5101:3-2-50 **Supplemental inpatient hospital upper limit payments for public hospitals.**

(A) Definitions.

(1) "Public hospital" means an Ohio hospital owned and operated by a governmental entity other than the state.

(2) "Available inpatient payment gap" means the difference between what is estimated using the methodology described in paragraph (C) of this rule that medicare would have paid for medicaid consumers and actual medicaid payments made in accordance with Chapter 5101:3-2 of the Administrative Code.

(3) "Intergovernmental transfer" means any transfer of money by a governmental hospital to the department.

(4) "Total medicaid inpatient payments" for each hospital means the amount paid by the medicaid program for services rendered to eligible medicaid patients, excluding supplemental payments, as reported on the medicaid cost report, as specified in paragraph (B) of this rule.

(5) "Total medicaid inpatient discharges" means for each public hospital the number of discharges from the facility for medicaid patients, as reported on the medicaid cost report, as specified in paragraph (B) of this rule.

(6) "Total medicaid inpatient charges" means for each public hospital the charges for covered medicaid inpatient services rendered, as reported on the medicaid cost report, as specified in paragraph (B) of this rule.

(7) "Medicare inpatient payments for hospitals exempt from medicare diagnosis related group (DRG) payments and Medicare inpatient payments for subproviders" means the inpatient payment amount as reported on the medicare cost report, as specified in paragraph (B) of this rule.

(8) "Medicare inpatient DRG payments" means the DRG payment amount as reported on the medicare cost report, as specified in paragraph (B) of this rule.

(9) "Medicare inpatient outlier payments" means the outlier payment amount as reported on the medicare cost report, as specified in paragraph (B) of this rule.

(10) "Medicare inpatient indirect medical education" means the indirect medical education adjustment amount as reported on the medicare cost report, as specified in paragraph (B) of this rule.

(11) "Medicare inpatient disproportionate share payments" means the inpatient disproportionate share adjustment amount as reported on the medicare cost report, as specified in paragraph (B) of this rule.

(12) "Medicare inpatient hospital capital payments" means the payment for inpatient program capital as reported on the medicare cost report, as specified in paragraph (B) of this rule.

(13) "Medicare inpatient direct medical education" means the direct graduate medical education payment amount as reported on the medicare cost report, as specified in paragraph (B) of this rule.

(14) "Medicare inpatient hospital payments - other" means the sum of net organ acquisition cost, cost of teaching physicians, routine service other pass through costs, and ancillary service other pass through costs, as reported on the medicare cost report, as specified in paragraph (B) of this rule.

(15) "Total medicare inpatient charges" means the amount of inpatient charges for each hospital and subprovider, as reported on the medicare cost report, as specified in paragraph (B) of this rule.

(16) "Cost based hospitals" means hospitals excluded from the DRG prospective payment system, as specified in rule 5101:3-2-07.1 of the Administrative Code.

(B) Source data for calculations.

The calculations described in this rule will be based on cost reporting data described in rule 5101:3-2-23 of the Administrative Code, which reflects the most recent completed interim settled medicaid cost report for all hospitals, and the medicare cost report for the corresponding cost reporting period.

(C) Calculation of available inpatient payment gap for public hospitals.

(1) For each public hospital, calculate the total medicare inpatient payment by adding the amounts described in paragraphs (A)(7) to (A)(14) of this rule.

(2) For each public hospital, calculate the medicare payment to charge ratio by dividing the amount calculated in paragraph (C)(1) of this rule by the total medicare inpatient charges as described in paragraph (A)(15) of this rule.

(3) For each public hospital, calculate the total estimated medicare inpatient payment for medicaid inpatient discharges by multiplying the amount calculated in paragraph (C)(2) of this rule by the total medicaid inpatient charges as described in paragraph (A)(6) of this rule.

(4) For each public hospital, calculate the available inpatient payment gap by taking total estimated medicare inpatient payments for medicaid inpatient discharges as calculated in paragraph (C)(3) of this rule and subtracting actual total medicaid inpatient payments as described in paragraph (A)(4) of this rule. For each cost based hospital, as defined in paragraph (A)(16) of this rule, the available inpatient gap equals zero.

(5) For each public hospital that has an available inpatient payment gap greater than zero resulting from the calculations in paragraph (C)(4) of this rule, calculate the available per discharge supplemental inpatient hospital payment amount by dividing the amount in paragraph (C)(4) of this rule by the amount in paragraph (A)(5) of this rule.

(D) For each supplemental upper limit payment made after the effective date of this rule, the resulting per discharge supplemental payment amount calculated in paragraph (C) of this rule will be in effect from the first day of January through the thirty-first day of December for each supplemental upper limit payment program year.

