services

The State has in place a public process which complies with the requirements of Section 1902(a)(13)(A) of the Social Security Act. Except as noted below, all hospital services provided by Medicaid providers of inpatient hospital services are reimbursed under a Diagnosis Related Groups (DRG) based prospective payment system (PPS).

### (A) Inputs Used In the Payment Formula for Hospital Reimbursement.

- (1) The hospital's ratio of cost to charge (CCR) is calculated with Medicaid inpatient costs, as reported on the ODM 02930, schedule H, section I, divided by Medicaid inpatient charges as reported on the ODM 02930, schedule H, section I. The cost report used to complete these calculations is the interim settled cost report ending in the state fiscal year ending in the calendar year preceding the immediate past calendar year prior to January 1 of the calendar year to which the new rate shall apply. For hospital payments, the rate year starts on January 1 of each calendar year.
- (2) DRG/Severity of Illness Assignment (SOI)
  - (a) All inpatient claims are analyzed by the All Patient Refined Diagnosis Related Groups (APR-DRG) grouping software based on the date of discharge. Each discharge is assigned a DRG and one of four Severity of Illness Assignment (SOI) factors based upon the date of discharge.
  - (b) 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 State.
- (3) The dataset used as inputs in the determination of hospital base rates consists of:
  - (a) Inpatient hospital claims with dates of discharge from January 1, 2012 through December 31, 2014;
  - (b) Cost reports submitted by Ohio hospitals to the State on its Medicaid cost report for the hospital years that end in state fiscal years 2013, 2014 and 2015; and
  - (c) Inflation factors computed for Ohio by a nationally-recognized research firm, which computes similar factors for the Medicare program.
  - (d) The inflation factors were used to apply an inflationary value to the total cost computed for each case inflating it to June 30, 2017.
- (4) The dataset used as inputs in the determination of relative weights consist of:
  - (a) Inpatient hospital claims with dates of discharge from October 1, 2015 through June 30, 2017;
  - (b) Cost reports submitted by Ohio hospitals to the State on its Medicaid cost report for the hospital years that end in state fiscal years 2016 and 2017; and
  - (c) Inflation factors computed for Ohio by a nationally-recognized research firm that computes similar factors for the Medicare program.

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(d) The inflation factors were used to apply an inflationary value to the total cost computed for each case inflating it to December 31, 2018.

(5) Computation of hospital base rate.

(a) The base rate for each Ohio children's hospital is equal to:

- (i) Ninety-seven percent of the total inflated costs for the cases assigned to children's hospitals divided by the number of cases assigned to the children's hospitals; divided by
- (ii) The peer group case-mix score as calculated in subsection (A)(5)(d) of this section.

(b) The base rate for each Ohio teaching hospital is equal to:

- (i) Ninety-seven percent of the total inflated costs for the cases assigned to teaching hospitals divided by the number of cases assigned to teaching hospitals; divided by
- (ii) The peer group case-mix score as calculated in subsection (A)(5)(d) of this section.

(c) The base rate for hospitals in Ohio peer groups other than Ohio children's or teaching hospitals is equal to:

- (i) Seventy 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
- (ii) The peer group case-mix score as calculated in subsection (A)(5)(d) of this section, except for hospitals described in subsection (A)(5)(c)(iii) of this section.
- (iii) For the purposes of setting base rates for inpatient services, children's hospitals that have less than 75 beds and are enrolled as a Medicaid provider on or after January 1, 2011 shall be grouped into their natural rural or urban hospital peer group as described in subsections (B)(1)(b) or (B)(1)(e) of this section. These hospitals shall also receive any pricing considerations or differentials as if they were in the children's hospital peer group.

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

- (i) The sum of the relative weight values across all cases assigned to a peer group; divided by
- (ii) The number of cases in the peer group.

(e) For non-Ohio hospital peer groups, effective for dates of discharge on or after July 6, 2017, the peer group base rate is equal to;

- (i) For non-Ohio children's hospitals, 80% of the base rate in effect on the effective date of this section for Ohio children's hospitals.
- (ii) For non-Ohio teaching hospitals, 82.02% of the base rate in effect on the effective date of this section for Ohio teaching hospitals.

- (iii) For all other non-Ohio hospitals, 77.61% of the base rate in effect on the effective date of this section of Ohio hospitals that are not considered teaching, children's and psychiatric hospitals.
  - (iv) For non-Ohio hospitals, the calculated base rate as described in subsection (A)(5)(e) of this section includes an allowance for medical education.
- (f) Peer group risk corridors.

Effective for discharges on or after July 6, 2017, the State will apply the following:

- (i) If a hospital is in the rural hospital or critical access hospital peer groups, then the hospital's base rate is equal to the greater of:
  - (a) The peer group base rate; or
  - (b) Seventy percent of the computed costs of the hospital's cases.
- (ii) For any other Ohio hospital, the hospital's base rate is equal to:
  - (a) The peer group base rate calculated in subsection (A)(5) of this section, if the peer group base rate does not result in more than a 5% reduction or gain in payments compared to the DRG prospective payment system in effect prior to July 6, 2017; or
  - (b) A hospital-specific base rate established to ensure the new peer group base rate does not result in more than a 5% reduction or gain in payments compared to the prior DRG prospective payment system.
- (iii) 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;
  - (a) The hospital base rate calculated in subsection (A)(5) 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
  - (b) A hospital-specific base rate established to ensure the new peer group base rate does not result in a reduction.

(6) Computation of Relative Weights

- (a) For all DRGs, the relative weight is equal to:
  - (i) The average inflated cost per case within the DRG/SOI; divided by

- (ii) The average inflated cost per case across all DRG/SOIs.
- (b) Long-acting reversible contraceptive (LARC) devices may be billed and paid separately when the device is provided postpartum during an inpatient hospitalization. To facilitate separate payment, the relative weights for DRGs 540-542 and 560 as calculated in subsection (A)(6)(a) of this section, were reduced by 3.08%.
- (7) A table of the calculated base rates and relative weights are published on the department's website, <http://medicaid.ohio.gov/PROVIDERS/FeeScheduleandRates.aspx>.

