Ohio Administrative Code

Rule 5160-2-60 Hospital cost coverage add-on.

Effective: July 4, 2021

Effective for services or discharges on or after the effective date of this rule, payments made to Ohio hospitals under the prospective payment systems or non-diagnostic related groups (DRG) prospective payment system will receive a cost coverage add-on. The provisions of this rule do not apply to the medicaid maximum allowed amount calculation described in rule 5160-2-25 of the Administrative Code.

(A) Definitions.

(1) "Inpatient case mix" means the sum of the relative weight values for all discharges during the calendar year preceding the calendar year that precedes the state fiscal year (SFY) of the cost coverage add-on divided by the total number of discharges during the same calendar year.

(2) "Freestanding psychiatric hospital" means a privately-owned psychiatric hospital with more than sixteen beds that is eligible to provide medicaid services as described in rule 5160-2-01 of the Administrative Code.

(3) "Outpatient case mix" means the sum of the relative weight values for each enhanced ambulatory patient grouping (EAPG) detail line paid with a relative weight during the calendar year preceding the calendar year that precedes the state fiscal year of the cost coverage add-on divided by the total number of EAPG detail lines paid with a relative weight during the same calendar year.

(4) "Psychiatric Emergency Department (PED)" means a dedicated psychiatric emergency department established prior to October 1, 2019 that is located in a general acute care hospital that does not participate in the care innovation and community improvement program (CICIP).

(5) "Total medicaid inpatient discharges" for each hospital means the sum of medicaid fee for service (FFS) discharges reported on "Ohio Medicaid Hospital Cost Report" ODM 02930, schedule C-1, section I, columns 2 and 3, line 54 for the applicable SFY and medicaid managed care plan (MCP)

discharges reported on ODM 02930, schedule C-1, section I, columns 7 and 8, line 54.

(6) "Total medicaid inpatient charges" for each hospital means the sum of FFS medicaid inpatient charges reported on ODM 02930, schedule H, column 1, line 8 and MCP inpatient charges reported on ODM 02930, schedule I, column 2, line 202.

(7) "Total medicaid outpatient charges" for each hospital means the sum of FFS medicaid outpatient charges reported on ODM 02930, schedule H, column 1, line 16 and MCP outpatient charges reported on ODM 02930, schedule I, column 4, line 202.

(8) "Total medicaid inpatient costs" for each hospital means the sum of FFS medicaid inpatient costs reported on ODM 02930, schedule H, column 1, line 1 and MCP inpatient costs reported on ODM 02930, schedule I, column 3, line 202.

(9) "Total medicaid outpatient costs" for each hospital means the sum of FFS medicaid outpatient costs reported on ODM 02930, schedule H, column 1, line 10 and MCP outpatient costs reported on ODM 02930, schedule I, column 5, line 202.

(10) "Total medicaid outpatient visits" for each hospital means the sum of medicaid FFS visits reported on ODM 02930, schedule C-1, section I, columns 2 and 3, line 56 and medicaid MCP visits reported on ODM 02930, schedule I, column 4, line 205, less the visits described in paragraph (A)(11) of this rule.

(11) "Total Outpatient Hospital Behavioral Health (OPHBH) visits" for each hospital means the sum of FFS OPHBH visits reported on ODM 02930, schedule K, column 1, line 18 and MCP OPHBH visits reported on ODM 02930, schedule K, column 5, line 18.

(B) Source data for calculations

The calculations described in this rule will be based on cost-reporting data described in rule 5160-2-23 of the Administrative Code, which reflects the interim settled Ohio medicaid hospital cost report (ODM 02930) for each hospital's cost reporting period ending in the SFY prior to the SFY that ends immediately preceding the SFY to which the cost coverage add-on will apply. The data policies

described in rules 5160-2-08 and 5160-2-09 of the Administrative Code that use the same cost report data described in this paragraph will apply to the data used for the cost coverage add-on, except for hospitals that have closed or are known to be closing.

(C) The appropriations authorized by the general assembly for each SFY will be divided into the following policy pools:

(1) Inpatient cost coverage standard pool, which is the lesser of 259,229,112.31 dollars or 36.38 per cent of the appropriated funds.

(2) Outpatient cost coverage standard pool, which is the lesser of 168,054,601.29 dollars or 23.59 per cent of the appropriated funds.

(3) Cost coverage sustainability pool is the sum of:

(a) The lesser of 233,000,000.00 dollars or 32.70 per cent of the appropriated funds; and

(b) The greater of 7.33 per cent or the balance of the appropriated funds.

