Ohio Administrative Code

Rule 5160-2-05 Classification of hospitals.

Effective: May 11, 2023

This rule describes how hospitals are classified into mutually exclusive peer groups for purposes 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 or to those hospitals excluded from the prospective payment systems.

(A) Definitions.

(1) "Cancer hospitals" are those hospitals recognized by medicare that primarily treat neoplastic disease in accordance with 42 C.F.R. 412.23(f) effective October 1, 2022.

(2) "Children's hospitals" are those hospitals that primarily serve patients eighteen years of age and younger and that are excluded from medicare prospective payment in accordance with 42 C.F.R. 412.23(d) effective October 1, 2022, or are registered with the Ohio department of health in accordance with section 3701.07 of the Revised Code. A children's hospital that has less than seventy-five beds and enrolled as a medicaid provider on or after January 1, 2011, will:

(a) For the purposes of setting base rates, for inpatient services as described in rule 5160-2-65 of the Administrative Code and outpatient services as described in rule 5160-2-75 of the Administrative Code, be grouped into its natural rural or urban hospital peer group as described in paragraph (A)(7) or (A)(9) of this rule; and

(b) Receive any pricing considerations or differentials as if they were in the children's hospital peer group.

(3) "Critical access hospitals" (CAH) are those hospitals that are certified as a critical access hospital by the centers for medicare and medicaid services (CMS) and excluded from medicare prospective payment in accordance with 42 C.F.R. 400.202 effective October 1, 2022.

(4) "Freestanding long-term acute care 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(e) effective October 1, 2022.

(5) ."Freestanding psychiatric hospitals" are those 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 defined in paragraphs (A)(2), (A)(3), (A)(7), (A)(8), and (A)(9) 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, 2022.

(7) "Rural hospitals" are those 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 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.

(8) "Teaching hospitals" are those 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. For non-Ohio hospitals, only those hospitals classified by the Ohio department of medicaid (ODM) as teaching hospitals as of June 30, 2016, will be considered non-Ohio teaching hospitals.

(9) "Urban hospitals" are those hospitals located in Ohio counties that are classified into CBSAs as designated in the 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, and not otherwise defined in paragraphs (A)(2), (A)(3), (A)(7), and (A)(8) of this rule.

(10) 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).

(11) 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.

(B) Ohio hospital prospective payment peer groups.

(1) Hospitals described in paragraphs (B)(1)(a) to (B)(1)(e) of this rule will be paid on a prospective payment basis for inpatient services as described in rule 5160-2-65 of the Administrative Code and for outpatient services as described in rule 5160-2-75 of the Administrative Code.

(a) Critical access hospitals;

(b) Rural hospitals;

(c) Children's hospitals;

(d) Teaching hospitals;

(e) Urban hospitals, which are grouped based on geographical regions listed in the appendix to this rule.

(2) Hospitals described in paragraphs (B)(2)(a) to (B)(2)(c) of this rule 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, any hospital geographically located in an Ohio county that has been newly included or newly excluded from a CBSA, as designated in the 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, will be placed into either the rural peer group as defined in paragraph (A)(7) of this rule or, based on the geographical location of the hospital, an urban peer group as defined in paragraph (A)(9) of this rule, for the new classification. The hospital's new base rate will be the average cost per discharge of the new peer group without any consideration for hospital-specific risk provisions, as described in rule 5160-2-65 of the Administrative Code and rule 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 in which they are classified into without any consideration for hospital-specific risk provisions as described in rule 5160-2-65 of the Administrative Code for inpatient services and rule 5160-2-75 of the Administrative Code for outpatient 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 both inpatient cost-to-charge ratio and outpatient 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 receive ninety per cent of the calculated rates as 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.