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**(B) Hospital Services Subject to Non-DRG Prospective Payment**

For hospital services subject to non-DRG prospective payment, providers are paid by applying a percentage of the hospital's CCR, as described in subsection (A)(1) of this section, to allowed charges. Billing must reflect the hospital's customary charge for the service rendered. Payment is made for those items and services recognized as reasonable and allowable under Title XVIII standards and principles. All non-DRG prospective payments are not subject to retrospective reimbursement. Hospital services subject to non-DRG prospective payment include:

- (1) Freestanding rehabilitation hospitals, as described at 42 CFR 412.23(b), which are excluded from the Medicare PPS shall be reimbursed at 90% of historical inpatient costs.
- (2) Freestanding long-term hospitals, as described at 42 CFR 412.23(e), which are excluded from the Medicare PPS shall be reimbursed at 90% of historical inpatient costs.
- (3) Hospitals that are excluded from Medicare's PPS due to providing services, in total; which are excluded due to a combination of long-term care and rehabilitative services.
- (4) Hospitals licensed as Health Insuring Corporations licensed by the Ohio Department of Insurance, which limit services to Medicaid recipients to those enrolled in a health insuring corporation or to short-term services provided on an emergency basis.
- (5) Hospitals recognized by Medicare as cancer hospitals, as described at 42 CFR 412.23(f) shall be reimbursed at 91.7% of historical inpatient costs.

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**(C) Inpatient Hospital Services Subject to APR-DRG Prospective Payment**

- (1) Payment for inpatient hospital services provided in hospitals other than those described in subsection (B)(3) of this section will be subject a prospective payment methodology utilizing the APR-DRG developed and maintained by 3M Health Information Systems.
- (2) Inpatient hospital services shall include outpatient services provided to the same patient, at the same hospital, within three calendar days prior to the date of an inpatient admission, except, for outpatient Behavioral Health services provided under Attachment 4.19-B, Item 2-a, section I, subsection (D)(2).
- (3) Payments under the prospective payment system are made on the basis of a prospectively determined rate as provided in this section. 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.
- (4) Each DRG is categorized into one of four SOI categories; 1- Minor, 2 - Moderate, 3 - Major and 4 - Extreme. Each DRG/SOI combination is assigned a relative weight and average length of stay.
- (5) The relative weight for a DRG/SOI is multiplied by the hospital base rate to determine the DRG base payment for a claim.
- (6) For hospitals that have a medical education rate, the medical education allowance is calculated by multiplying the medical education rate by the relative weight for the DRG/SOI.
- (7) Each hospital is paid a hospital-specific capital allowance for each claim.
- (8) A claim may also be eligible to receive an additional payment for high cost cases and/or an additional payment related to organ acquisition for transplant cases.
- (9) The final payment for inpatient hospital services is the sum of:
  - (a) DRG Base Payment (see subsection (C)(5) of this section);
  - (b) Capital allowance (see subsection (D) of this section);
  - (c) Medical Education allowance (see subsection (E) of this section);
  - (d) Applicable Outlier allowance (see subsection (F) of this section); and
  - (e) Applicable Organ Acquisition allowance (see subsection (G) of this section).
  - (f) The final payment is rounded to the nearest whole cent.

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This sum is the total DRG payment. The formula to calculate the total DRG payment is:

$$\begin{array}{rcccccc} \text{Total} & & \text{DRG} & & & & \text{Organ} \\ \text{DRG} & = & \text{Base} & + & \text{Capital} & + & \text{Acquisition} \\ \text{Payment} & & \text{Payment} & & \text{Allowance} & & \text{Allowance} \\ & & & & & + & \text{Allowance} \\ & & & & \text{Medical} & + & \text{Allowance} \\ & & & & \text{Education} & & \text{(if applicable)} \\ & & & & \text{Allowance} & & \text{(if applicable)} \\ & & & & & & \text{(if applicable)} \end{array}$$

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**(D) Computation of Capital Allowance Payments**

- (1) Capital costs include the categories of costs recognized by Medicare on the Centers for Medicare and Medicaid Services (CMS) CMS 2552-10 revised October 2012 and filed in accordance with CMS instructions, available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals.html> (revised September 2016).
- (2) Capital-related costs for services provided by Ohio hospitals paid under prospective payment will be subject to prospective payment without subsequent settlement to actual capital costs.
- (3) On an annual basis, the interim capital payments will be re-determined by identifying 85% of the capital-related costs reported on the ODM 02930, "Ohio Medicaid Hospital Cost Report"; multiplying that cost by the percent of Medicaid inpatient charges to total charges; and dividing the result by the number of Medicaid discharges that occurred during the cost-reporting period. The cost report used to complete these calculations is the interim settled cost report ending in the state fiscal year ending in the calendar year preceding the immediate past calendar year prior to January 1 of the calendar year to which the new capital rate shall apply.
- (4) Non-Ohio hospital capital reimbursement.
  - (a) The average statewide capital cost is computed by summing, for all Ohio hospitals, the identified capital costs as described in subsection (D)(3) of this section and multiplying that cost by the percent of Medicaid inpatient charges to total charges for all Ohio hospitals, and dividing by total discharges for all Ohio hospitals as described in subsection (D)(3) of this section.
  - (b) The capital allowance for non-Ohio hospitals shall be 85% of the amount calculated in subsection (D)(3) of this section.
  - (c) The average statewide capital cost is updated annually using capital costs from cost reports as described in subsection (D)(3) of this section.
  - (d) The amounts derived in subsection (D)(4) of this section will reflect a statewide average calculated to be in effect on January 1 of the calendar year and not subject to retrospective adjustments.