(E) Payment of supplemental inpatient hospital upper limit payments.

(1) In January and July of each year, the department will notify public hospitals of the available per discharge supplemental inpatient hospital payment amount as described in paragraph (C)(5) of this rule, the number of actual medicaid inpatient discharges paid for through the department's medicaid management information system (MMIS) for each public hospital in the six months prior to the month of notification, and the maximum allowable supplemental payment that the public hospital is eligible to receive for the prior six months. The maximum allowable supplemental payment amount is the product of the actual number of medicaid discharges paid during the prior six months and the available per discharge supplemental inpatient hospital payment amount as described in paragraph (C)(5) of this rule, subject to the limitations described in paragraph (E)(2~~3~~) of this rule.

~~(2) Public hospitals electing to receive supplemental inpatient hospital payments must notify the department within fourteen days of the date of the notice described in paragraph (E)(1) of this rule of their intent to participate. Public hospitals that elect to participate and have notified the department of that intent shall provide an intergovernmental transfer, via electronic funds transfer, up to but not to exceed an amount that equals the maximum allowable supplemental payment amount as described in paragraph (E)(1) of this rule multiplied by [1-(federal medical assistance percentage)] by no later than thirty days from the date of the notice described in paragraph (E)(1) of this rule. Failure to submit the intergovernmental transfer by this deadline will preclude the hospital from receiving the supplemental payment for the six-month payment period.~~

~~(3)~~(2) The total supplemental inpatient hospital payments funds that will be paid to each public hospital ~~electing to receive supplemental inpatient hospital payments from~~ by the department shall be the amount calculated in ~~supplied by each hospital in~~ paragraph (E)(1~~2~~) of this rule~~, divided by [1-(federal medical assistance percentage)]~~. If the total of the funds that will be paid to all public hospitals ~~electing to participate~~ exceeds the aggregate upper payment limit for all public hospitals calculated each supplemental inpatient upper limit payment program year as described in paragraph (C) of this rule, then the amount paid to each public hospital ~~electing to participate~~ will be limited to its proportion of the aggregate upper payment limit. The department may request adjustments to the amounts ~~transferred from and~~ paid to public hospitals ~~electing to participate~~ for the six-month time period.

(F) The total supplemental inpatient hospital payments funds that will be paid to each public hospital ~~electing to receive supplemental inpatient hospital payments from~~ by the department as described in paragraph (E)(2~~3~~) of this rule will be included in the calculation of disproportionate share limits as described in rule 5101:3-2-07.5 of the Administrative Code.

Effective:

R.C. 119.032 review dates: 04/01/2014

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Certification

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Date

Promulgated Under:	119.03
Statutory Authority:	5111.02
Rule Amplifies:	5111.01, 5111.02, 5111.021, Section 309.30.17 of Am. Sub. H.B. 1 of the 128th G.A.
Prior Effective Dates:	11/15/01, 7/1/04, 4/1/09

5101:3-2-51 **Supplemental inpatient hospital upper limit payments for state hospitals.**

(A) Definitions.

(1) "State hospital" means an Ohio hospital owned and operated by the state.

(2) "Available inpatient payment gap" means the difference between what is estimated using the methodology described in paragraphs (C) and (D) of this rule that medicare would have paid for medicaid consumers and actual medicaid payments made in accordance with Chapter 5101:3-2 of the Administrative Code.

(3) "Intergovernmental transfer" means any transfer of money by a governmental hospital to the department.

(4) "Total medicaid inpatient payments" for each hospital means the amount paid by the medicaid program for services rendered to eligible medicaid patients, excluding supplemental payments, as reported on the medicaid cost report, as specified in paragraph (B) of this rule.

(5) "Total medicaid inpatient discharges" means for each state hospital the number of discharges from the facility for medicaid patients, as reported on the medicaid cost report, as specified in paragraph (B) of this rule.

(6) "Total medicaid inpatient charges" means for each state hospital the charges for covered medicaid inpatient services rendered, as reported on the medicaid cost report, as specified in paragraph (B) of this rule.

(7) "Medicare inpatient payments for hospitals exempt from medicare diagnosis related group (DRG) payments and Medicare inpatient payments for subproviders" means the inpatient payment amount as reported on the medicare cost report, as specified in paragraph (B) of this rule.

(8) "Medicare inpatient DRG payments" means the DRG payment amount as reported on the medicare cost report, as specified in paragraph (B) of this rule.

(9) "Medicare inpatient outlier payments" means the outlier payment amount as reported on the medicare cost report, as specified in paragraph (B) of this rule.

