

SENT BY: MEDICAID POLICY

: 12- 9- 2 : 9:57AM : HEALTH PLAN POLICY-

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DEPARTMENT OF HEALTH AND HUMAN SERVICES  
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED  
OMB NO. 0938-0193

**TRANSMITTAL AND NOTICE OF APPROVAL OF  
STATE PLAN MATERIAL**

1. TRANSMITTAL NUMBER:  
02-025

2. STATE  
OHIO

FOR: CENTERS FOR MEDICAID AND MEDICAID SERVICES

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

TO: REGIONAL ADMINISTRATOR  
HEALTH CARE FINANCING ADMINISTRATION  
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE  
January 1, 2003

5. TYPE OF PLAN MATERIAL (Check One):

NEW STATE PLAN

AMENDMENT TO BE CONSIDERED AS NEW PLAN

AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)

6. FEDERAL STATUTE/REGULATION CITATION:  
42 CFR part 441 - Subpart C; 42 CFR Part 441 - Subpart D; 42 CFR  
part 447 - Subpart C

7. FEDERAL BUDGET IMPACT:  
a. FFY 2003 \$ (7,061,225)  
b. FFY 2004 \$ 26,542,901

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:  
Rule 5101:3-2-07.4

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION  
OR ATTACHMENT (if Applicable):  
Rule 5101:3-2-07.4

10. SUBJECT OF AMENDMENT:

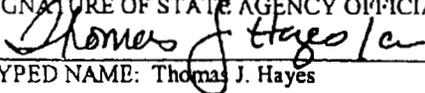
Hospital Inpatient Payment Rates

11. 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:

12. SIGNATURE OF STATE AGENCY OFFICIAL:



13. TYPED NAME: Thomas J. Hayes

14. TITLE: Director

15. DATE SUBMITTED: December 2002

16. RETURN TO:

Becky Jackson  
ODJFS/BHPP  
30 E. Broad St. 27<sup>th</sup> floor  
Columbus, OHIO 43215-3414

**FOR REGIONAL OFFICE USE ONLY**

17. DATE RECEIVED:  
12/09/02

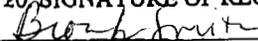
18. DATE APPROVED:  
3/4/03

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:

1/1/03

20. SIGNATURE OF REGIONAL OFFICIAL:



21. TYPED NAME:  
CHARLENE BROWN

22. TITLE:  
Deputy Director, CMSO

23. REMARKS:

Bob Taft  
Governor

Tom Hayes  
Director



30 East Broad Street • Columbus, Ohio 43215  
www.state.oh.us/odjfs

November 27, 2002

Ms. Gwendolyn Sampson,  
Division of Medicaid and Insurance Oversight  
Centers for Medicare and Medicaid Services  
233 North Michigan Avenue, Suite 600  
Chicago, Illinois 60601

Attn: Yvonne Dyson, Assistant

Subject: Transmittal Number 02-025, basic methodology for determining prospective payment rates

Dear Ms. Sampson

Enclosed is State Plan Amendment Transmittal Number 02-025. This transmittal replaces rule 5101:3-2-07.4 found in Appendix A of Attachment 4.19-A of the State Plan. The changes in this amendment result in a delay of the inpatient inflationary update from January 1, 2003 until June 1, 2003.

Rule 5101:3-2-07.4 entitled "Basic methodology for determining prospective payment rates" describes the methodology for determining prospective payment rates for inpatient hospital services and sets the annual inflationary update. This rule is being proposed for amendment on a permanent basis and also proposed for amendment on an emergency basis to be effective January 1, 2003.

This rule inflates inpatient hospital rates for hospitals subject to the DRG prospective payment system by market basket minus 1.0 percent (inflation is 3.9 percent, yielding a rate adjustment of 2.9 percent) for the rate period beginning January 1, 2003. The amendment to the rule proposed on an emergency and permanent basis would delay this rate update until June 1, 2003. This proposed change essentially holds inpatient hospital rates at the calendar year (CY) 2002 levels for the first five months of CY 2003, and then provides for the 2.9 percent rate increase on June 1, 2003. Proposed changes are intended to contain the rate of increase in inpatient hospital reimbursement rates in light of the resources available to the State. The department estimates that delaying this rate update would result in decreased spending on inpatient hospital services of \$ 7,061,225 federal funds in FFY 2003 and an slower increase in spending for FFY 2004, at \$26,542,901 federal funds.

