

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES INPATIENT HOSPITAL SERVICES

III. PAYMENT METHODOLOGY FOR FREESTANDING REHABILITATION, AND FREESTANDING PSYCHIATRIC HOSPITALS *(continued)*

C. Updates

1. The level of care operating and fixed capital per diem rates in effect on December 31, 2006, for psychiatric hospitals will be updated by a factor of 9.76% and 22.9% for rehabilitation hospitals. The rates in effect on December 31, 2007 will be updated by a factor of 3.2%.
2. Effective 05-01-09, Valir Rehab Hospital will be paid at a fixed rate per-diem based on its reported cost per day reported on the 12-31-07 cost report brought forward to the base rate period of Calendar year 2009 by the latest available Global Insight published "2002 Based CMS Hospital Prospective Reimbursement Market Basket" forecasts.
3. The rates will be reviewed annually and any annual updates will not exceed the marketbasket increase in rehabilitation, psychiatric, and long term care facilities (RPL) marketbasket index for the current rate year.
4. Effective 04-01-10, the rate in effect as of 03-31-10 will be decreased by 3.25%.
5. Effective 07-01-14, the rate in effect as of 06-30-14 will be decreased by 7.75%.
6. Effective for services provided on or after 01-01-16, the rate in effect as of 12-31-15 will be decreased by 3% for freestanding rehabilitation hospitals only.
7. Effective for services provided on or after 05-01-16, the rate in effect as of 04-30-16 will be decreased by 3% for freestanding psychiatric hospitals only.
8. Effective for services provided on or after 07-01-18, the rate in effect as of 06-30-18 will be increased by 3% for freestanding psychiatric hospitals only.
9. Effective for services provided on or after 10-01-18, the rate in effect as of 09-30-18 will be increased by 3% for freestanding rehabilitation hospitals only.

IV. PAYMENT METHODOLOGY FOR LONG TERM CARE HOSPITALS SERVING CHILDREN (LTCHs-C)

Effective for services provided on or after July 1, 2012, payment will be made to freestanding long term care hospitals serving children for sub-acute care level of services.

A. Definitions

1. Ancillary Services. Refers to those services that are not considered inpatient routine services. Ancillary services include laboratory, radiology, and prescription drugs. Ancillary services may also include other special items and services for which charges are customarily made in addition to a routine VI service charge.
2. Average Length of Stay. To be determined a long term care hospital, the hospital must have a Medicaid average length of stay of greater than 25 days.
3. Children. For the purpose of this reimbursement rate, children are defined as individuals under the age of 21.
4. Routine Services. Services include but are not limited to: regular room, dietary and nursing services, minor medical and surgical supplies, over-the-counter medications, transportation, and the use and maintenance of equipment and facilities essential to the provision of routine care. Routine services should be patient specific and in accordance with standard medical care.

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**METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
INPATIENT HOSPITAL SERVICES****VI. PER DISCHARGE PROSPECTIVE PAYMENT METHODOLOGY FOR HOSPITALS** *(continued)***C. Computation of Hospital Base Rates** *(continued)*

4. The five hospital classification variables were joined to claim and encounter records that had been assigned a DRG by the DRG diagnosis grouper. Due to underreporting of encounter records, discharges that were reported as managed care encounters were given greater weight (1.335) than discharges reported as FFS claims (1.0) to account for the estimated likelihood that denied encounters would have been revised and resubmitted if providers had a financial incentive to do so. A multiple regression equation was estimated from the claim and encounter data to determine the expected cost associated with each of the five classification variables, controlling for DRG and length of stay.
5. The five classification variables formed 32 possible combinations, or classes. Impossible combinations were eliminated. The expected cost for each remaining class was computed with the regression equation. Expected costs were totaled over all classes and the cumulative proportion of expected cost computed. Classes were grouped into five quintiles, such that each group accounts for 20% of the total expected cost.
6. For each group, the discharge-weighted average expected cost was calculated. After computing the discharge-weighted average expected cost for each peer group, the overall discharge weighted average was computed. The relative base rate was computed for each group as the ratio of the group-specific average to the over-all average.
7. The base year expected cost for each group was updated by the method in Section VI.B.4. of this plan.
8. The OHCA will determine the peer group assignment and appeal of assignment will be allowed only through the methods described in Section VI. F. of this Plan.

D. Updates

The DRG rates will be updated annually using the above described method.

Effective 4-01-10, the rate in effect on 03-31-10 is reduced by 3.25%.

Effective 7-01-14, the rate in effect on 06-30-14 is reduced by 7.75%.

Effective for services provided on or after 01-01-16, the rate in effect as of 12-31-15 will be decreased by 3% for DRG hospitals only.

Effective for services provided on or after 10-01-18, the rate in effect as of 09-30-18 will be increased by 3% for DRG hospitals only.

E. Special Prospective Payment Provisions**1. Cost Outlier Adjustment**

- a. Effective for discharges on or after October 1, 2005, and in accordance with Section 4605 of the Omnibus Budget Reconciliation Act (OBRA) of 1990, the OHCA provides for an outlier adjustment in payment amounts for medically necessary inpatient services involving exceptionally high costs for children who have not attained the age of six years in disproportionate share hospitals, and for infants under age one in all hospitals.

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