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**(E) Computation of Medical Education Allowance Payments**

Effective for dates of discharge on or after July 6, 2017, to qualify for a medical education allowance rate as described in this section, Ohio hospitals must have an approved medical education program as defined in 42 CFR 415.152 effective as of October 1, 2016 and the costs of the approved medical education program were reflected in their state fiscal year 2014 Ohio Medicaid hospital cost report (ODM 02930 rev. 6/2014). This section describes the methodology used for computing the direct graduate medical education and indirect medical education components of each hospital's medical education allowance rate.

- (1) Computation of direct graduate medical education (DGME) costs, which are the costs that are directly related to the training of interns & residents and allied professionals in an approved medical education program.
  - (a) Tabulate the costs captured on the cost report for interns & residents and allied professionals.
  - (b) Tabulate the total facility charges and total Medicaid fee-for-service and managed care charges reported on the cost report. Calculate the Medicaid factor by dividing the sum of total Medicaid fee-for-service and managed care charges by total charges.
  - (c) Tabulate the total Medicaid fee-for-service and managed care discharges from the cost report.
  - (d) The Medicaid portion of DGME costs equal the total DGME costs as described in subsection (E)(1)(a) of this section multiplied by the Medicaid factor as described in subsection (E)(1)(b) of this section.
  - (e) A cost per discharge is computed using the Medicaid portion of DGME costs as described in subsection (E)(1)(d) of this section divided by the total number of Medicaid discharges as described in subsection (E)(1)(c) of this section.
- (2) Computation of indirect medical education (IME) costs, which are the costs that recognize the increased costs of patient care that results from operating an approved medical education program.
  - (a) Identify the number of interns & residents and number of beds reported on the cost report.
  - (b) Compute the IME factor by using the logarithmic formula  $1.35 * ((1 + ((\text{interns} \& \text{residents}) / \text{beds})^{0.405}) - 1)$ .
  - (c) Tabulate the total Medicaid fee-for-service and managed care net operating costs reported on the cost report.
  - (d) The Medicaid portion of IME is the Medicaid net operating costs as described in subsection

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(E)(2)(c) of this section multiplied by the IME factor as described in subsection (E)(2)(b) of this section.

(e) A cost per discharge is computed using the Medicaid portion of IME costs as described in subsection (E)(2)(d) of this section divided by the total number of Medicaid discharges as described in subsection (E)(1)(c) of this section.

(i) The IME cost per discharge is capped. The capped value is the statewide mean IME cost per discharge plus one standard deviation.

(ii) If the hospital's IME cost per discharge is greater than the capped IME cost per discharge as described in subsection (E)(2)(e)(i) of this section, then the IME cost per discharge is limited to the capped value.

(3) Case-mix adjustment of medical education allowance rate.

(a) The case-mix score for each hospital equals the sum of the relative weight values for all state fiscal year 2014 discharges divided by the total number of Medicaid discharges as described in subsection (E)(1)(c) of this section.

(b) Sum the DGME cost per discharge as described in subsection (E)(1)(e) of this section and the IME cost per discharge as described in subsection (E)(2)(e) of this section.

(c) Divide the sum of the DGME cost per discharge and IME cost per discharge as described in subsection (E)(3)(b) of this section by the case-mix score as described in subsection (E)(3)(a) of this section. The resulting value is the hospital's total medical education allowance rate.

(d) The hospital's total medical education allowance rate as described in subsection (E)(3)(c) of this section shall be subject to a payment neutrality adjustment of 59.70%.

(4) Medical education and stop-loss/stop-gain.

(a) For each hospital, determine the total value of current medical education payments as reimbursed by the APR-DRG prospective payment system prior to July 1, 2017 by multiplying the hospital's medical education allowance rate effective January 1, 2017 by the hospital's case-mix score in effect prior to July 1, 2017 by the total number of Medicaid discharges for the 12 month period used to estimate the fiscal impact.

(b) Determine the hospital's projected medical education payments by multiplying the case-mix adjusted medical education allowance rate as described in subsection (E)(3) of this section by the total number of Medicaid discharges for the 12 month period used to estimate the fiscal impact.

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- (c) If the hospital's current medical education payments as described in subsection (E)(4)(a) of this section are greater than the projected medical education payments as described in subsection (E)(4)(b) of this section, then the hospital's medical education allowance rate shall be the medical education allowance rate used to calculate current medical education payments as described in subsection (E)(4)(a) of this section.
  - (d) If the hospital's projected medical education payments as described in subsection (E)(4)(b) of this section are more than 110% of current medical education payments as described in subsection (E)(4)(a) of this section, then the hospital's medical education payments shall be the current medical education allowance rate multiplied by 110%.
  - (e) If the hospital's projected medical education payments as described in subsection (E)(4)(b) of this section are greater than its current medical education payments as described in subsection (E)(4)(a) of this section but less than 110% of its current medical education payments as described in subsection (E)(4)(a) of this section, then the hospital's medical education allowance rate is the allowance rate used to calculate projected medical education payments as described in subsection (E)(4)(b) of this section.
- (5) Recognition of approved medical education programs outside of rebasing.
- (a) For rate years when rebasing is not being conducted, hospitals that have added an approved graduate medical education program and demonstrate such costs on the interim-settled cost report that ends in the state fiscal year ending in the calendar year preceding the immediate past calendar year prior to January 1 of the rate year, the interim medical education allowance rate shall be the sum of 80% of the statewide average DGME allowance rate plus 50% of the statewide average IME allowance rate.
  - (b) For a hospital that only demonstrates costs for medical education of allied professionals on the interim-settled cost report that ends in the SFY ending in the calendar year preceding the immediate past calendar year prior to January 1 of the rate year, the medical education allowance rate will be 50% of the statewide average DGME allowance rate.
  - (c) For a hospital that has a newly approved graduate medical education program but whose costs are not yet reflected on a cost report, the medical education allowance rate will be 50% of the statewide average DGME allowance rate.
    - (i) A hospital with a newly approved graduate medical education program must notify the State no later than October 1 of the calendar year in order for the State to develop rates for the following rate year.
    - (ii) Notification to the State must include documentation from the Accreditation Council of Graduate Medical Education that the hospital has an approved medical education program or documentation of Medicare's recognition of the hospital's approved full-time equivalent interns

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& residents count, or both.

