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 as described in rule 5101:3-2-07.3 of the Administrative Code for the diagnosis related group (DRG) as defined in rule 5101:3-2-02 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; and

(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

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 (ODHS or JFS as appropriate) 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. The department will combine the total cost, total charges, total days, medicaid charges, and medicaid discharges for the hospitals. A new report will be prepared by the department 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.

(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 ODHS 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.

(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.

(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.

(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)(e) 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

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 5101:3-2-07.3 of the Administrative Code and includes outlier cases described in rule 5101:3-2-07.9 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 5101:3-2-07.3 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 the 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.

(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

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 that 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.

(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 except as provided in paragraph (G)(2) of this rule, 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 weights shown in this paragraph. Price growth increase values for these weighted items are determined by "Global Insight" 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"

The categories and indexes are those identified in paragraphs (G)(1)(a) to (G)(1)(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.

(m) Apparel: PPI - textile products and apparel, U.S. The weight is .0087.

(n) Machinery and equipment: PPI - machinery and equipment, U.S. The weight is .0021.

(o) Miscellaneous products: PPI - finished goods, U.S. The weight is .0224.

(p) Postage: CPIU - postage, U.S. The weight is .0027.

(q) Telephone services: CPIU - telephone services, U.S. The weight is .0058.

(r) All other, labor intensive: ECI - compensation business services, U.S. The weight is .0728.

(s) All other, non-labor intensive: CPIU - all items, ENC. The weight is .0080.

(t) Miscellaneous: CPIU - medical care, ENC. The weight is .0849.

(2) Application of estimated inflation factors.

The inflation values applied at the beginning of each rate year to produce a new composite inflation factor shall be based on the estimate of price indicators outlined in paragraphs (G) and (G)(1) of this rule that have been supplied to the department by three months prior to the beginning of a new rate year, except for the rate year beginning ~~January 1, 2006 and ending December 31, 2006 and the rate year beginning January 1, 2007 and ending December 31, 2007 when the composite inflation factor will be adjusted to 0.00 percent, and the rate year beginning January 1, 2008 and ending December 31, 2008 the composite inflation factor will be adjusted to 0.00 per cent and the rate year beginning~~ January 1, 2009 and ending December 31, 2009, and the rate year beginning January 1, 2010 and ending December 31, 2010 and the rate year beginning January 1, 2011 and ending December 31, 2011 the composite inflation factor will be adjusted to 0.00 per cent. Not withstanding the 0.00 per cent composite inflation factor updates in this paragraph, for discharges occurring during the period beginning October 1, 2009 and ending June 30, 2011 a five per cent increase shall be applied to the rates in effect on September 30, 2009. The inflation factors shall be uniformly applied to the average cost per discharge component and shall remain fixed for that rate period.

(3) Calculation of inflated peer group adjusted average cost per discharge, including each children's hospital adjusted average cost per discharge.

(a) For each hospital/peer group, the peer group adjusted average cost per discharge derived from paragraph (F)(3) or (F)(4) of this rule, as applicable, is multiplied by an inflation factor derived from paragraph (G)(2) of this rule. Round the result to the nearest whole penny.

(b) For each children's hospital as defined in rule 5101:3-2-07.2 of the Administrative Code, the hospital-specific adjusted average cost per discharge derived from paragraph (F)(4) of this rule is multiplied by an inflation factor derived from paragraph (G)(2) of this rule. Round the result to the nearest whole penny.

(H) Addition of hospital-specific allowances.

Hospital-specific allowances include those described in paragraphs (H)(1) to (H)(3) of this rule.

(1) For Ohio hospitals having approved teaching programs as defined in 42 C.F.R. 405.421 as effective on October 1, 1985, an education allowance amount is added. The medical education allowance amount is described in rule 5101:3-2-07.7 of the Administrative Code.

(2) For Ohio hospitals, a hospital-specific capital allowance amount is added. The capital allowance amount is described in rule 5101:3-2-07.6 of the Administrative Code.

(3) For non-Ohio hospitals, a single capital allowance amount is added. The capital allowance amount is described in rule 5101:3-2-07.6 of the Administrative Code.

