Ohio | Department of Medicaid

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TO: Contracted Medicaid Managed Care Plans
Contracted MyCare Ohio Plans

FROM: Roxanne Richardson, Deputy Director
Office of Managed Care

DATE: July 28, 2020

SUBJECT: Hospital Inpatient Readmission Policy

Background

Hospital readmissions are always a topic of concern as we ensure proper medical care has been provided to Medicaid recipients while also limiting unnecessary hospitalization. After recent complaints received from providers, and the request from managed care plans (MCP) to include behavioral health claims in their readmission policy, the managed care policy team completed a review of the hospital readmission policies from each MCP. For comparison, we used the current fee-for-service policies and processes to reduce payments for readmissions. The Ohio Administrative Code (OAC) rules define how readmissions are enforced for hospitals paid under the department's prospective payment system as follows:

1. OAC rule 5160-2-02, General provisions: hospital services, defines readmissions as an admission to the same institution within thirty days of discharge.

2. OAC rule 5150-2-65, Inpatient hospital reimbursement, states a readmission within one calendar day of discharge, to the same institution, is considered one discharge for payment purposes so that one DRG payment is made. If two claims are submitted, the second claim processed will be rejected. In order to receive payment for the entire period of hospitalization, the hospital will need to submit an adjustment claim reflecting services and charges for the entire hospitalization.

3. OAC rule 5160-2-07.13, Utilization control, states ODM may review readmissions to determine if the readmission is appropriate. (Retrospectively, post payment, through a medical record review.)

    (a) If the readmission is related to the first hospitalization, ODM will determine if the readmission resulted from complications or other circumstances that arose because of an early discharge and/or other treatment errors.
    (b) If the readmission is unrelated, ODM will determine if the treatment or care provided during the readmission should have been provided during the first hospitalization.

(c) If it is determined the readmission was inappropriate, then any payment made for the separate admissions will be recouped. A new payment amount will be determined by collapsing any affected admissions into one payment.

Overall, the MCPs follow the fee-for-service hospital readmission within 24 hours, but they varied when it comes to a readmission within 30 days. Some of the managed care policies would deny a readmission request if deemed related to the first hospitalization, which would result in denied payment to the hospital for the second admission. This practice results in many hospital claim denials which should not be denials, but instead collapsed or adjusted into the previous claim.

Recommendation

After internal discussion with ODM clinical and hospital policy teams, ODM is requiring all MCPs to make the changes to follow the same policy as defined by the OAC:

1. Readmissions within 30 days, that are due to complications or other circumstances that arose because of an early discharge and/or other treatment errors, the two inpatient hospital stays will be combined into one claim, and the second admission would no longer be denied.

   a. The MCP will maintain their exceptions list of type of conditions or admission that are exempt from review to combine claims including behavioral health admissions.
   b. Before adding behavioral health claims to the readmission policy, ODM will be reviewing the criteria to be used with these types of readmissions.

2. The decision to have two admissions combined as one will require a clinical review to make the determination.

3. A prior authorization request cannot be denied due to a readmission but must be determined based on a medical necessity review.

With all MCPs following the FFS policy to combine two related readmissions, it will also ensure the claims are represented in the encounter data when hospital policy performs rebasing and weight-setting activities and completes their analysis for potentially preventable readmissions as defined in OAC 5160-2-14. Retrospectively, all claims (encounter and FFS) are reviewed to find inpatient readmissions within 30 days from the same and different hospitals, across FFS and MCPs (including members who have switched Plans). Hospitals can be penalized for all future reimbursement for inpatient claims by reducing their base rate if they are found to have too many readmissions.

This requirement will be included in the 1/1/2021 managed care provider agreements. This will allow the MCP the time needed to make the system configurations to comply with the requirement.