(4) Freestanding psychiatric hospitals as described in paragraph (A)(2) of this rule will receive 1.86 per cent of the amount described in paragraph (C)(3)(b) of this rule.

(5) Hospitals that meet the definition of a PED as described in paragraph (A)(4) of this rule will receive 9,500,000.00 dollars.

(D) Inpatient cost coverage.

(1) Cost coverage standard pool.

(a) From the amount specified in paragraph (C)(1) of this rule, 15,939,479.00 dollars will be allocated to children's hospitals, as defined in rule 5160-2-05 of the Administrative Code, based on the payments made to each children's hospital from funds specifically appropriated by Am. Sub. HB 49 of the 132nd General Assembly.

(b) Each hospital will be allocated from paragraph (C)(1) of this rule, an amount equal to the inpatient non-claims specific lump sum payments not resulting from an alternative payment model or the hospital care assurance program (HCAP) as described in rule 5160-1-70 or 5160-2-09 of the Administrative Code, less the amount allocated in paragraph (D)(1)(a) of this rule.

(c) Any amounts in paragraph (D)(1)(b) of this rule allocated to a closed hospital are reallocated to the remaining hospitals based on the ratio of each hospital's allocation in paragraph (D)(1)(b) of this rule to the sum of the allocation for all remaining hospitals.

(d) For each hospital, sum the amount allocated in paragraphs (D)(1)(a) to (D)(1)(c) of this rule.

(2) Divide ten per cent of the cost coverage sustainability pool described in paragraph (C)(3) of this rule by the total medicaid discharges for all hospitals, then multiply the resulting quotient by the number of total medicaid discharges for each hospital.

(3) For freestanding psychiatric hospitals, divide the amount described in paragraph (C)(4) of this rule by the total medicaid discharges for all freestanding psychiatric hospitals, then multiply the resulting quotient by the number of medicaid discharges for each freestanding psychiatric hospital.

(4) For all hospitals with a PED, divide fifty per cent of the amount described in paragraph (C)(5) of this rule by the total medicaid discharges for all hospitals with a PED, then multiply the resulting quotient by the number of medicaid discharges for each hospital with a PED.

(E) Outpatient cost coverage.

(1) Cost coverage standard pool.

(a) Each hospital will be allocated from paragraph (C)(2) of this rule an amount equal to the outpatient non-claims specific lump sum payments not resulting from an alternative payment model or HCAP as described in rule 5160-1-70 or 5160-2-09 of the Administrative Code.

(b) Any amounts in paragraph (E)(1)(a) of this rule allocated to a closed hospital are reallocated to

the remaining hospitals based on the ratio of each hospital's allocation in paragraph (E)(1)(a) of this rule to the sum of the allocation for all remaining hospitals.

(c) For each hospital, sum the amount allocated in paragraph (E)(1)(a) of this rule and the amount calculated in paragraph (E)(1)(b) of this rule.

(2) Divide ninety per cent of the cost coverage sustainability pool described in paragraph (C)(3) of this rule less the amount described in paragraph (C)(4) of this rule by the total medicaid visits for all hospitals, then multiply the resulting quotient by the number of total medicaid visits for each hospital.

(3) For all hospitals with a PED, divide fifty per cent of the amount described in paragraph (C)(5) of this rule by the total medicaid visits for all hospitals with a PED, then multiply the resulting quotient by the number of medicaid visits for each hospital with a PED.

(F) Inpatient cost coverage add-on amount per discharge for hospitals paid in accordance with rule 5160-2-65 of the Administrative Code.

(1) For each hospital, divide the sum of paragraphs (F)(1)(a) to (F)(1)(b) of this rule by the total medicaid discharges used in the inpatient case-mix calculation as described in paragraph (A)(1) of this rule.

(a) The sum of paragraphs (D)(1) to (D)(4) of this rule.

(b) Any outpatient amounts allocated in paragraphs (E)(1) to (E)(3) of this rule to a freestanding psychiatric hospital.

(2) For each hospital, divide the results in paragraph (F)(1) of this rule by the inpatient case-mix as defined in paragraph (A)(1) of this rule.

(3) The cost coverage add-on per discharge amount is equal to the amount calculated in paragraph (F)(2) of this rule, rounded to two decimal places.

(4) The amount calculated in paragraph (F)(3) of this rule will be added to the hospital's inpatient base rate.

(G) Outpatient cost coverage add-on amount per detail for hospitals paid in accordance with rule 5160-2-75 of the Administrative Code.