(I) The final prospective payment rate is calculated by multiplying the adjusted inflated average cost per discharge, derived from paragraphs (G)(3)(a) and (G)(3)(b) of this rule, by the relative weight appropriate to the DRG (see rule 5101:3-2-07.3 of the Administrative Code), rounding the result to the nearest whole penny, then adding all applicable hospital-specific allowance amounts described in paragraphs (H)(1) to (H)(3) of this rule, i.e.:

"Adjusted Inflated Average	X	DRG Relative Weight	+	Hospital-Specific Capital Allowance (as	+	Hospital-Specific Education Allowance (as	=	Final Prospective Payment Rate"

Cost Per Discharge	applicable)	applicable)

5101:3-2-07.4

Effective:

R.C. 119.032 review dates: 07/31/2009

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Certification

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Date

Promulgated Under:	119.03
Statutory Authority:	5111.02
Rule Amplifies:	5111.01, 5111.02
Prior Effective Dates:	10/4/84, 7/1/85, 7/5/86, 10/19/87, 7/1/88 (Emer), 9/29/88, 7/1/89, 6/29/90 (Emer), 9/23/90, 9/3/91(Emer), 11/10/91, 7/1/92, 7/1/93, 12/29/95 (Emer), 3/16/96, 7/1/96, 7/2/98, 1/1/00, 1/1/02, 12/31/02 (Emer), 2/6/03, 8/21/03, 12/8/05, 12/31/07 (Emer), 3/30/08

Existing

I. CALCULATION OF NEW BASE YEAR HOSPITAL SPECIFIC AVERAGE COST PER DISCHARGE

A. For each hospital, identify total Medicaid inpatient costs, adjusted to remove the cost of blood replaced by patient donors, to include PSRO/UR cost separately identified, and to include the cost of malpractice insurance. This amount is the amount derived as identified in paragraph (D)(6)(e) of rule 5101:3-2-074 of the Administrative Code. Divide this amount by the number of discharges for each hospital as discharges are described in paragraph (D)(11)(a) of rule 5101:3-2-074 of the Administrative Code to produce the initial average cost per discharge.

B. Remove Direct Costs of Medical Education

1. For each hospital, identify direct costs of medical education from paragraph (D)(7)(b) of rule 5101:3-2-074 of the Administrative Code.

2. Divide the direct medical education amount from Section (I)(B)(1) of this Appendix by total Medicaid inpatient costs adjusted as described in Section (I)(A) of this Appendix and add 1.00.

3. Divide the initial average cost per discharge described in Section (I)(A) of this Appendix by the direct medical education factor derived from Section (I)(B)(2) of this Appendix.

C. Remove Capital-Related Costs

1. For each hospital, identify capital-related cost from paragraph (D)(8)(b) of this rule.

2. Divide capital-related cost from Section (I)(C)(1) of this Appendix by total Medicaid inpatient costs adjusted as described in Section (I)(A) of this Appendix and add 1.00.

3. Divide the average cost per discharge amount derived from Section (I)(B)(3) of this Appendix by the capital factor derived from Section (I)(C)(2) of this Appendix.

D. Remove Indirect Teaching

1. For each hospital, identify the number of interns and residents described in paragraph (A)(1) of rule 5101:3-2-077 of the Administrative Code.

2. For each hospital, identify the number of beds described in paragraph (B) (1) of rule 5101:3-2-077 of the Administrative Code.

3. Divide the number of interns and residents described in Section (I)(D)(1) of this Appendix by the number of beds described in Section (I)(D)(2) of this Appendix to obtain the intern-and resident-to-bed ratio. Divide this ratio by .10, multiply the resulting product by .05795, then add 1.00.

4. Divide the average cost per discharge derived from Section (I)(B)(3) of this Appendix by the indirect medical education factor derived from Section (I)(D)(3) of this Appendix.

II. CALCULATION OF LIMITS ON REIMBURSABLE COSTS AND CEILINGS ON RATE OF HOSPITAL INCREASES

Hospital-specific values referenced in this Section of this Appendix are those shown in Attachment 1 to this Appendix. The values shown in Attachment 1 were calculated in accordance with the provisions of Chapter 5101:3-2 of the Administrative Code as such provisions were in effect as of October 1, 1984, with three exceptions. Peer Group Values reflect those peer grouping criteria described in rule 5101:3-2-072 of the Administrative Code and, for purposes of this Appendix, Children's hospitals as defined in rule 5101:3-2-072 of the Administrative Code are peer grouped. Where such values were revised at the request of hospitals, the values reflect those in effect for the rate period beginning July 1, 1985. For certain hospital values indicated in Attachment 1, values have been revised to reflect revisions made by the Health Care Finance Administration and made available to the department by July 1, 1987. Where a hospital believes that the values shown in Attachment 1 are different than those described in this paragraph or believes that those values which reflect revisions made by the Health Care Finance Administration are incorrect, the provisions of Rules 5101:3-2-078 and 5101:3-2-0712 of the Administrative Code regarding reconsideration and redetermination of payment rates shall apply.

