Ohio Administrative Code

Rule 5160-2-22 Non-DRG prospective payment for hospital services.

Effective: December 5, 2019

This rule applies to all hospital services excludedfrom the inpatient hospital and outpatient hospital prospective paymentsystems.

(A) Applicability.

(1) Cost-related reimbursement, where payments are made for services to approximate cost based on a historical cost-to-charge ratio, and where no subsequent reconciliation occurs, applies to:

(a) All outpatient hospital services provided by hospitals excluded from outpatient prospective payment as set forth in rule 5160-2-05 of the Administrative Code.

(b) All inpatient hospital services provided by hospitals excluded from inpatient prospective payment as set forth in rule 5160-2-05 of the Administrative Code.

(B) Payments under non-DRG prospective payment.

(1) Payments for services subject to non-DRG prospective payment are made by applying a historic cost-to-charge ratio to hospital allowed charges.

(a) For outpatient services, the ratio used is medicaid outpatient costs as reported on ODM 02930, schedule H, section II divided by medicaid outpatient charges as reported on ODM 02930, schedule H, section II. For inpatient hospital services, the ratio used is 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.

(b) For those hospitals which do not file the ODM 02930 cost-report, the ratio used is the statewide average. For outpatient services, the ratio used is the sum of medicaid outpatient costs as reported on ODM 02930, schedule H, section II for all Ohio hospitals, divided by the sum of medicaid outpatient

charges as reported on ODM 02930, schedule H, section II for all Ohio hospitals. For inpatient hospitals services, the ratio used is the sum of medicaid inpatient costs as reported on the ODM 02930, schedule H, section I for all Ohio hospitals, divided by the sum of medicaid inpatient charges as reported on the ODM 02930, schedule H, section I for all Ohio hospitals.

(c) The ratio used for a claim payment will be the ratio that is operational in the claims processing system on the date the claim is paid and effective on the date of admission. The ratios which are operational during a prospective rate year in the claims processing system reflect data from each hospital's cost-report filed with the department during the calendar year proceeding the year during which the prospective rate year begins.

(2) For hospitals subject to non-DRG prospective payment, the historical cost-to-charge ratio described in paragraph (B)(1) of this rule shall be either:

(a) Ninety per cent of the calculated cost-to-charge ratio for freestanding rehabilitation hospitals and freestanding long-term acute care hospitals, as defined in rule 5160-2-05 of the Administrative Code; or

(b) Ninety-one and seven tenths per cent of the calculated cost-to-charge ratio for cancer hospitals, as defined in rule 5160-2-05 of the Administrative Code.

(C) In general, reasonable cost reimbursement recognizes costs that are reasonable and allowable under Title XVIII standards and principles described in 42 C.F.R 413.1 to 413.40 effective as of October 1, 2018, except as otherwise provided in this paragraph. These Title XVIII standards and principles are applicable to those covered inpatient and outpatient hospital services as identified in Chapter 5160-2 of the Administrative Code which are subject to cost-related reimbursement as described in this rule.

(1) The costs identified in paragraphs (C)(1)(a) to (C)(1)(f) of this rule are nonallowable.

(a) Cost of goods or services furnished free, by the hospital, or at less than fair market value. For example, the cost of office space or hospital employee time used to prepare physician invoices for physicians who invoice the department on a fee-for-service basis.

(b) Cost of services not reimbursable due to not having been billed timely as defined in rule 5160-1-19 of the Administrative Code.

(c) Cost of services which would be or are covered by a third-party payer as described in rule 5160-1-08 of the Administrative Code.

(d) The amount of any interest expense for money borrowed to alleviate cash flow problems resulting from rate reductions imposed for delinquent filing of cost reports as provided in rule 5160-2-23 of the Administrative Code.

(e) The amount of any interest on overpayments and any interest expense for money borrowed to alleviate cash flow problems resulting from an interest assessment as defined in rule 5160-1-25 of the Administrative Code.

(f) Costs which exceed limits described in 42 C.F.R. 413.30 effective as of October 1, 2018 except that the department may exempt certain facilities from these limits as described in 42 C.F.R. 413.30. The determinations to exempt facilities according to 42 C.F.R. 413.30 will be made during the final settlement process.

(2) Provisions of Title XVIII related to prospective payment for inpatient hospital services as described in 42 C.F.R. 412.1 to 412.125 effective as of October 1, 2018 are not applicable to hospital services reimbursed under the provisions of this rule. Hospital services described in this rule are reimbursed under the provisions described in paragraphs (C) to (C)(1)(f) of this rule except in instances when those regulations have been altered to accommodate the Title XVIII prospective payment system.