- (d) For a hospital whose interim-settled cost report no longer reflects costs for interns & residents, and that ends in the state fiscal year ending in the calendar year preceding the immediate past calendar year prior to January 1 of the rate year, the medical education allowance rate will be reduced by the portion of the allowance rate that represented their IME costs.
- (e) For a hospital whose interim-settled cost report no longer reflects costs for interns & residents and allied professionals, and that ends in the state fiscal year ending in the calendar year preceding the immediate past calendar year prior to January 1 of the rate year, the medical education allowance rate will be reduced to zero.
- (6) Each hospital's medical education allowance rate as determined in either subsections (E)(3), (E)(4), or (E)(5) of this section shall be multiplied by the relative weight of the assigned APR-DRG and SOI as described in subsection (C)(4) of this section.

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**(F) Computation of Outlier Payments**

- (1) If a discharge is eligible for an outlier payment, the payment will be equal to 90% 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 claims 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 CCR. The inpatient CCR 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 DRG base payment as described in subsection (C)(5) of this section plus a fixed outlier threshold as described in subsection (F)(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 \$25,000. 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 \$60,000. The fixed outlier threshold for cases other than neonate and tracheostomy billed by hospitals among other peer groups is \$75,000.
- (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 subsection (C)(9) of this section.

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**(G) 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 State.
- (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 State. Reimbursement is further contingent upon:
  - (a) Membership in the "Ohio Hematopoietic Stem Cell Transplant Consortium"; or
  - (b) Compliance with the performance standards 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 100% of billed charges.
- (4) For harvesting costs for bone marrow transplant services, the prospective payment amount will be either:
  - (a) The DRG amount 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 CCR if the donor is not a Medicaid recipient.

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**(H) Other Payment Policies**

- (1) 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 30<sup>th</sup> day of a consecutive inpatient stay and at 30-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 CCR as described in subsection (A)(1) of this section. For those hospitals which are not required to file a cost report, the statewide average Medicaid inpatient CCR will be used. The statewide average Medicaid inpatient CCR 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 subsection (C) of this section, for the final discharge will be reconciled when the final admit thru discharge bill is processed.
- (3) Except for psychiatric hospitals, payments for transfers 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, then each hospital is paid a per diem rate for each day of the patient's stay in that hospital. The State'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 subsection (C)(4) of this section by the statewide average length of stay calculated for the specific DRG/SOI into which the case falls. The sum of the per diem rate for each day is known as the per diem base payment. The per diem base payment cannot exceed the DRG base payment as described in subsection (C)(5) of this section, that would have been paid for the appropriate DRG/SOI. The total transfer payment is the sum of the lesser of the per diem base payment or the DRG base payment, plus capital, medical education and outlier allowances, as applicable.
- (4) 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) Transfers received by or discharging from a freestanding psychiatric hospital are not subject to the provisions of subsection (H)(3) of this section. For transfers from one unit of a hospital to another distinct unit of the same hospital, the claim with an admit source indicating that the transfer results in a separate claim to Medicaid is not subject to the provisions of subsection (H)(3) of this section, provided that the discharge status does not indicate transfer.

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- (6) 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 subsection (H)(3) of this section plus the allowance for capital, medical education and outliers, as applicable.
- (7) 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.
- (8) In the case of deliveries, the State requires hospitals to submit separate claims based respectively on the mother's individual eligibility and the child's individual eligibility.
- (9) Payment for LARC devices provided postpartum will be paid in accordance with the State's Provider-Administered Pharmaceuticals fee schedule at the rate in effect on the date of service, when submitted on a separate claim. The fee schedule is published on the department's website, <http://medicaid.ohio.gov/PROVIDERS/FeeScheduleandRates.aspx>. Payment for related obstetrical services will be made in accordance with the State's inpatient payment policies in effect on the date of discharge from the hospital.

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**(I) Audits and Appeals**

Audits are performed for hospital services subject to reasonable cost reimbursement to determine reasonable and allowable costs. Underpayments or overpayments are adjusted through settlement. For hospital services subject to PPS, audits are performed to determine reasonable and allowable base year costs and discharge statistics; to determine whether, overall, payments exceeded charges; to verify that services billed were provided and provided to eligible recipients; and to determine whether third party payments received were reported.

In general, hospitals may request reconsideration of payment rates if they believe source data used by the State is inaccurate. Certain components of rate calculation are excluded from reconsideration in order to preserve the predictability of the prospective payment system.

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### III. Potentially Preventable Readmissions (PPRs)

All hospitals that are subject to the all patient refined diagnosis related groups (APR-DRG) prospective payment methodology are subject to the Potentially Preventable Readmissions Program. Hospitals that have 20 or more Medicaid discharges in the reporting year are subject to a PPR rate adjustment.

Hospitals with excess clinically-related and clinically-preventable readmissions in the reporting year as determined by the 3M Health Information Systems PPR software will be subject to a one percent reduction of their inpatient hospital-specific base rate. The excess readmission penalty will be applied on January 1 of each calendar year and will remain in effect for that calendar year.

