Ohio Administrative Code

Rule 5160-2-05 Classification of hospitals.

Effective: February 9, 2026

(A) Definitions in Chapter 5160-2.

(1) "Cancer hospitals" are hospitals recognized by medicare that primarily treat neoplastic disease in accordance with 42 C.F.R. 412.23(f), effective October 1, 2025.

(2) "Children's hospitals" are hospitals that primarily serve patients eighteen years of age and younger, have at least seventy-five beds, and are excluded from medicare prospective payment in accordance with 42 C.F.R. 412.23(d), effective October 1, 2025, or are licensed with the Ohio department of health in accordance with Chapter 3722 of the Revised Code.

Medicare-defined children's hospitals that do not meet this definition are grouped into their natural rural or urban hospital peer groups as described in paragraphs (A)(8) or (A)(9) of this rule for the purposes of setting base rates but receive pricing considerations or differentials as if they were in the children's hospital peer group.

(3) "Critical access hospitals" (CAH) are hospitals that are certified as a critical access hospitals by the centers for medicare and medicaid services (CMS) and excluded from medicare prospective payment in accordance with 42 C.F.R.485 subpart F, effective October 1, 2025.

(4) "Freestanding long-term acute care hospitals" are hospitals that the department of health and human services has determined to be excluded from medicare prospective payment in accordance with 42 C.F.R. 412.23(e), effective October 1, 2025.

(5) "Freestanding psychiatric hospitals" are hospitals that are eligible to provide medicaid services as described in rule 5160-2-01 of the Administrative Code and are grouped into their natural peer group as described in paragraphs (A)(2), (A)(3), (A)(8), (A)(9), and (A)(10) of this rule.

(6) 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 C.F.R. 412.23(b), effective October 1, 2025.

(7) "Hospital peer groups" are how hospitals are classified into mutually exclusive groups for the purpose of setting rates and making payments under the "All Patient Refined-Diagnosis Related Group" (APR-DRG) inpatient prospective payment system, the "Enhanced Ambulatory Patient Grouping" (EAPG) outpatient prospective payment system, and for the hospitals excluded from the prospective payment systems. The peer groups are:

(a) Critical access hospitals;

(b) Rural hospitals;

(c) Children's hospitals;

(d) Teaching hospitals;

(e) Urban hospitals.

(8) "Rural hospitals" are 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.

(a) Rural hospitals include hospitals certified as rural emergency hospitals by CMS as described in C.F.R. 485 subpart E, effective October 1, 2025.

(b) A copy of the medicare IPPS case-mix and wage index table by CMS certification number (CCN) is available on the department's website at medicaid.ohio.gov.

(9) "Teaching hospitals" are 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. Only non-Ohio hospitals classified by the Ohio department of medicaid (ODM) as teaching hospitals as of June 30, 2016, will be

considered non-Ohio teaching hospitals.

(10) "Urban hospitals" are hospitals located in Ohio counties that are classified into CBSAs, as described in paragraph (A)(8) of this rule. Urban hospitals are grouped based on geographical regions listed in the appendix to this rule and are not otherwise defined in paragraphs (A)(2), (A)(3), (A)(7), (A)(8), and A(9) of this rule.

(11) For the purposes of this rule, 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).

(12) For the purposes of this rule, "interns and residents" is the net number of interns and residents reported on the hospital's SFY 2014 Ohio medicaid hospital cost report (ODM 02930, rev. 06/14).

(B) Ohio hospital prospective payment peer groups.

(1) The following hospitals will be paid on a prospective payment basis for inpatient services as described in rule 5160-2-65 of the Administrative Code

(a) Critical access hospitals;

(b) Rural hospitals, excluding rural emergency hospitals;

(c) Children's hospitals;

(d) Teaching hospitals;

(e)) Urban hospitals.

(2) The following hospitals will be paid on a prospective payment basis for outpatient services, as described in rule 5160-2-75 of the Administrative Code:

(a) Critical access hospitals;

(b) Rural hospitals, including rural emergency hospitals;

(c) Children's hospitals;

(d) Teaching hospitals;

(e) Urban hospitals.

(3) The following hospitals will be paid in accordance with rule 5160-2-22 of the Administrative Code:

(a) Cancer hospitals;

(b) Rehabilitation hospitals;

(c) Long-term acute care hospitals.

(C) Reassignment of hospitals among peer groups.

On January first of each year, peer group classification will be reassigned for any hospital geographically located in an Ohio county that has been newly included or excluded from a CBSA, as described in paragraph (A)(8) of this rule. Affected hospitals will be classified into either the rural peer group or the urban peer group based on the geographic location of the hospital. The hospital's new base rate will be the average cost per discharge of the new peer group without any consideration of hospital-specific risk provisions described in rules 5160-2-65 and 5160-2-75 of the Administrative Code, of either the new or previous peer group.

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

(1) Hospitals new to medicaid.

(a) Hospitals described in paragraph (B)(1) of this rule that are newly enrolled with medicaid, will be classified into mutually exclusive peer groups as defined in paragraph (A) of this rule. Until data is

available to calculate hospital-specific rates, the hospital will receive:

(i) The base rate of the peer group into which they are classified without any consideration for hospital-specific risk provisions as described in rule 5160-2-65 of the Administrative Code for inpatient services,

(ii) The statewide average for capital allowance in accordance with rule 5160-2-66 of the Administrative Code, and

(iii) The statewide average for the inpatient cost-to-charge ratio as described in paragraph (B)(2) of rule 5160-2-22 of the Administrative Code.

(b) Hospitals described in paragraph (B)(2) of this rule that are newly enrolled with medicaid, will be classified into mutually exclusive peer groups, as defined in paragraph (A) of this rule. Until data is available to calculate hospital-specific rates, the hospital will receive:

(i) The base rate of the peer group into which they are classified without any consideration for the hospital-specific risk provisions, as described in rule 5160-2-75 of the Administrative Code for outpatient services, and

(ii) The statewide average for outpatient cost-to-charge ratio, as described in paragraph (B)(2) of the rule 5160-2-22 of the Administrative Code.

(c) Hospitals described in paragraph (B)(3) of this rule that are newly enrolled with medicaid, will receive ninety per cent of the calculated rates described in paragraph (D)(1)(a)(iii) of this rule until data is available to calculate hospital-specific rates in accordance with rule 5160-2-22 of the Administrative Code.

(2) Acquired hospitals.

Hospitals that have a change of ownership will receive the prior owner's rates for reimbursement until a cost report is filed by the new owner in accordance with rule 5160-2-23 of the Administrative Code and rates are calculated in accordance with rule 5160-2-22 of the Administrative Code.

(3) 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 will be used for reimbursement, if the conditions of paragraphs (C)(4)(a) to (C)(4)(c) of rule 5160-2-09 of the Administrative Code are met, and until a cost report is filed by the new owner in accordance with rule 5160-2-23 of the Administrative Code and rates are calculated in accordance with rule 5160-2-22 of the Administrative Code.

(4) Hospital mergers.

When hospitals identifiable by a unique medicaid provider number are involved in a merger, the rates for the surviving medicaid provider number will be used for reimbursement until a cost report is filed in accordance with rule 5160-2-23 of the Administrative Code and rates are calculated in accordance with rule 5160-2-22 of the Administrative Code.