(10) "Medicare inpatient indirect medical education" means the indirect medical

education adjustment amount as reported on the medicare cost report, as specified in paragraph (B) of this rule.

(11) "Medicare inpatient disproportionate share payments" means the inpatient disproportionate share adjustment amount as reported on the medicare cost report, as specified in paragraph (B) of this rule.

(12) "Medicare inpatient hospital capital payments" means the payment for inpatient program capital as reported on the medicare cost report, as specified in paragraph (B) of this rule.

(13) "Medicare inpatient direct medical education" means the direct graduate medical education payment amount as reported on the medicare cost report, as specified in paragraph (B) of this rule.

(14) "Medicare inpatient hospital payments - other" means the sum of net organ acquisition cost, cost of teaching physicians, routine service other pass through costs, and ancillary service other pass through costs, as reported on the medicare cost report, as specified in paragraph (B) of this rule.

(15) "Total medicare inpatient charges" means the amount of inpatient charges for each hospital and subprovider, as reported on the medicare cost report, as specified in paragraph (B) of this rule.

(16) "Cost based hospitals" means hospitals excluded from the DRG prospective payment system, as specified in rule 5101:3-2-07.1 of the Administrative Code.

(B) Source data for calculations.

The calculations described in this rule will be based on cost reporting data described in rule 5101:3-2-23 of the Administrative Code, which reflects the most recent completed interim settled medicaid cost report for all hospitals, and the medicare cost report for the corresponding cost reporting period.

(C) Calculation of available inpatient payment gap for state hospitals that are not free-standing psychiatric hospitals.

(1) For each state hospital, calculate the total medicare inpatient payment by adding the amounts described in paragraphs (A)(7) to (A)(14) of this rule. For available inpatient payment gap calculations for payment periods ending in calendar year 2002, reduce medicare indirect medical education payments

described in paragraph (A)(10) of this rule by 15.4 per cent prior to calculating the total medicare inpatient payment.

(2) For each state hospital, calculate the medicare payment to charge ratio by dividing the amount calculated in paragraph (C)(1) of this rule by the total medicare inpatient charges as described in paragraph (A)(15) of this rule.

(3) For each state hospital, calculate the total estimated medicare inpatient payment for medicaid inpatient discharges by multiplying the amount calculated in paragraph (C)(2) of this rule by the total medicaid inpatient charges as described in paragraph (A)(6) of this rule.

(4) For each state hospital, calculate the available inpatient payment gap by taking total estimated medicare inpatient payments for medicaid inpatient discharges as calculated in paragraph (C)(3) of this rule and subtracting actual total medicaid inpatient payments as described in paragraph (A)(4) of this rule. For each cost based hospital, as defined in paragraph (A)(16) of this rule, the available inpatient gap equals zero.

(5) For each state hospital that has an available inpatient payment gap greater than zero resulting from the calculations in paragraph (C)(4) of this rule, calculate the available per discharge supplemental inpatient hospital payment amount by dividing the amount in paragraph (C)(4) of this rule by the amount in paragraph (A)(5) of this rule.

(D) Calculation of available inpatient payment gap for state psychiatric hospitals (SPH) subject to medicaid prospective payment as described in Chapter 5101:3-2 of the Administrative Code and excluded from prospective payment under medicare, 42 C.F.R. 412.23(a) in effect as of October 1, 2003.

(1) For each SPH described in this paragraph, "medicaid inpatient costs" means medicaid inpatient costs as reported on the medicaid cost report, as specified in paragraph (B) of this rule.

(2) For each SPH described in this paragraph, "medicaid inpatient payments" means medicaid inpatient payments as reported on the medicaid cost report, as specified in paragraph (B) of this rule.

(3) For each SPH described in this paragraph, "medicaid discharges" means medicaid discharges as reported on the medicaid cost report, as specified in paragraph (B) of this rule.

(4) For each SPH described in this paragraph, calculate the available inpatient payment gap by subtracting the amount in paragraph (D)(2) of this rule from the amount in paragraph (D)(1) of this rule.

(5) For each SPH described in this paragraph that has an available inpatient payment gap greater than zero resulting from the calculations in paragraph (D)(4) of this rule, calculate the available per discharge supplemental inpatient hospital payment amount by dividing the amount in paragraph (D)(4) of this rule by the amount in paragraph (D)(3) of this rule.

(E) For the first supplemental upper payment limit program year, the resulting per discharge supplemental payment amount calculated in paragraphs (C) and (D) of this rule will be in effect from April 1, 2002 through December 31, 2002. For each supplemental upper payment limit program year after calendar year 2002, the resulting per discharge supplemental payment amount calculated in paragraphs (C) and (D) of this rule will be in effect from the first day of January through the thirty-first day of December of each year.