#### (A) Definitions

- (1) "Potentially preventable readmission (PPR)" is a readmission that follows a prior discharge from any hospital within 30 days and that is deemed clinically-related and clinically-preventable by the PPR software.
- (2) "Clinically-related readmission chain" is a series of admissions for the same patient where the underlying reason for admission is related, as determined by the PPR software, to the care rendered during or within 30 days following a prior hospital admission. The hospital in which the initial admission occurred is the hospital that is responsible for the clinically-related readmission chain.
- (3) "Actual PPR rate" is the PPR rate computed as total clinically-related readmission chains divided by the sum of initial admissions and only admissions.
- (4) "Expected PPR rate" is the PPR rate computed as total clinically-related readmission chains divided by the sum of initial admissions and only admissions. The expected PPR rate is adjusted, by the PPR software, for severity of illness and risk of mortality.
- (5) "Actual-to-expected ratio" is the actual PPR rate divided by the expected PPR rate.

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**(B) Readmission Criteria**

- (1) A readmission is a return hospitalization within 30 days of a prior discharge that meets all of the following criteria:
  - (a) The readmission is potentially preventable by the provision of appropriate care consistent with accepted care standards, based on the PPR software, in the prior discharge or during the post-discharge follow-up period.
  - (b) The readmission is for a condition or procedure that is clinically -related to the care provided during the prior discharge or resulting from inadequate discharge planning during the prior discharge.
  - (c) The PPR chain may contain one or more readmissions that are clinically-related to the initial admission. If the first readmission is within thirty days after the initial admission, the thirty day timeframe may begin again at the discharge of either the initial admission or the most recent readmission clinically-related to the initial admission.
  - (d) The readmission is to the same or any other hospital.
- (2) Readmissions, for the purposes of determining PPRs, exclude the following circumstances:
  - (a) The original discharge was a patient initiated discharge, was against medical advice (AMA), and the circumstances of such discharge and readmission are documented in the patient's medical record.
  - (b) The original discharge was for the purpose of securing treatment of a major or metastatic malignancy, major trauma, neonatal and obstetrical admission, transplant, HIV, and nonevents as defined by the PPR software.
  - (c) Only admissions and planned admissions as defined by the PPR software.

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**(C) Methodology**

- (1) Rate adjustments for calendar year 2017 for each hospital shall be based on each hospital's paid fee for-service and managed care claims data for discharges that occurred on July 1, 2014 through June 30, 2015. For each calendar year thereafter, rate adjustments shall be based on each hospital's paid claims data from the state fiscal year ending in the calendar year preceding the calendar year immediately preceding the effective date of the PPR rate adjustment.
- (2) Excess readmission rates are determined by examining hospital-specific actual-to-expected ratios.
  - (a) An actual-to-expected ratio of one indicates that the hospital had readmissions within 30 days at a rate that is expected given their patient mix.
  - (b) An actual-to-expected ratio of less than one indicates that the hospital had less readmissions within 30 days than is expected given their patient mix.
  - (c) An actual-to-expected ratio of greater than one indicates that the hospital had more readmissions within 30 days than is expected given their patient mix.

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#### IV. Provider Preventable Conditions (PPCs)

The Medicaid agency meets the requirements of 42 CFR Part 447, Subpart A, and sections 1902(a)(4), 1902(a)(6), and 1903 of the Social Security Act with respect to non-payment for provider-preventable conditions (PPCs).

The State identifies the following Health Care-Acquired Conditions (HCACs) for non-payment: Hospital-Acquired Conditions as identified by Medicare other than Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE) following total knee replacement or hip replacement surgery in pediatric and obstetric patients. Non-payment of HCACs applies to all inpatient hospitals.

The State identifies the following PPCs for non-payment in any health care setting where they may occur: Wrong surgical or other invasive procedure performed on a patient; surgical or other invasive procedure performed on the wrong body part; surgical or other invasive procedure performed on the wrong patient.

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## VI. Hospital Cost Coverage Add-On

This section applies to all Ohio hospitals reimbursed under the inpatient prospective payment system as described in Attachment 4.19-A, section II, subsection (A) or reimbursed under non-DRG prospective payment as described in Attachment 4.19-A, section II, subsection (B). This section does not apply to the coordination of benefits calculation pertaining to beneficiaries eligible for both Medicare and Medicaid.

### (A) Source Data for Calculations

The calculations used in determining the cost coverage add-on will be based on data provided by annual cost reports submitted to the department. The cost reports used will be the hospital's cost reporting year ending in the state fiscal year prior to the state fiscal year that ends immediately preceding the state fiscal year to which the cost coverage add-on applies.

### (B) Cost Coverage Add-on Policy Pools

Appropriations authorized by the Ohio General Assembly each state fiscal year will be divided into the following inpatient policy pools:

- (1) The inpatient cost coverage standard pool, which is the lesser of \$259,229,112.31 or 36.38 percent of the appropriated funds.
- (2) The cost coverage sustainability pool is ten percent of the sum of:
  - (a) The lesser of \$233,000,000.00 or 32.70 percent of the appropriated funds; and
  - (b) The greater of 7.33 percent or the balance of the appropriated funds.
- (3) Privately-owned, free-standing psychiatric hospitals as described in Attachment 4.19-A, section I, subsection (A)(2), will receive 1.86 percent of the amount which is described in subsection (B)(2)(b) of this section.
- (4) General acute care hospitals that have a dedicated Psychiatric Emergency Department (PED) established prior to October 1, 2019 and do not receive payments as described in Attachment 4.19-B, Item 5-a will receive \$4,750,000.00.