An Equal Opportunity Employer

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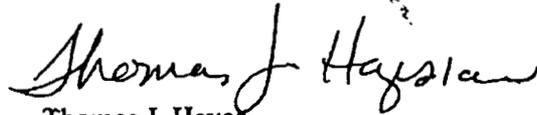
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Gwendolyn Sampson  
November 27, 2002  
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I would also like to call your attention to attached rule 5101:3-2-07.4 which has been proposed for filing. While the comment "ACTION: Original ... DATE: 11/22/2002 9:33 A.M." appears as a header, this comment is generated by the state's new electronic rule filing software. We shall provide you with a copy of the final filed and effective rule when it becomes available.

Please contact Ogbe Aideyman at (614) 728-8435 or [aideyo@odifs.state.oh.us](mailto:aideyo@odifs.state.oh.us) if additional information is needed.

Sincerely,



Thomas J. Hayes  
Director

Enclosures

R:\OMBMP\Hospital Rules\SPA 02-025\spa02-025 letter.wpd

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ACTION: Original

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LEGAL NOTICE
STATE OF OHIO
DEPARTMENT OF JOB AND FAMILY SERVICES

PURSUANT TO SECTIONS 5111.02 AND CHAPTER 119. OF THE OHIO REVISED CODE AND 42 CFR 447.205 AND SECTION 1902(a)(13)(A) OF THE SOCIAL SECURITY ACT, THE DIRECTOR OF THE DEPARTMENT OF JOB AND FAMILY SERVICES GIVES NOTICE OF THE DEPARTMENT'S INTENT TO AMEND RULE 5101:3-2-074 ON A PERMANENT BASIS, AND AN EMERGENCY BASIS TO BE EFFECTIVE DECEMBER 31, 2002, AND OF A PUBLIC HEARING THEREON.

Rule 5101:3-2-074 entitled "Basic methodology for determining prospective payment rates" describes the methodology for determining prospective payment rates for inpatient hospital services and sets the annual inflationary update. This rule is being proposed for amendment on a permanent basis and also proposed for amendment on an emergency basis to be effective December 31, 2002, to delay until June 1, 2003, the inpatient inflationary update that would have taken effect January 1, 2003.

This rule inflates inpatient hospital rates for hospitals subject to the DRG prospective payment system by market basket minus 1.0 percent (inflation is 3.9 percent, yielding a rate adjustment of 2.9 percent) for the rate period beginning January 1, 2003. This amendment to the rule proposed on an emergency and permanent basis would delay this rate update until June 1, 2003. This proposed change essentially holds inpatient hospital rates at the calendar year (CY) 2002 levels for the first five months of CY 2003, and then provides for the 2.9 percent rate increase on June 1, 2003. Proposed changes are intended to contain the rate of increase in inpatient hospital reimbursement rates in light of the current rates paid and the resources available to the State. The department estimates that delaying this rate update would result in decreased spending on inpatient hospital services of \$12.83 million in CY 2003. The rates that will result from this amendment are available upon request by calling the Hospital Unit of the Bureau of Health Plan Policy at 614-466-6420.

A copy of the proposed and emergency rule is available for review in each county department of job and family services and also at http://www.state.oh.us/odjfs/legal/index.htm.

A copy of the rules is also available without charge at the address listed below. A public hearing on the proposed and emergency rules will be held on December 23, 2002 at 10:00A.M. until all testimony is heard in the Rhodes Lobby Tower Conference Room, 30 East Broad Street, Columbus, Ohio. Either written or verbal testimony on the proposed rules will be taken at the public hearing. Additionally, the department urges the submission of written comments as soon as possible; written comments submitted by December 23, 2002 will be treated as testimony.

Requests for a copy of the rules or comments on them should be submitted by mail to "Ohio Department of Job and Family Services, Office of Legal Services, 30 East Broad Street, 31st Floor, Columbus, Ohio 43266-0423", by fax at (614) 752-8298, or by e-mail at "public\_records@odjfs.state.oh.us". Written comments received may be reviewed at the Department at the address listed above.

