Ohio Administrative Code

Rule 5160-2-65 Inpatient hospital reimbursement.

Effective: July 1, 2024

This rule sets forth the payment policies for inpatient hospital services for discharges on or after the effective date of this rule.

(A) Hospitals defined as eligible providers of hospital services in rule 5160-2-01 of the Administrative Code and grouped in paragraph (B)(1) of rule 5160-2-05 of the Administrative Code are subject to the all patient refined diagnosis related groups (APR-DRG) prospective payment methodology as described in this rule.

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

(1) Children's hospitals as defined in rule 5160-2-05 of the Administrative Code that are located in Ohio.

(2) Children's hospitals as defined in rule 5160-2-05 of the Administrative Code that are not located in Ohio.

(3) Critical access hospitals as defined in rule 5160-2-05 of the Administrative Code that are located in Ohio.

(4) Rural hospitals as defined in rule 5160-2-05 of the Administrative Code that are located in Ohio.

(5) Teaching hospitals as defined in rule 5160-2-05 of the Administrative Code that are located in Ohio.

(6) Teaching hospitals as defined in rule 5160-2-05 of the Administrative Code that are not located

in Ohio.

(7) Urban hospitals as defined in rule 5160-2-05 of the Administrative Code that are located in Ohio.

(8) For purposes of this rule, freestanding psychiatric hospitals (FSPs) as defined in rule 5160-2-05 of the Administrative Code are so named for the implementation of special payment policies as described in this rule.

(9) All other hospitals that are not located in Ohio that are not classified in paragraph (B)(2) or (B)(6) of this rule.

(C) DRG/severity of illness assignment.

(1) Each discharge is assigned a DRG and one of four severity of illness (SOI) factors based upon the date of discharge.

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

(D) Payment formula.

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

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

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

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

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

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

(2) The formula used for per diem payments is described in paragraph (M) of this rule.

(E) Payments under the prospective payment system are made on the basis of a prospectively determined rate as provided in this rule. No year-end retrospective adjustment is made for prospective payments. Except as provided in rules 5160-2-24, 5160-2-13, and 5160-2-40 of the Administrative Code, 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.

(F) Sources for inputs in the payment formula.

(1) 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, 2018 through December 31, 2021;

(b) Cost reports submitted by hospitals to ODM on its medicaid cost report for the hospital years that end in state fiscal years 2019 (ODM 02930 rev. 5/2019), 2020 (ODM 02930 rev. 5/2020), 2021 (ODM 02930 rev. 5/2021) and 2022 (ODM 02930 rev. 5/2022); and

(c) Inflation factors computed for Ohio by a nationally-recognized research firm that computes similar factors for the medicare program. The inflation factors were used to apply an inflationary value to the total cost computed for each case inflating it to December 31, 2023.

(2) The dataset used as inputs in the determination of relative weights consists of:

(a) Inpatient hospital claims with dates of discharge from January 1, 2018 through December 31, 2021;

(b) Cost reports submitted by hospitals to ODM on its medicaid cost report for the hospital years that end in state fiscal years 2019 (ODM 02930 rev. 5/2019), 2020 (ODM 02930 rev. 5/2020), 2021 (ODM 02930 rev. 5/2021) and 2022 (ODM 02930 rev. 5/2022); and

(c) Inflation factors computed for Ohio by a nationally-recognized research firm that computes similar factors for the medicare program. The inflation factors were used to apply an inflationary value to the total cost computed for each case inflating it to December 31, 2023.

(G) Computation of hospital peer group base rates.

(1) The base rate for Ohio children's hospitals is equal to:

(a) Fifty-two and three hundredths per cent of the total inflated costs for the cases assigned to a children's hospital divided by the number of cases assigned to the children's hospital; divided by

(b) The peer group case mix score as calculated in paragraph (G)(5) of this rule.

(2) The base rate for Ohio teaching hospitals as described in rule 5160-2-05 of the Administrative Code is equal to:

(a) Fifty-eight and three tenths per cent of the total inflated costs for the cases assigned to a teaching hospital divided by the number of cases assigned to the teaching hospital; divided by

(b) The peer group case mix score as calculated in paragraph (G)(5) of this rule.

(3) The base rate for each Ohio FSP hospital is equal to:

(a) Ninety and thirty-two hundredths per cent of the total inflated costs for the cases assigned to a hospital divided by the number of cases assigned to the FSP hospital; divided by

(b) The case mix score as calculated in paragraph (G)(6) of this rule.

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

(a) Forty-nine and three tenths per cent of the total inflated costs for the cases assigned to a peer group; divided by the number of cases in the peer group; divided by

(b) The peer group case mix score as calculated in paragraph (G)(5) of this rule.

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

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

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

(6) For non-Ohio hospital peer groups, the peer group base rate is equal to the value assigned to the peer group effective January 1, 2024. For dates of service on or after the effective date of this rule, the amount will be equal to;

(a) For non-Ohio children's hospitals, eighty-seven and thirty-nine hundredths per cent of the base rate in effect on the effective date of this rule for Ohio children's hospitals.

(b) For non-Ohio teaching hospitals, eighty-five and seventy-one hundredths per cent of the base rate in effect on the effective date of this rule for Ohio teaching hospitals.

(c) For all other non-Ohio hospitals, seventy-six and seventy-three hundredths per cent of the base rate in effect on the effective date of this rule of Ohio hospitals that are not considered teaching, children's and psychiatric hospitals.

(7) The statewide per diem rate for each FSP hospital is equal to:

(a) Eighty-nine and six tenths per cent of the total inflated costs for all cases; divided by

(b) The total length of stay (LOS) for all cases.