**(C) Inpatient Cost Coverage**

(1) Cost Coverage Standard Pool

- (a) From the amount specified in subsection (B)(1) of this section, children's hospitals as defined in Attachment 4.19-A, section I, subsection (B), will be allocated \$15,939,479.00, based on payments made to each children's hospital from funds specifically appropriated by Amended Substitute House Bill 49 of the 132<sup>nd</sup> Ohio General Assembly.
  - (b) From the amount specified in subsection (B)(1) of this section less the amount allocated in subsection (C)(1)(a) of this section, each hospital will be allocated an amount equal to the inpatient non-claims specific lump sum payments not resulting from payments described in Supplement 1 to Attachment 4.19-A, and Attachment 4.19-A, subsection (D).
  - (c) Any amounts in subsection (C)(1)(b) of this section allocated to a closed hospital are reallocated to the remaining hospitals based on the ratio of each hospital's allocation in subsection (C)(1)(b) of this section to the sum of the allocation for all remaining hospitals.
  - (d) For each hospital, sum the amounts allocated in subsections (C)(1)(a) to (C)(1)(c) of this section.
- (2) Divide ten percent of the amount in subsection (B)(2) of this section by the total Medicaid discharges for all hospitals, then multiply the results by the number of total Medicaid discharges for each hospital.
- (3) For privately owned freestanding psychiatric hospitals as described in subsection (B)(3) of this section, divide the amount described in subsection (B)(2)(b) of this section by the total Medicaid discharges for all freestanding psychiatric hospitals, then multiply the results by the number of total Medicaid discharges for each freestanding psychiatric hospital.
- (4) For all hospitals with a PED, divide the amount described in subsection (B)(4) of this section by the total Medicaid discharges for all hospitals with a PED, then multiply the results by the number of Medicaid discharges for each hospital with a PED.

**(D) Inpatient Cost Coverage Add-On Amount Per Discharge for Hospitals Subject to the Payment Methodology Under Attachment 4.19-A, Section II, Subsection (C)**

- (1) For each hospital, divide the sum of subsections (D)(1)(a) to (D)(1)(b) of this section by the total Medicaid discharges used in the inpatient case-mix calculation.
  - (a) The sum of subsections (C)(1) to (C)(4) of this section.
  - (b) Any outpatient amounts allocated under Attachment 4.19-B, Item 2-a, Section III, subsection (C) to a freestanding psychiatric hospital.
- (2) For each hospital, divide the results in subsection (D)(1) of this section by the inpatient case-mix.
- (3) The cost coverage add-on per discharge amount is equal to the amount calculated in subsection (D)(2) of this section, rounded to two decimal places.
- (4) The amount calculated in subsections (D)(3) of this section will be added to the hospital's inpatient base rate as described in Attachment 4.19-A, Section II, subsection (A)(5).

**(E) Inpatient Cost Coverage Add-On for Hospitals Subject to the Payment Methodology Under Attachment 4.19-A, Section II, subsection (B)**

- (1) For each hospital, calculate total inpatient payments by multiplying total Medicaid inpatient charges by the inpatient cost-to-charge ratio described under Attachment 4.19-A, Section II, subsection (B) calculated from the source data described in subsection (A) of this section.
- (2) For each hospital, divide the amounts in subsection (E)(1) of this section by the total Medicaid inpatient costs.
- (3) For each hospital, sum the total inpatient payments calculated in subsection (E)(1) of this section and the amounts distributed in subsection (C)(1) to (C)(4) of this section.
- (4) For each hospital, divide the result in subsection (E)(3) of this section by the total Medicaid inpatient costs.
- (5) For each hospital, calculate the inpatient cost coverage increase by subtracting the result in subsection (E)(2) of this section from the result in subsection (E)(4) of this section and dividing the result by subsection (E)(2) of this section, rounded to four decimal places.

- (6) For each hospital, multiply the result in subsection (E)(5) of this section by the inpatient cost-to-charge ratio calculated in subsection (E)(1) of this section.
- (7) Apply the amount calculated in subsection (E)(6) of this section as an increase to the hospital's inpatient cost-to-charge ratio.

Disproportionate Share and Indigent Care for General Hospitals

This Section applies to all general acute care hospitals eligible to participate in Medicaid.

**(A) SOURCE DATA FOR CALCULATIONS**

The calculations used in determining disproportionate share hospitals and in making disproportionate share and indigent care payments will be based on data provided in annual cost reports submitted to the department. The cost reports used will be for the hospital's cost reporting period ending in the state fiscal year that ends in the federal fiscal year preceding each program year. If specific program data is not available from these reports, the otherwise most recent, reviewed, cost report information will be used. The CMS data used will be as reported by CMS for the prior federal fiscal year.

**(B) DETERMINATION OF DISPROPORTIONATE SHARE HOSPITALS**

The department makes additional payments to hospitals that qualify for a disproportionate share adjustment. Hospitals that qualify (including Children's and DRG exempt hospitals) are those that meet at least one of the criteria described under (1) and (2) below and that also meet the criteria described under (3) below:

- (1) Have a Medicaid utilization rate greater than or equal to one percent.
- (2) Have a low income utilization rate in excess of 25 percent, where low income utilization rate is:

(Medicaid Payments + Cash subsidies from patient services received directly from state and local government)/Total hospital revenues (incl. cash subsidies from patient services received directly from state and local government)

+

Total charges for inpatient services for charity care/Total charges for inpatient services

- (3) Have at least two obstetricians who have staff privileges at the hospital and who have agreed to provide obstetric services to individuals who are entitled to Medicaid, except that:
  - (i) The provisions of (3) do not apply to hospitals the inpatients of which are predominantly individuals under 18 years of age; or
  - (ii) The provisions of (3) do not apply if the hospital does not offer non-emergency obstetric services to the general population as of December 22, 1987; or
  - (iii) In the case of hospitals located in a rural area (as defined for purposes of Section 1886 of the Social Security Act), the term "obstetrician" includes any physician with staff privileges at the hospital to perform non-emergency obstetric procedures.

Hospitals that do not qualify for a disproportionate share adjustment receive additional payments in the form of an indigent care adjustment.