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5101:3-2-07.4 Basic methodology for determining prospective payment rates.

(A) General description.

Except as provided in paragraph (B) of this rule, in computing the payment rate, the average cost per discharge determined and adjusted as described in paragraphs (D) to (G)(3)(b) of this rule is multiplied by the relative weight for the DRG as described in rule 5101:3-2-07.3 of the Administrative Code. Applicable allowances for capital and medical education, as described in this rule, are added after the average cost per discharge component is multiplied by the relative weight. The components of the prospective payment rates for each recipient discharged from a hospital are:

- (1) The DRG assigned to that discharge;
- (2) The adjusted inflated average cost per discharge component described in paragraphs (D) to (G)(3)(b) of this rule;
- (3) Relative weights defined in rule 5101:3-2-07.3 of the Administrative Code for each DRG;
- (4) An allowance for capital described in rule 5101:3-2-07.6 of the Administrative Code;
- (5) For certain hospitals, a medical education allowance as described in rule 5101:3-2-07.7 of the Administrative Code.

(B) Payment rates.

Payment rates consist of the components described in paragraphs (A) to (A)(5) of this rule, subject to special payment provisions for certain types of cases, as described in rules 5101:3-2-07.9 and 5101:3-2-07.11 of the Administrative Code.

(C) Determination of average cost per discharge component.

- (1) For children's hospitals as defined in rule 5101:3-2-07.2 of the Administrative Code, the average cost per discharge component is one hundred per cent hospital specific and is determined in accordance with paragraphs (D) to (G)(3)(b) of this rule.
- (2) For out-of-state hospitals for discharges on or after July 1, 1990, the average cost per discharge component is determined in accordance with the methodology described in paragraphs (C)(1) to (C)(3)(b) of rule

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5101:3-2-07.2 of the Administrative Code.

- (3) For hospitals other than those identified in paragraphs (C)(1) and (C)(2) of this rule, the average cost per discharge component will be one hundred per cent of the peer group average costs per discharge determined in accordance with paragraphs (E) to (G)(3)(a) of this rule using the peer groups defined in rule 5101:3-2-07.2 of the Administrative Code.

(D) Calculation of hospital-specific adjusted average cost per discharge.

Unless otherwise indicated, two types of source documents are used to obtain information needed to calculate the hospital-specific average cost per discharge defined in this rule. Those documents are the ODHS 2930 "Cost Report" and the HCFA 2552-85, as submitted to the department as required in rule 5101:3-2-23 of the Administrative Code. The ODHS 2930 will be adjusted by the department in accordance with rules 5101:3-2-22, 5101:3-2-23, and 5101:3-2-24 of the Administrative Code using data made available to the department as of June 15, 1987. The documents used are those reflecting costs associated with the hospital's 1985 or 1986 fiscal year reporting period. For purposes of this rule, the 1985 cost report will be used for those hospitals with fiscal periods ending September thirtieth, October thirty-first, or December thirty-first; the 1986 cost report will be used for those hospitals with fiscal periods ending March thirty-first, May thirty-first, June thirtieth, or August thirty-first. The hospital-specific average cost per discharge component is calculated in accordance with the provisions set forth in paragraphs (D)(1) to (D)(13) of this rule.

- (1) For those hospitals that have merged since the end of the fiscal year period specified in paragraph (D) of this rule and had the same fiscal reporting period, the cost reports for the hospitals will be combined. ODHS will combine the total cost, total charges, total days, medicaid charges, and medicaid discharges for the hospitals. A new report will be prepared by ODHS for the merged hospital.
- (2) For those hospitals that have merged since the end of the fiscal year period specified in paragraph (D) of this rule and had different fiscal reporting periods, the procedures described in paragraphs (D)(3) to (D)(13)(d) of this rule will be followed. At that point, the average cost per discharge for the hospitals will be combined by:
  - (a) Multiplying the average cost per discharge for each hospital derived from paragraph (D)(12)(g) of this rule, as applicable, by the number of discharges for each hospital derived from paragraph (D)(11)(a) of this rule. Round the result to the nearest whole dollar.

