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State/Territory Name: OH

State Plan Amendment (SPA) #: 23-0037

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

Financial Management Group

February 5, 2024

Maureen Corcoran, Director
Ohio Department of Medicaid
50 West Town Street, Suite 400
Columbus, Ohio 43215

RE: Ohio State Plan Amendment (SPA) 23-0037

Dear Ms. Corcoran:

We have reviewed the proposed amendment to Attachments 4.19-A of your Medicaid State plan submitted under transmittal number 23-0037 titled "Payment for Services - Inpatient Hospital Reimbursement and Capital Costs."

We conducted our review of your submittal according to the statutory requirements at sections 1902(a)(2), 1902(a)(13), 1902(a)(30), 1903(a), and 1923 of the Social Security Act and the implementing Federal regulations at 42 CFR 447 Subpart C. We have found that the proposed reimbursement methodology complies with applicable requirements and therefore have approved them with an effective date of January 1, 2024. We are enclosing the CMS-179 and the amended approved plan pages.

If you have any questions, please contact Fredrick Sebree at Fredrick.Sebree@cms.hhs.gov.

Sincerely,

[redacted]

Rory Howe
Director

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB No. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 23-0037

2. STATE: OH

3. PROGRAM IDENTIFICATION: TITLE OF THE SOCIAL SECURITY ACT: (●) XIX ( ) XXI

TO: CENTER DIRECTOR
CENTERS FOR MEDICAID & CHIP SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
January 1, 2024

5. FEDERAL STATUTE/REGULATION CITATION
42 CFR 447 Subpart C

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)
a. FFY 24 $ 8,696,248
b. FFY 25 $ 11,505,978

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
Attachment 4.19-A pages 1-6 thru 1-9
Attachment 4.19-A page 1-11
Attachment 4.19-A page 1-13
Attachment 4.19-A page 1-18
Attachment 4.19-A page 1-20, 1-21

8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
Attachment 4.19-A pages 1-6 thru 1-9 (TN 18-021)
Attachment 4.19-A page 1-11 (TN 17-029)
Attachment 4.19-A page 1-13 (TN 17-029)
Attachment 4.19-A page 1-18 (TN 17-029)
Attachment 4.19-A page 1-20, 1-21 (TN 22-005)

9. SUBJECT OF AMENDMENT

Payment for Services - Inpatient Hospital Reimbursement and Capital Costs

10. GOVERNOR'S REVIEW *(Check One)*

( ) GOVERNOR'S OFFICE REPORTED NO COMMENT
( ) COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
( ) NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
(●) OTHER, AS SPECIFIED:
The State Medicaid Director is the Governor's designee

11. SIGNATURE OF STATE AGENCY OFFICIAL
[redacted]

12. TYPED NAME: **MAUREEN M. CORCORAN**

13. TITLE: **STATE MEDICAID DIRECTOR**

14. DATE SUBMITTED
November 21, 2023

15. RETURN TO

Greg Niehoff
Ohio Department of Medicaid
P.O. BOX 182709
Columbus, Ohio 43218

FOR CMS USE ONLY

16. DATE RECEIVED
11/21/2023

17. DATE APPROVED
February 5, 2024

PLAN APPROVED - ONE COPY ATTACHED

18. EFFECTIVE DATE OF APPROVED MATERIAL
1/1/2024

19. SIGNATURE OF APPROVING OFFICIAL
[redacted]

20. TYPED NAME OF APPROVING OFFICIAL
Rory Howe

21. TITLE OF APPROVING OFFICIAL
Director, FMG

22. REMARKS

Instructions on Back

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, 2018 through December 31,2021;

(b) Cost reports submitted by Ohio hospitals to the State on its Medicaid cost report for the hospital years that end in state fiscal years2019, 2020, 2021 and 2022; 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 December 31, 2023.

(4) The dataset used as inputs in the determination of relative weights consist of:

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

(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 2019, 2020, 2021 and 2022; and

(c) Inflation factors computed for Ohio by a nationally-recognized research firm that 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 December 31, 2023.

(5) Computation of hospital peer group base rates.

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

(i) Fifty-two and three hundredths 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)(e) of this section.

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

(i) Fifty-eight and three tenths 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)(e) of this section.

(c) The base rate for each Ohio Free-Standing Psychiatric (FSP) hospital is equal to:

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

(ii) The case mix score as calculated in subsection (A)(5)(e) of this section.

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

(i) Forty-nine and three tenths 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)(e) of this section, except for hospitals described in subsection (A)(5)(d)(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.

(e) 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.

(f) For non-Ohio hospital peer groups, effective for dates of discharge on or after January 1, 2024, the peer group base rate is equal to;

(i) For non-Ohio children's hospitals, 87.39% of the base rate in effect on the effective date of this section for Ohio children's hospitals.
(ii) For non-Ohio teaching hospitals, 85.71% of the base rate in effect on the effective date of this section for Ohio teaching hospitals.
(iii) For all other non-Ohio hospitals, 76.73% 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.

(g) The statewide per diem rate for Free Standing Psychiatric (FSP) hospitals is equal to:

(i) 89.6% of the total inflated costs for all cases; divided by
(ii) The total length of stay (LOS) for all cases.

(h) The FSP peer group per diem rate for each peer group defined in Attachment 4.19-A, section I, subsections (B)(2)(b) and (B)(2)(g) of this section is equal to:

(i) Between 88.29% and 96.93% of total inflated costs for all cases, dependent upon the peer group; divided by
(ii) The total LOS for all cases within the peer group.

(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.

(iii) 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.

(b) Long-acting reversible contraceptive (LARC) devices may be billed and paid separately when the device is provided postpartum during an inpatient hospitalization.

(c) The relative weights for neonate DRGs 580-640 with an SOI of major or extreme, as calculated in this section, were increased by 5.13% to provide for enhanced payments for donor breast milk and milk fortifiers.

(7) A table of the calculated base rates and relative weights are published on the department's website, https://medicaid.ohio.gov/resources-for-providers/billing/fee-schedule-and-rates/fee-schedule-and-rates.

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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.

(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.

(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 2016 and filed in accordance with CMS instructions, available at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals.html (revised June 2022).

(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 the sum of Medicaid inpatient charges to total charges; and dividing the result by the sum of 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 will 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 the sum 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 will 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.

(F) Computation of Outlier Payments

(1) If a discharge is eligible for an outlier payment, the payment will be equal to 80% 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 $50,000. 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.

(H) Other Payment Policies

(1) A claim for inpatient services qualifies for interim payment on the 30th 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.

(2) 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.

(3) 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.

(4) Transfers received by or discharging from a freestanding psychiatric (FSP) hospital are not subject to the provisions of subsection (H)(2) 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)(2) of this section, provided that the discharge status does not indicate transfer.

(5) The per diem rates for the FSPs are calculated based on the sum of all the amounts calculated in paragraph (C) of this subsection plus the eligible hospital specific add-on amounts in Attachment 4.19-A, section VI, subsections (B)-(F), 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 (C) of this subsection.

The FSP per diem payment is calculated by multiplying each covered billed day by the per diem rate as described in Attachment 4.19-A, section II, subsection (A)(5)(h).

(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)(2) 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, https://medicaid.ohio.gov/resources-for-providers/billing/fee-schedule-and-rates/fee-schedule-and-rates. 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.