(F) Payment of supplemental inpatient hospital upper limit payments.

(1) In January and July of each year after April 1, 2002, the department will notify state hospitals of the available per discharge supplemental inpatient hospital payment amount as described in paragraph (C)(5) or (D)(6) of this rule, the number of actual medicaid inpatient discharges paid for through the department's medicaid management information system (MMIS) for each state hospital in the six months prior to the month of notification, and the maximum allowable supplemental payment that the state hospital is eligible to receive for the prior six months. The maximum allowable supplemental payment amount is the product of the actual number of medicaid discharges paid during the prior six months and the available per discharge supplemental inpatient hospital payment amount as described in paragraph (C)(5) or (D)(6) of this rule, subject to the limitations described in paragraph (F)(2~~3~~) of this rule. The first six-month supplemental upper limit payment will be prorated from April 1, 2002 to the end of the six-month period from which the actual medicaid inpatient discharges were obtained.

~~(2) State hospitals electing to receive supplemental inpatient hospital payments must notify the department within fourteen days of the date of the notice described in paragraph (F)(1) of this rule of their intent to participate. State hospitals that elect to participate and have notified the department of that intent shall provide an intergovernmental transfer, via electronic funds transfer, up to but not to exceed an amount that equals the maximum allowable supplemental payment amount as described in paragraph (F)(1) of~~

~~this rule multiplied by [1-(federal medical assistance percentage)] by no later than thirty days from the date of the notice described in paragraph (F)(1) of this rule. Failure to submit the intergovernmental transfer by this deadline will preclude the hospital from receiving the supplemental payment for the six month payment period.~~

(~~3~~)(2) The total supplemental inpatient hospital payments funds that will be paid to each state hospital by ~~electing to receive supplemental inpatient hospital payments from~~ the department shall be the amount calculated ~~supplied by each hospital~~ in paragraph (F)(~~2~~1) of this rule~~, divided by [1-(federal medical assistance percentage)]~~. If the total of the funds that will be paid to all state hospitals ~~electing to participate~~ exceeds the aggregate upper payment limit for all state hospitals calculated each supplemental inpatient upper limit payment program year as described in paragraphs (C) and (D) of this rule, then the amount paid to each state hospital ~~electing to participate~~ will be limited to its proportion of the aggregate upper payment limit. The department may request adjustments to the amounts ~~transferred from and~~ paid to state hospitals ~~electing to participate~~ for the six month time period.

(G) The total supplemental inpatient hospital payments funds that will be paid to each state hospital ~~electing to receive supplemental inpatient hospital payments from~~ by the department as described in paragraph (F)(2~~3~~) of this rule will be included in the calculation of disproportionate share limits as described in rules 5101:3-2-07.5 and 5101:3-2-10 of the Administrative Code.

Effective:

R.C. 119.032 review dates: 04/01/2014

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Certification

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Date

Promulgated Under:	119.03
Statutory Authority:	5111.02
Rule Amplifies:	5111.01, 5111.02, 5111.021, Section 309.30.17 of Am. Sub. H.B. 1 of the 128th G.A.
Prior Effective Dates:	7/22/02, 9/1/03, 4/1/09

OS Notification

State/Title/Plan Number: **Ohio 09-006**

Type of Action: **SPA Approval**

Required Date for State Notification: **March 31, 2010**

Fiscal Impact: **FY 2010 $0**
FY 2011 $0

Number of Services Provided by Enhanced Coverage, Benefits or Retained Enrollment: 0

Number of Potential Newly Eligible People: 0

Eligibility Simplification: No

Provider Payment Increase: No

Delivery System Innovation: No

Number of People Losing Medicaid Eligibility: No

Reduces Benefits: No

Detail: **Effective for services on or after April 1, 2009, this amendment makes revisions to methodology for supplemental upper payment limit (UPL) payments to public and state hospitals. Specifically this amendment clarifies that "cost-based" hospitals will not receive a payment under this methodology. Ohio defines "cost-based hospitals as hospitals excluded from the DRG prospective payment system.**

Other Considerations:

This plan amendment has not generated significant outside interest and we do not recommend the Secretary contact the governor.

Recovery Act Impact:

The Regional office has reviewed this state plan amendment in conjunction with the Recovery Act and, based on the available information provided by the State regarding 1) MOE; 2) local match; 3) prompt pay; 4) rainy day funds, and 5) eligible expenditures, the Regional Office believes that the State is not in violation of the Recovery Act requirements noted above.

CMS Contact:

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