**(C) LIMITATION ON DISPROPORTIONATE SHARE PAYMENTS**

No hospital shall receive more in disproportionate share payments than the cap, or hospital-specific disproportionate share limit, established by the Omnibus Budget Reconciliation Act of 1993 (OBRA Cap). For each hospital the OBRA Cap is the sum of Medicaid shortfall (for both Fee-for-Service and Medicaid Managed Care recipients) plus the cost of care to the uninsured less payments from Section 1011.

## (D) DISTRIBUTION OF DISPROPORTIONATE SHARE FUNDS

In accordance with the requirements in Section 1923 of the Social Security Act, the State will distribute to hospitals 100 percent of the State's Federal Disproportionate Share Allotment for each year. Hospitals will be considered disproportionate share if their Medicaid Inpatient Utilization Rate (MIUR) is greater than or equal to 1.00 percent. The State will distribute the total Disproportionate Share Allotment from seven payment pools:

- 1) The first pool is the High Federal Disproportionate Share and Indigent Care Payment Pool, which is distributed to those hospitals meeting the high federal disproportionate share hospital definition. A hospital is considered to be a high federal disproportionate share hospital if their MIUR is greater than the statewide mean MIUR plus one standard deviation. Distribution is based on the ratio derived by dividing each hospital's Medicaid costs by the sum of Medicaid costs for all hospitals meeting the high federal disproportionate share definition. The percentage allocated to this payment pool is 12 percent of the total allowable amount.
- 2) The second pool, the Medicaid shortfall and Uncompensated Care Payment Pool, is distributed to all acute care hospitals based upon the ratio derived by dividing each hospital's remaining portion of their hospital-specific disproportionate share limit (hospital-specific DSH limit less amount from Pool 1) to the total remaining disproportionate share limit for all hospitals in the pool. The percentage allocated to this payment pool is 72.01 percent of the total allowable amount for program year 2016, and 77.26 percent of the total allowable amount for program year 2017, and each year thereafter.
- 3) The third pool, the Disability Assistance (DA) and Uncompensated Care Indigent Care Payment Pool, is distributed to acute care hospitals based on the ratio derived by dividing each hospital's uncompensated care costs for services provided to persons who are at or below the Federal Poverty Level (FPL) by the total uncompensated care costs for services provided to persons who are at or below the FPL for all hospitals. The percentage allocated to this payment pool is 5.25 of the total allowable amount for program year 2016, and 0 percent for program year 2017, and each year thereafter.
  - a) The uncompensated care cost for services provided to persons at or below the FPL are calculated by using hospital reported cost center charges multiplied by the cost center-specific cost-to-charge ratio and summing the resulting costs for all cost centers and subtract any reported payments received during the cost report period.
  - b) For each hospital, calculate the ratio of the uncompensated care costs to the sum of all the hospitals' uncompensated care costs and multiply that ratio by an amount allocated for the uncompensated care pool below 100% of the FPL.
- 4) The fourth pool, the Rural and Critical Access Payment Pool, distributes a total allocation of 8.76 percent of the total allowable amount. Critical Access Hospitals (CAH) receive 38.81 percent of this pool, based on the ratio of each hospital's remaining disproportionate share limit (hospital-specific DSH limit less amount from Pools 1 – 3) to the total remaining disproportionate share limit for all CAHs. The balance of the pool is distributed to the Rural Hospitals (RH) based on the ratio of the remaining disproportionate share limit for each RH and the total remaining disproportionate share limit for each RH in the pool.
  - a) For the purpose of this subsection, a Rural Hospital is any hospital geographically located in an Ohio county that is not classified into a Core Based Statistical Area (CBSA).
- 5) The fifth pool, the County Redistribution of Closed Hospitals Payment Pool, only distributes money within a county if a hospital facility that is identifiable to a unique Medicaid provider number closed. If another hospital does not exist in that county, the money is instead distributed among hospitals in bordering counties. The available money is distributed to hospitals within a county (or bordering counties) based upon the ratio derived by dividing a hospital's cost of care to the uninsured to the countywide (or bordering counties) total cost of care to the uninsured.
- 6) The sixth pool, the Children's Hospital Pool, provides funds to children's hospitals with room in their OBRA cap based on the ratio derived by dividing each Children's Hospital's remaining OBRA cap by the sum of the remaining OBRA cap for all Children's Hospitals. The percentage allocated to this payment pool is 1.98 percent of the total allowable amount.
- 7) The Statewide Residual Pool is the seventh pool. In this pool, if a hospital has received more in distributions than the OBRA cap allows, the excess money is subtracted, and then redistributed to hospitals with room in their OBRA cap. Funds are distributed based on the ratio derived by dividing the remaining OBRA cap for each hospital by the remaining OBRA cap for all hospitals.

The sum of all payment pools will be paid to hospitals on an annual basis. The methodology in this section applies to the disproportionate share allotment awarded for Federal Fiscal Years 2016, 2017 and thereafter.

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**Audits of Disproportionate Share Programs**

The state shall contract with an independent audit firm to conduct an audit of the state's DSH programs as they apply to general and psychiatric hospitals in accordance with 42 CFR 447.299 and 42 CFR 455.304, for DSH State Plan years beginning 2005. In the event that the independent auditor determines that any hospital has received a DSH payment in excess of their hospital-specific disproportionate share limit, the state shall:

1. Collect from each hospital which has received payment in excess of their hospital-specific DSH limit, the amount of the overpayment.
2. Redistribute the aggregate amount of the overpayment(s) to all hospitals which, according to the independent auditor, still have room under their hospital-specific DSH limit.
3. The amount to be redistributed to each eligible hospital shall be determined by the Statewide Residual Payment Pool policies for the State Plan Year of the audit. The redistribution shall use the independent auditor's revised hospital-specific DSH limits to ensure that no hospital receives a payment that is in excess of their audited hospital-specific DSH limit.