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- (b) Sum the products.
- (c) Divide the resulting sum by the sum of the hospital's discharges. Round the result to the nearest whole penny.
- (3) The case-mix computation for merged providers will be performed by combining the hospital's claim records as described in paragraphs (D)(13) to (D)(13)(d) of this rule.
- (4) Determination of medicaid inpatient cost adjusted to remove the cost of blood replaced by patient donors.
  - (a) Identify medicaid inpatient service cost on ODIIS 2930, schedule H, section I, line 1, column 12.
  - (b) Identify cost of blood replaced by donor for medicaid inpatients on ODHS 2930, schedule H, section I, line 2, column 12.
  - (c) Subtract the amount identified in paragraph (D)(4)(b) of this rule from the amount identified in paragraph (D)(4)(a) of this rule.
- (5) Determination of medicaid inpatient cost adjusted to include PSRO/UR cost separately identified.
  - (a) Identify PSRO/UR cost on ODHS 2930, schedule H, section I, line 3, column 12.
  - (b) Add the amount derived from paragraph (D)(5)(a) of this rule to the amount described in paragraph (D)(4)(c) of this rule.
- (6) Determination of medicaid inpatient cost adjusted to include the cost of malpractice insurance.
  - (a) Identify the hospital's malpractice insurance premium cost on HCFA 2552-85, worksheet D-8, part II, line 11, for the hospital's fiscal reporting period ending in 1986.
  - (b) Compute the hospital's per cent of medicaid inpatient charges to total charges.

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- (i) Identify medicaid inpatient charges on ODHS 2930, schedule H, section I, line 11, column 12.
  - (ii) Identify total charges for all patients on ODHS 2930, schedule A, line 101B, column 1.
  - (iii) Divide the amount identified in paragraph (D)(6)(b)(i) of this rule by the amount identified in paragraph (D)(6)(b)(ii) of this rule. Round the result to six decimal places.
- (c) For those hospitals whose fiscal year ends on or prior to December 31, 1985, divide the amount identified in paragraph (D)(6)(a) of this rule by the appropriate deflation factor described in paragraph (G)(1) of this rule. Round to the nearest whole dollar.
- (d) Multiply the amount identified in paragraph (D)(6)(a) or (D)(6)(c) of this rule, as applicable, by the percentage derived from paragraph (D)(6)(b)(iii) of this rule. Round the result to the nearest dollar.
- (e) Add the amount computed in paragraph (D)(6)(d) of this rule to the amount derived in paragraph (D)(5)(b) of this rule.
- (7) Determination of medicaid inpatient cost adjusted to remove the direct cost of medical education.
- (a) Identify the hospital direct medical education on the HCFA 2552-85, worksheet B, part I, line 95, columns 20, 21, 22, 23, and 24.
  - (b) Multiply the sum of the amounts in paragraph (D)(7)(a) of this rule by the percentage derived from paragraph (D)(6)(b)(iii) of this rule. Round the result to the nearest dollar.
  - (c) Subtract the amount computed in paragraph (D)(7)(b) of this rule from the amount computed in paragraph (D)(6)(e) of this rule.
- (8) Determination of medicaid inpatient cost adjusted to remove capital-related cost.
- (a) Identify the hospital capital-related cost on the HCFA 2552-85, worksheet B, part II, line 95, column 25.

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- (b) Multiply the amount in paragraph (D)(8)(a) of this rule by the percentage derived from paragraph (D)(6)(b)(iii) of this rule. Round the result to the nearest dollar.
- (c) Subtract the amount derived from paragraph (D)(8)(b) of this rule from the amount derived from paragraph (D)(7)(c) of this rule.
- (9) Determination of medicaid inpatient cost adjusted to remove the indirect cost of medical education.
- (a) Identify the hospital's indirect medical education percentage described in rule 5101:3-2-07.7 of the Administrative Code. Add 1.00.
- (b) Divide the amount derived from paragraph (D)(8)(c) of this rule by the factor derived in paragraph (D)(9)(a) of this rule. Round the result to the nearest dollar.
- (10) Determination of medicaid inpatient cost adjusted to remove the effects of wage differences for hospitals in the teaching hospital peer group defined in rule 5101:3-2-07.2 of the Administrative Code.
- (a) The labor portion of hospital cost is .7439.
- (b) Multiply the amount derived from paragraph (D)(9)(b) of this rule by the labor portion of hospital cost identified in paragraph (D)(10)(a) of this rule. Round the result to the nearest whole dollar.
- (c) Subtract the amount derived from paragraph (D)(10)(b) of this rule from the amount derived in paragraph (D)(9)(b) of this rule.
- (d) Divide the labor portion of medicaid inpatient cost derived from paragraph (D)(10)(b) of this rule by the wage index for urban areas as published in Federal Register, Volume 51, Number 170, Wednesday, September 3, 1986, as applicable for the geographic area in which the teaching hospital is located. Round the result to the nearest whole dollar.
- (e) Add the amount derived from paragraph (D)(10)(c) of this rule to the amount derived from paragraph (D)(10)(d) of this rule.

