Ohio | Department of Medicaid

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Hospital Handbook Transmittal Letter (HHTL) 3352-20-03

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TO: **All Hospital Providers**
Directors, County Departments of Job and Family Services

FROM: **Maureen Corcoran, Director**

SUBJECT: **Hospital Cost Coverage Add-on**

Summary

This Hospital Handbook Transmittal Letter (HHTL) provides information pertaining to the cost coverage add-on rule, Ohio Administrative Code (OAC) rule 5160-2-60, which has been amended effective July 1, 2020.

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

This rule has been amended for the following: (1) In paragraph (A), removed paragraph (A)(3) since this data element is no longer being used in the cost coverage add-on calculation and added paragraphs (A)(6) and (A)(7), to define total Medicaid inpatient charges and total Medicaid outpatient charges, respectively. (2) In paragraph (C)(5), updated a paragraph reference. (3) In paragraph (F)(3), removed language that no longer applies. (4) In paragraph (F)(4), removed a paragraph reference. (5) In paragraphs (G)(1) and (G)(2), updated paragraph references. (6) In paragraph (G)(3), removed language that no longer applies. (7) In paragraph (G)(4), removed a paragraph reference. (8) In paragraph (H)(1), updated the language on how total inpatient payments are calculated. (9) In paragraphs (H)(2) and (H)(4), updated paragraph references. (10) In paragraph (H)(3), updated language to reference the inpatient payments calculated in paragraph (H)(1). (11) In paragraph (H)(6), updated language to multiply the results in paragraph (H)(5) by the inpatient cost-to-charge ratio described in paragraph (H)(1). (12) In paragraph (H)(7), original language was stricken and replaced with language that adds the cost coverage add-on increase to the inpatient-cost-to-charge ratio and also added language to specify which inpatient cost-to-charge ratio in which to apply the cost coverage add-on increase. (13) In paragraph (I)(1), updated

the language on how total outpatient payments are calculated. (14) In paragraphs (I)(2) and (I)(4), updated paragraph references. (15) In paragraph (I)(3), updated language to reference the outpatient payments calculated in paragraph (I)(1). (16) In paragraph (I)(6), updated language to multiply the results in paragraph (I)(5) by the outpatient cost-to-charge ratio described in paragraph (I)(1). (17) In paragraph (I)(7), original language was stricken and replaced with language that adds the cost coverage add-on increase to the outpatient-cost-to-charge ratio and added language to specify which outpatient cost-to-charge ratio to apply the cost coverage add-on increase to. The Department is proposing these technical corrections in paragraphs (H) and (I) to ensure the amounts allocated to hospitals excluded from the non-prospective payment systems are using the most recently available cost report data. (18) In paragraphs (A)(2) and (C)(4) updated the naming convention of a psychiatric hospital from "Low volume psychiatric hospital" to "Freestanding psychiatric hospital," and removed the discharge threshold of less than four hundred Medicaid discharges from the definition of a private psychiatric hospital. By making these revisions, all private freestanding psychiatric hospitals are now eligible for an allocation from the private psychiatric hospital policy pool. (19) In paragraph (D)(3) removed the language that explained what happened when there are no low volume psychiatric hospitals because now all private freestanding psychiatric hospitals will receive allocations from the private freestanding psychiatric hospital policy pool.

Access to Rules and Related Material

Stakeholders who want to receive notification when ODM original or final files a rule package may visit JCARR's RuleWatch at www.rulewatchohio.gov where an account can be created to be notified of rule actions by rule number or department.

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https://www.apps.das.ohio.gov/RegReform/enotify/subscription.aspx

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To access ODM Fee Schedule and Rates, go to medicaid.ohio.gov > Providers > Fee Schedule and Rates > Click "I Agree":

Additional Information

Questions pertaining to this letter should be addressed to:

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