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Disproportionate share and indigent care payment policies for psychiatric hospitals

This section applies to hospitals eligible to participate in Medicaid only for the provision of inpatient psychiatric services to eligible recipients:

1. Age 65 and older; and
2. Under age 21, or if the recipient was receiving services immediately before he/she reached age 21, services are covered until the earlier of the date he/she no longer requires the services or the date he/she reaches age 22.

The payment policies described below are in accordance with rule 5101:3-2-10. Hospitals eligible to participate only for the provision of inpatient psychiatric services are limited, in accordance with rule 5101:3-2-01, to psychiatric hospitals, and certain alcohol and drug abuse rehabilitation hospitals, that are certified by Medicare for reimbursement of services and are licensed by the Ohio Department of Mental Health or operated under the state mental health authority.

A. Source data for calculations

The calculations described in determining disproportionate share psychiatric and certain alcohol and drug abuse rehabilitation hospitals (hospitals) and in making disproportionate share and indigent care payments will be based on financial data and patient care data for psychiatric inpatient services provided for the hospital fiscal year ending in the state fiscal year that ends in the federal fiscal year preceding each program year.

B. Determination of disproportionate share hospitals

The department makes additional payments to hospitals that qualify for a disproportionate share adjustment. Hospitals that qualify are those that meet at least one of the criteria described under (1) and (2) below, and that also meet the criteria described under (3) below:

- (1) The hospital's Medicaid inpatient utilization rate is at least one standard deviation above the mean Medicaid inpatient utilization rate for all hospitals receiving Medicaid payments in the state.

The Medicaid inpatient utilization rate is the ratio of the hospital's number of inpatient days attributable to patients who were eligible for medical assistance and who are age twenty-one and under or age sixty-five and older, divided by the hospitals total inpatient days.

- (2) The hospital's low-income utilization rate is in excess of twenty-five percent.

The low-income utilization rate is the sum of:

- (a) The sum of total Medicaid revenues for inpatient services and cash subsidies for inpatient services received directly from state and local governments, divided by the sum of total facility inpatient revenues and cash subsidies for patient services received directly from state and local governments, plus
- (b) Total charges for inpatient services for charity care (less cash subsidies above, and not including contractual allowances and discounts other than for indigent patients ineligible for Medicaid) divided by the total charges for inpatient services.

- (3) A Medicaid inpatient utilization rate greater than or equal to one percent.

C. Determination of hospital disproportionate share groups for payment distribution

Hospitals determined to be disproportionate share as described above will be classified into one of four three tiers for payment distribution based on the data described in paragraph a-(A) above. The tiers are described below:

- (1) Tier one includes all hospitals deemed to be disproportionate share hospitals based on a low-income utilization rate greater than 25% but less than 40%, or hospitals with a low-income utilization rate less than or equal to 25% that are deemed a disproportionate share hospital based on a Medicaid inpatient utilization rate that is one standard deviation above the mean Medicaid inpatient utilization rate for all hospitals receiving Medicaid payments in the state.
- (2) Tier two includes all hospitals deemed to be disproportionate share hospitals based on a low-income utilization rate greater than or equal to 40% but less than 50%.

- (3) Tier three includes all hospitals deemed to be disproportionate share hospitals based on a low-income utilization rate greater than or equal to 50% ~~but less than 60%.~~
- ~~(4) Tier four includes all hospitals deemed to be disproportionate share hospitals based on a low-income utilization rate greater than or equal to 60%.~~

D. Distribution of funds within each hospital tier

The funds available in a tier are distributed among hospitals in that tier according to the payment formulas described below. Hospitals will be distributed a payment amount based on the lesser of their uncompensated care costs or their disproportionate share payment. Uncompensated care costs are defined as total inpatient allowable costs less insurance revenues, self-pay revenues, total Medicaid revenues and uncompensated care costs rendered to patients with insurance for the service provided. Each hospital's disproportionate share payment is calculated on a tier-specific basis as follows:

Hospital specific uncompensated care Costs /	X	Disproportionate share funds available for distribution in the tier
Sum of uncompensated care costs for all hospitals in the tier		

(1) Funds available for distribution by tier.

- (a) Tier 1. A maximum of ~~5%~~ 10% of the disproportionate share funds will be distributed to the hospitals in tier one.

If no hospitals fall into tier one, or all funds are not distributed, then undistributed funds from tier one will be added to the funds available for distribution in tier ~~four~~ three.

- (b) Tier 2. A maximum of ~~25%~~ 30% of the disproportionate share funds will be distributed to hospitals in tier two.

If no hospitals fall into tier two, or all funds are not distributed, then undistributed funds will be added to the funds available for distribution in tier ~~four~~ three.

- (c) Tier 3. A ~~maximum~~ minimum of ~~45%~~ 60% of the disproportionate share funds will be distributed to hospitals in tier three.

~~If no hospitals fall into tier three, or all funds are not distributed, then undistributed funds will be added to the funds available for distribution in tier four.~~

- ~~(d) Tier 4. A minimum of 40% of the disproportionate share funds will be distributed to hospitals in tier four.~~

(2) Payment distribution

Each hospital will be distributed a payment amount based on the lesser of their:

- (a) Uncompensated care costs; or
- (b) Disproportionate share payment amount.

E. Disproportionate share funds

The maximum amount of disproportionate share funds available for distribution to psychiatric hospitals will be determined by subtracting the funds distributed in accordance with rule 5101:3-2-09 of the administrative code from the state's disproportionate share limit as described in subparagraph (f) of section 1923 of the Social Security Act, 49 Stat. 620 (1935), 42 USC 1396-r-4 (f), as amended.

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1. Inpatient Hospital Services.

There may be positive or negative incentive payments, based on provider performance for episodes of care as described in Supplement 1 to Attachment 4.19-A.