(1) For each hospital, divide the sum of paragraphs (E)(1) to (E)(3) of this rule by the total EAPG detail lines used in the outpatient case-mix calculation as described in paragraph (A)(3) of this rule.

(2) For each hospital, divide the results in paragraph (G)(1) of this rule by the outpatient case-mix as defined in paragraph (A)(3) of this rule.

(3) The cost coverage add-on per detail amount is equal to the amount calculated in paragraph (G)(2) of this rule, rounded to two decimal places.

(4) The amount calculated in paragraph (G)(3) of this rule will be added to the hospital's outpatient base rate.

(H) Inpatient cost coverage add-on for hospitals paid in accordance with rule 5160-2-22 of the Administrative Code.

(1) For each hospital, calculate total inpatient payments by multiplying total medicaid inpatient charges as described in paragraph (A)(6) of this rule by the inpatient cost-to-charge ratio described in rule 5160-2-22 of the Administrative Code calculated from the source data described in paragraph (B) of this rule.

(2) For each hospital, divide the amount in paragraph (H)(1) of this rule by the total medicaid inpatient costs as described in paragraph (A)(8) of this rule.

(3) For each hospital, sum the inpatient payments calculated in paragraph (H)(1) of this rule and the amounts distributed in paragraphs (D)(1) to (D)(4) of this rule.

(4) For each hospital, divide the result in paragraph (H)(3) of this rule by the total medicaid inpatient

costs as described in paragraph (A)(8) of this rule.

(5) For each hospital, calculate the inpatient cost coverage increase by subtracting the result in paragraph (H)(2) of this rule from the result in paragraph (H)(4) of this rule and dividing the result by paragraph (H)(2) of this rule, rounded to four decimal places.

(6) For each hospital, multiply the result in paragraph (H)(5) of this rule by the inpatient cost-to-charge ratio calculated in paragraph (H)(1) of this rule.

(7) Apply the amount calculated in paragraph (H)(6) of this rule as an increase to the hospital's inpatient cost-to-charge ratio as follows:

(a) For each July first, the hospital's inpatient cost-to-charge ratio calculated the previous January in accordance with rule 5160-2-22 of the Administrative Code.

(b) For each January first, the hospital's inpatient cost-to-charge ratio as calculated in rule 5160-2-22 of the Administrative Code.

(I) Outpatient cost coverage add-on for hospitals paid in accordance with rule 5160-2-22 of the Administrative Code.

(1) For each hospital, calculate total outpatient payments by multiplying total medicaid outpatient charges as described in paragraph (A)(7) of this rule by the outpatient cost-to-charge ratio described in rule 5160-2-22 of the Administrative Code calculated from the source data described in paragraph (B) of this rule.

(2) For each hospital, divide the amount in paragraph (I)(1) of this rule by the total medicaid outpatient costs as described in paragraph (A)(9) of this rule.

(3) For each hospital, sum the outpatient payments calculated in paragraph (I)(1) of this rule and the distribution pools in paragraphs (E)(1) to (E)(3) of this rule.

(4) For each hospital, divide the result in paragraph (I)(3) of this rule by the total medicaid outpatient

costs as described in paragraph (A)(9) of this rule.

(5) For each hospital, calculate the outpatient cost coverage increase by subtracting the result in paragraph (I)(2) of this rule from the result in paragraph (I)(4) of this rule and dividing the result by paragraph (I)(2) of this rule, rounded to four decimal places.

(6) For each hospital, multiply the result in paragraph (I)(5) of this rule by the outpatient cost-to-charge ratio calculated in paragraph (I)(1) of this rule.

(7) Apply the amount calculated in paragraph (I)(6) of this rule as an increase to the hospital's outpatient cost-to-charge ratio as follows:

(a) For each July first, the hospital's outpatient cost-to-charge ratio calculated the previous January in accordance with rule 5160-2-22 of the Administrative Code.

(b) For each January first, the hospital's outpatient cost-to-charge ratio as calculated in rule 5160-2-22 of the Administrative Code.

(J) To ensure that funds appropriated for the cost coverage add-on are fully expended in support of the intended purpose, the department may make short term adjustments to increase or decrease hospital-specific rates. Such adjustments will be calculated in accordance with the cost coverage sustainability pool as described in paragraphs (D)(2) and (E)(2) of this rule. The number of discharges or visits used to establish a case-mix adjusted hospital-specific rate, may be adjusted to reflect the time period for which the rate will be in effect. Any such adjustments will be developed in consultation with the department's actuary and approved by the medicaid director.