

**METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
INPATIENT HOSPITAL SERVICES****VI. PER DISCHARGE PROSPECTIVE PAYMENT METHODOLOGY FOR HOSPITALS**
(continued)

E. Special Prospective Payment Provisions (continued)

1. Payment for Readmissions

Readmissions occurring within 30 days of prior acute care admission for a related condition will be reviewed under a retrospective utilization review policy to determine medical necessity and appropriateness of care. If it is determined that either or both admissions were unnecessary or inappropriate, payment for either or both admissions may be denied. Such review may be focused to exempt certain cases at the sole discretion of the OHCA.

OHCA does not have any prior authorization requirement for inpatient services. Utilization reviews of inpatient stays occur after members have been served and the hospitals file claims; an analysis by the QIO is based on a review of the claims.

~~Effective April 1, 2016 the OHCA implemented a hospital readmissions initiative designed to reduce the rate of potentially preventable readmissions (PPR). The OHCA approach to achieving this goal is payment reduction for those facilities that have higher than expected PPR rates after adjusting for the types of diagnoses, severity of illness, age groups, and mental health comorbidities seen at individual facilities.~~

~~The methodology is as follows:
PPR Assignment~~

~~OHCA collects data from all inpatient admissions, but some admissions are excluded from the analysis by third party software. Global exclusions currently include Medicare crossover claims for dual eligible members, admissions related to HIV or eye care, admissions where the patient left against medical advice, most malignancy and neonatal admissions, and non-events such as transfers between acute care facilities or admission to non-acute care facilities. A maximum of 30 days can elapse between the discharge date of an admission and the admitting date of a readmission. If the third party software algorithm determines that a readmission is clinically related to a prior admission, it is considered a PPR. The prior hospitalization that is clinically related to the PPR is called an Initial Admission (IA). An initial admission is the start of a PPR chain that includes at least one PPR; more than one PPR can be attributed to a single initial admission. A hospitalization that is not clinically related to a prior or subsequent admission within a 30-day period is considered an Only Admission (OA). Initial Admissions and Only Admissions combined are Qualifying Admissions (QA), which are used in calculating PPR rates.~~

~~Revised 04-01-16 Revised 1-1-24~~

**METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
INPATIENT HOSPITAL SERVICES**

(reserved)

VI. PER DISCHARGE PROSPECTIVE PAYMENT METHODOLOGY FOR HOSPITALS

(continued)

Clinically Related Admissions

The key component of the third party software assignment is the proprietary algorithm that determines whether admissions are clinically related. Readmissions are considered to be potentially preventable in the following cases:

- Medical readmission for a continuation or recurrence of the reason for the IA, or for a condition closely related to the reason for the IA
- Ambulatory care sensitive conditions as designated by the Agency for Healthcare Research and Quality (AHRQ)
- All other readmissions for a chronic problem that may be related to care either during or after the IA
- Medical readmission for an acute medical condition or complication that may be related to or may have resulted from care during the IA or in the post-discharge period after the IA
- Readmission for a surgical procedure to address a continuation or a recurrence of the problem causing the IA
- Readmission for a surgical procedure to address a complication that may be related to or may have resulted from care during the IA
- Readmission for mental health or substance abuse reasons

Statewide PPR Calculations

Each admission is assigned to an All Patient Refined Diagnosis Related Groups (APR DRGs) according to the reason for admission. Each admission is also assigned to one of four severity of illness (SOI) levels based on both comorbidities and severity of the underlying illness. A statewide average PPR rate for each APR-DRG-SOI combination is defined by the ratio of IA/QA for that APR-DRG-SOI. APR-DRG-SOI combinations with less than 5 QA across the state are excluded from the analysis.

The third party software also identifies admissions with secondary diagnoses of major mental health conditions. It is well established that individuals with mental health comorbidities are more likely to be readmitted. Therefore, the third party software output can be used to calculate a PPR adjustment factor to account for the presence or absence of mental health comorbidities when determining the number of expected PPRs for a facility. Likewise, an age group adjustment factor is applied to account for the fact that pediatric patients are less likely to be readmitted than adults.

**METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
INPATIENT HOSPITAL SERVICES****VI. PER DISCHARGE PROSPECTIVE PAYMENT METHODOLOGY FOR HOSPITALS**

(continued)

Facility Specific PPR Calculations

The third party software classifies each admission within a specific facility as an IA, OA, readmission, or excluded admission. Each admission is also assigned to an APR DRG-SOI. For each APR DRG-SOI observed within each hospital's data set, the expected number of PPR chains is calculated by multiplying the statewide average PPR rate for that APR DRG-SOI by the number of QA for that APR DRG-SOI. That expected value is also multiplied by the adjustment factor for the appropriate age group and mental health status. Some states set a "target" PPR rate that is different from the statewide average PPR rate. At this time, OHCA has chosen a target rate of 102% decreasing annually by one percent until the target rate reaches 100%. The expected number of PPR chains for the hospital is the sum of the expected number of PPR chains across all APR DRG-SOI. If a hospital has a higher number of actual PPR chains than would be expected based on the statewide average, then the number exceeding the expectation are considered excess PPR chains and are subject to payment reduction. The payment reduction is equal to the number of excess PPR chains multiplied by the average reimbursement for PPRs clinically related to initial admissions originating at that facility. Currently, to be included in the reporting process, a hospital must have at least 40 qualifying admissions, 5 actual PPR chains, and 5 expected PPR chains. The minimum number of qualifying admissions, actual PPR chains, and expected PPR chains may be reconsidered as the program evolves. At this time, only facilities that are paid on a DRG basis are subject to payment reduction. Included and excluded facilities may be reconsidered as the program evolves.

Penalty Recoupment Process

OHCA will process the payment reduction through a lump sum recoupment process. After the penalty calculations are completed in the final quarter of the state fiscal year, OHCA will distribute PPR data and notify all hospitals of total penalty amount owed. OHCA will then create accounts receivable for each facility in the MMIS for the total amount of the facility specific penalty. OHCA may set up the accounts receivable to recoup the penalty amount over more than one week. The PPR penalty shall not be included in uncompensated care claims submitted by the hospitals. If the State determines that a participating provider has erroneously filed an uncompensated care claim that incorporates denials for preventable readmissions, the State will notify pertinent auditors of the need to take appropriate steps to disallow these amounts and educate the providers accordingly.

2. Payment for Inappropriate Brief Admissions

Hospital stays less than three days in length will be reviewed under a retrospective utilization review policy for medical necessity and appropriateness of care. (Discharges involving healthy mother and healthy newborns may be excluded from this review requirement.) If it is determined that the inpatient stay was unnecessary or inappropriate, the prospective payment for the inpatient stay will be denied.

3. Provisions Relating to Organ Transplants

In order for a hospital to receive payment for medically necessary organ transplant services, the following criteria must apply:

The transplant must be prior authorized by the OHCA. Prior authorization request must be submitted jointly by the hospital and the transplant surgeon, and must include written documentation attesting to the appropriateness of the proposed transplant. Payment will not be made without prior authorization approval.

New Page 04-01-16 Revised 1-1-24