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- (11) Determination of medicaid inpatient hospital-specific average cost per discharge.
  - (a) Identify total medicaid discharges on adjusted ODHS 2930, schedule D, section II, line 6.
  - (b) Divide the adjusted medicaid inpatient cost derived from paragraph (D)(10)(c) or (D)(9)(b) of this rule, as applicable, by the discharges identified in paragraph (D)(11)(a) of this rule. Round the result to the nearest whole penny.
  - (c) For hospitals exceeding the limits described in section (III)(A) or (III)(B) of appendix A of this rule, the average cost per discharge is reduced by multiplying the amount derived from paragraph (D)(11)(b) of this rule is multiplied by .97.
  
- (12) Determination of medicaid average cost per discharge adjusted to account for varying fiscal year ends.
  - (a) Compute a daily inflation factor by dividing the inflation factor for 1986 or 1987, as applicable, described in paragraph (G)(1) of this rule, by three hundred sixty-five. Round the result to six decimal places.
  - (b) With the exception of those hospitals whose fiscal years end on August thirty-first, compute the number of days between the hospital's fiscal year end and June 30, 1986.
  - (c) With the exception of those hospitals whose fiscal years end on August thirty-first, multiply the applicable daily inflation factor from paragraph (D)(12)(a) of this rule by the days computed in paragraph (D)(12)(b) of this rule. Round the result to six decimal places, then add 1.0 to yield an inflation adjustment factor.
  - (d) With the exception of those hospitals whose fiscal years end on August thirty-first, multiply the medicaid average cost per discharge derived from paragraph (D)(11)(b) or (D)(11)(c) of this rule by the inflation factor derived from paragraph (D)(12)(c) of this rule, as applicable. Round the result to the nearest whole penny.
  - (e) For those hospitals whose fiscal year ends on August thirty-first, determine the number of days from June 30, 1986 to the hospitals' fiscal

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year-end.

(f) For those hospitals whose fiscal year ends on August thirty-first, multiply the applicable daily inflation factor derived from paragraph (D)(12)(a) of this rule by the days derived from paragraph (D)(12)(e) of this rule. Round the result to six decimal places, then add 1.0 to yield an inflation adjustment factor.

(g) For those hospitals whose fiscal year ends on August thirty-first, divide the hospital-specific average cost per discharge derived from paragraph (D)(11)(b) or (D)(11)(c) of this rule, as applicable, by the inflation adjustment factor derived from paragraph (D)(12)(f) of this rule, as applicable. Round the result to the nearest whole penny.

(13) Determination of medicaid average cost per discharge adjusted for case mix.

For each hospital the average cost per discharge, adjusted as described in paragraphs (D)(12)(a) to (D)(12)(g) of this rule, is adjusted to remove the effects of the hospital's case mix. The data used to compute the hospital's case mix index are the hospital's claim records for discharges occurring during the hospital's fiscal period as described in paragraph (D) of this rule and paid as of May 1, 1987. For purposes of this paragraph, case mix is determined using the DRG categories and relative weights described in rule 5101:3-2-073 of the Administrative Code and includes outlier cases described in rule 5101:3-2-079 of the Administrative Code.

(a) For each hospital the number of cases in each DRG is multiplied by the relative weight for each DRG. Round the result to five decimal places. The relative weights are those described in rule 5101:3-2-073 of the Administrative Code.