(8) The FSP peer group per diem rate for each peer group defined in paragraphs (B)(4) and (B)(7) of this rule is equal to:

(a) Between eighty-eight and twenty-nine hundredths per cent and ninety-six and ninety-three hundredths per cent of total inflated costs for all cases, dependent upon the peer group; divided by

(b) The total LOS for all cases within the peer group.

(H) The computation of relative weights for all DRGs is equal to:

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

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

(3) ODM computed two sets of relative weights:

(a) One set of relative weights within the behavioral health and substance use disorder (BH/SUD) DRGs 740-776. The average relative weight within the BH/SUD DRGs was adjusted to eighty per cent of the natural result.

(b) One set of relative weights for acute care DRGs.

(I) Computation of outlier payments.

(1) If a discharge is eligible for an outlier payment, the payment will be equal to eighty per cent of the value of eligible outlier costs.

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

(a) When discharges are submitted for payment by hospitals, the cost of the case is computed as the product of covered billed charges and a hospital-specific medicaid inpatient cost-to-charge ratio as described in rule 5160-2-22 of the Administrative Code.

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

(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 fifty thousand dollars. The fixed outlier threshold for cases other than neonate and tracheostomy billed by hospitals among other peer groups is seventy-five thousand dollars.

(3) For any claim that qualifies for an outlier payment, the final claim payment will be limited to the lesser of covered billed charges or the total payment calculated in paragraph (D)(1) of this rule.

(J) Computation of capital payments.

(1) For Ohio hospitals, a capital allowance will be paid as described in rule 5160-2-66 of the Administrative Code.

(2) For non-Ohio hospitals a capital allowance will be paid as described in rule 5160-2-66 of the Administrative Code.

(K) Computation of medical education payments.

(1) For Ohio hospitals, a medical education allowance will be paid as described in rule 5160-2-67 of the Administrative Code.

(2) For non-Ohio hospitals, the calculated base rate as described in paragraph (G)(6) of this rule includes an allowance for medical education.

(L) 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 ODM.

(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 ODM. Reimbursement is further contingent upon:

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

(b) Compliance with the performance standards described in agency 3701 of the Administrative Code, and the performance of ten autologous or ten allogeneic bone marrow transplants, dependent on which volume criteria is appropriate for the transplant requested.

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

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

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

(b) The product of the covered billed charges times the hospital-specific, medicaid inpatient cost-to-charge ratio as described in rule 5160-2-22 of the Administrative Code, if the donor is not a medicaid recipient.

(M) Other payment policies.

(1) A claim for inpatient services qualifies for interim payment on the thirtieth day of a consecutive inpatient stay and at thirty-day intervals thereafter. Under interim payment, hospitals will be paid on

a percentage basis of charges. The percentage will represent the hospital-specific medicaid inpatient cost-to-charge ratio as described in rule 5160-2-22 of the Administrative Code. For those hospitals which do not file a cost report under the provisions of rule 5160-2-23 of the Administrative Code, the statewide average medicaid inpatient cost-to-charge ratio as described in rule 5160-2-22 of the Administrative Code will be used. Interim payments are made as a credit against final payment of the final discharge bill. Amounts of difference between interim payment made and the prospective payment described in paragraph (A) of this rule for the final discharge will be reconciled when the final discharge bill is processed.

(2) Payments for transfers as defined in rule 5160-2-02 of the Administrative Code are subject to the following provisions. If a hospital paid under the prospective payment system transfers an inpatient to another hospital or receives an inpatient from another hospital and that transfer is appropriate as defined in rule 5160-2-13 of the Administrative Code, then each hospital is paid a per diem rate for each day of the patient's stay in that hospital, plus capital, medical education and outlier allowances, as applicable, not to exceed, for nonoutlier cases, the final prospective payment rate that would have been paid for the appropriate DRG/SOI as described in paragraph (D) of this rule. When a patient is transferred, ODM's payment is based on the DRG/SOI under which the patient was treated at each hospital.

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

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.

Transfers received by or discharging from a freestanding psychiatric hospital are not subject to the provisions of paragraph (M)(2) of this rule. 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 paragraph (M)(2) of this rule, provided that the discharge status does not indicate transfer.

(3) The per diem rates for the FSPs are calculated based on the sum of all the amounts calculated in paragraph (D) of this rule plus the eligible hospital specific add-on amounts in accordance with rule 5160-2-60 of the Administrative Code, divided by the total days for these claims in the rate setting database. As a transitional step, FSPs may be paid the resulting value in accordance with paragraph (D) of this rule.

The FSP per diem payment is calculated by multiplying each covered billed day by the per diem rate as described in paragraph (G) of this rule.

(4) In instances when a recipient's eligibility begins after the date of admission to the hospital or is terminated during the course of a hospitalization, payment will be made on a per diem basis as described in paragraph (M)(2) of this rule plus the allowance for capital, medical education and outliers, as applicable.

(5) Readmissions are defined in rule 5160-2-02 of the Administrative Code. A readmission within one calendar day of discharge, to the same institution, is considered to be one discharge for payment purposes so that one DRG payment is made. If two claims are submitted, the second claim processed will be rejected. In order to receive payment for the entire period of hospitalization, the hospital will need to submit an adjustment claim reflecting services and charges for the entire hospitalization.

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

(N) Adjustments to relative weights.

(1) In accordance with section 5164.721 of the Revised Code, long-acting reversible contraceptive (LARC) devices may be billed and paid separately when provided during an inpatient hospitalization.

(2) In accordance with section 5164.072 of the Revised Code, the relative weights for neonate DRGs 580-640 with an SOI of major or extreme, as calculated in paragraph (H) of this rule, were increased by five and thirteen hundredths per cent to provide for enhanced payments for donor breast milk and

milk fortifiers.