(b) Sum the result of each computation in paragraph (D)(13)(a) of this rule.

(c) Divide the product from paragraph (D)(13)(b) of this rule by the number of cases in hospital's sample as described in paragraph (D)(13) of this rule. Round the result to five decimal places. This produces a hospital-specific case mix index.

(d) Divide the medicaid inpatient hospital-specific average cost per discharge derived from paragraphs (D)(12)(a) to (D)(12)(g) of this rule by the hospital-specific case mix index computed in paragraph (D)(13)(c) of this rule. Round the result to the nearest whole penny.

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## (E) Computation of peer group average cost per discharge.

- (1) Within each peer group (except for the children's hospital peer group as defined in rule 5101:3-2-07.2 of the Administrative Code), multiply each hospital's average cost per discharge from paragraph (D)(13)(d) of this rule by each hospital's number of medicaid discharges from paragraph (D)(11)(a) of this rule.
  - (2) Sum the results of each computation in paragraph (E)(1) of this rule.
  - (3) Sum the number of medicaid discharges described in paragraph (E)(1) of this rule.
  - (4) Divide the result derived from paragraph (E)(2) of this rule by the result derived from paragraph (E)(3) of this rule. Round the result to the nearest whole penny.
- (F) Adjustments to the peer group average cost per discharge component described in paragraphs (E)(1) to (E)(4) of this rule and each children's hospital average cost per discharge component described in paragraph (D)(13)(d) of this rule are those described in paragraphs (F)(1) to (F)(3) of this rule.
- (1) Disproportionate share payments will be made in accordance with rules 5101:3-2-09 and 5101:3-2-10 of the Administrative Code.
  - (2) An outlier set-aside is determined for each peer group except the teaching hospital and children's hospitals peer groups as described in rule 5101:3-2-07.2 of the Administrative Code. For teaching hospitals and children's hospitals identified in rule 5101:3-2-07.2 of the Administrative Code, an amount is calculated using each hospital's information to determine a hospital-specific group set-aside amount. This set-aside amount is calculated using the methodology described in paragraphs (F)(2)(a) to (F)(2)(f) of this rule.
    - (a) The additional payments that would be paid for outlier cases for discharges on and after July 1, 1985 to June 30, 1986 is determined using payment rates developed in accordance with this rule except that payment rates do not reflect the adjustment described in paragraph (F)(2)(f) of this rule. Relative weights as described in rule 5101:3-2-07.3 of the Administrative Code, and the day thresholds, cost thresholds, and geometric mean length of stay, excluding outliers, for each DRG as described in rule 5101:3-2-07.9 of the Administrative

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Code are used.

- (b) For each hospital, the total additional payments made for outlier cases is divided by the sum of the total payment amount for all cases in that hospital, less payment amounts for teaching and capital allowances as described in paragraphs (H)(1) and (H)(2) of this rule and payments made for day outliers as described in paragraph (F)(2)(a) of this rule. The resulting per cent is rounded to four decimal places and represents the hospital-specific outlier per cent.
- (c) For all hospitals, the total additional payment for outlier cases is calculated by summing each hospital's additional payments described in paragraph (F)(2)(a) of this rule and is divided by the summed total payment amounts for all cases in all hospitals, less payment amounts for teaching and capital allowances as described in paragraphs (H)(1) and (H)(2) of this rule, plus total payments in all hospitals for day outliers. The resulting per cent is rounded to four decimal places and represents the statewide average outlier per cent.
- (d) For hospitals which have a hospital-specific outlier per cent (as described in paragraph (F)(2)(b) of this rule) over the statewide average outlier per cent as described in paragraph (F)(2)(c) of this rule, the outlier payments that are used in the peer group calculation described in paragraph (F)(2)(e) of this rule are capped by multiplying the hospital-specific additional payment amount described in paragraph (F)(2)(a) of this rule by seventy-five per cent.
- (e) The outlier set-aside amount is calculated on a peer group basis using the following methodology:
- (i) For each peer group except the teaching hospital and children's hospital peer groups as described in rule 5101:3-2-07.2 of the Administrative Code and for each teaching hospital and children's hospital (identified in rule 5101:3-2-07.2 of the Administrative Code), sum the total additional payments for outliers as described in paragraph (F)(2)(a) or (F)(2)(d) of this rule, as applicable.
- (ii) For each peer group except the teaching hospital and children's hospital peer groups and for each teaching and children's hospital, divide the sum from paragraph (F)(2)(e)(i) of this rule by the sum of the total payment amount, less payment amounts for teaching and capital allowances as described in paragraphs (H)(1) and (H)(2) of this rule, plus total day outlier payments.

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(f) The outlier adjustment amount is calculated by multiplying the percentage described in paragraph (F)(2)(e)(ii) of this rule by the applicable average cost per discharge component for each peer group as described in paragraphs (E) to (E)(4) of this rule and for each children's hospital as described in paragraph (D)(13)(d) of this rule. Round the result to the nearest whole penny to determine the outlier adjustment amount. Subtract the outlier adjustment amount from the applicable average cost per discharge component described in paragraph (F)(1)(a) of this rule for discharges occurring on and after July 1, 1988 and prior to February 1, 1989. For discharges occurring on and after February 1, 1989, subtract the outlier adjustment amount from the average cost per discharge component for each peer group as described in paragraph (E)(4) of this rule and for each children's hospital as described in paragraph (D)(13)(d) of this rule. Round the result to the nearest whole penny.

(3) For purposes of coding adjustment, the applicable average cost per discharge component described in paragraph (F) of this rule is divided by 1.005. Round the result to the nearest whole penny.

(4) For Ohio hospitals meeting the teaching hospital peer group criteria defined in rule 5101:3-2-07.2 of the Administrative Code, the peer group average cost per discharge described in paragraph (F)(3) of this rule is multiplied by a wage factor and rounded to the nearest whole penny. The wage factor is determined by dividing the amount derived from paragraph (D)(9)(b) of this rule by the amount derived from paragraph (D)(10)(e) of this rule, rounded to six decimal places.

(G) Adjustments for inflation.

In calculating the prospective payment rate, it is necessary to adjust costs to reflect inflation at various points in the calculation.

(1) In order to assure hospitals an annual allowance for inflation, an inflation factor is developed. The Ohio specific "inflation factor" is a weighted average of twenty-three price and wage indexes, either regional or national. The weights are those published shown below. Price growth increase values for these weighted items are determined by DRI-WEFA for the department. Annual inflation factors are derived from summing the result of the following calculation for each item and adding one to produce a factor:

Factor X Weight X Projected Price Increase

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The categories and indexes are those identified in paragraphs (G)(1)(a) to (G)(1)(m)(t) of this rule. When more than one period is being inflated, annual factors are multiplied by one another to produce a composite factor.

- (a) Wages: average hourly earnings (AHE), general medical and surgical hospitals, midwest region. The weight is .4339.
- (b) Benefits: supplements to wages and salaries per employee, east north central (ENC). The weight is .0949.
- (c) Professional fees, nonmedical: "Employment Cost Index" (ECI) wages and salaries, midwest region. The weight is .0213.
- (d) Malpractice insurance: Health care financing administration, professional liability insurance premium index. The weight is .0119.
- (e) Utilities: producer price index (PPI) - electricity, commercial sector, ENC (the weight is .0093); price of natural gas for the commercial sector, ENC (the weight is .0037); "Consumer Price Index - All Urban" CPIU - water and sewerage maintenance, U.S. (the weight is .0025). The combined weight is .0155.
- (f) Prescription pharmaceuticals: PPI - pharmaceutical preparations, prescription (chemicals), U.S. The weight is .0416.
- (g) Food: direct purchase, PPI - processed foods and feeds, U.S. (the weight is .0231); contract purchase, CPIU, food at home, ENC (the weight is .0107).
- (h) Chemicals: PPI - industrial chemicals, U.S. The weight is .0367.
- (i) Medical instruments: PPI - surgical and medical instruments and apparatus, U.S. The weight is .0308.
- (j) Photographic supplies: PPI - photographic supplies, U.S. the weight is .0039.
- (k) Rubber and plastics: PPI - rubber and plastics products, U.S. The weight is .0475.
- (l) Paper products: PPI - paper and paperboard, U.S. The weight is .0208.

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