A. Calculation of Limits on Reimbursable Costs

1. Adjustment of Calendar Year 1982 Peer Group Average Cost Per Discharge Amount for Growth

For each Ohio Peer Group, the Peer Group Average Cost Per Discharge shown in Attachment 1 is multiplied by the following composite growth factor as indicated:

DATE OF HOSPITAL'S FISCAL YEAR END	GROWTH FACTOR
September 30	1.480679
October 31	1.493045
December 31	1.518000
March 31	1.533342
May 31	1.543741
June 30	1.548855
August 31	1.559425

2. Wage Adjustment for Hospitals in the Teaching Hospital Peer Group

For hospitals identified in paragraph (A)(1) of rule 5101:3-2-072 of the Administrative Code, the value derived from Section (II)(A)(1) of this Appendix is multiplied by a wage factor for the base year period. The wage factors are:

METROPOLITAN STATISTICAL AREA	WAGE FACTOR
Cincinnati, Ohio	1.0744
Cleveland, Ohio	1.1628
Columbus, Ohio	1.0625
Toledo, Ohio	1.1092

3. Case Mix Adjustment

The amounts derived from Section (II)(A)(2) of this Appendix are multiplied by the hospital-specific case mix factor shown in Attachment 1 of this Appendix, to produce a case mix adjusted limit on reimbursable costs.

B. Calculation of Ceilings on Rate of Hospital Increases

1. Inflation of calendar year 1982 Hospital-Specific Average Cost Per Discharge Amounts.

For each Ohio hospital, the Hospital-Specific Average Cost Per Discharge shown in Attachment 1 is multiplied by the following composite inflation factor, as indicated:

DATE OF HOSPITALS FISCAL YEAR END	INFLATION FACTOR
September 30	1.174485
October 31	1.179754
December 31	1.190261
March 31	1.205151
May 31	1.215243
June 30	1.220207
August 31	1.230464

2. Wage Adjustment for Hospitals in the Teaching Hospital Peer Group

For hospitals identified in paragraph (A)(1) of rule 5101:3-2-072 of the Administrative Code, the value derived from Section (II)(B)(1) of this Appendix is multiplied by a wage factor for the base year period. The wage factors are:

METROPOLITAN STATISTICAL AREA	WAGE FACTOR
Cincinnati, Ohio	1.0744
Cleveland, Ohio	1.1628
Columbus, Ohio	1.0625
Toledo, Ohio	1.1092

3. Case Mix Adjustment

The amounts derived from Section (II)(B)(2) of this Appendix are multiplied by the hospital-specific case mix factor shown in Attachment 1 of this Appendix, to produce a case mix adjusted ceiling on rate of hospital increase.

III. IDENTIFICATION OF HOSPITALS SUBJECT TO A REDUCTION IN HOSPITAL-SPECIFIC AVERAGE COST PER DISCHARGE AMOUNTS

Hospitals subject to a reduction in the hospital-specific average cost per discharge amount described in paragraph (D)(11)(b) of rule 5101:3-2-074 of the Administrative Code are those whose new base year average cost per discharge, as derived from Section (I)(D) of this Appendix, exceeds either:

A. the case mix adjusted limit on reimbursable cost derived from Section (II)(A)(2) of this Appendix; or

B. the case mix adjusted ceiling on rate of increase derived from Section (II)(B)(2) of this Appendix.

5101:3-2-07.4

APPENDIX A

Attachment 1

Provider #	Provider Name	Peer Group	B2 BaseCasemix	B2 Base Hospital-Specific Avg. Cost Per Discharge
0461807	Barnesville Hosp. Assoc. Inc.	01	1.24641	$1,323.93
1514276	City Hospital-Bellaire	01	0.85925	$1,416.05
5020506	Lawrence County General Hosp	01	0.86360	$1,080.35
5511566	Marietta Memorial Hospital	01	1.03979	$1,878.11
5569406	E Ohio Reg Hosp Martins Ferry	01	1.04330	$1,119.57
6543968	Ohio Valley Hospital	01	0.91490	$1,028.58
7647069	St John Medical Center	01	1.02950	$1,466.39
7943257	Selby General Hospital	01	0.92262	$1,268.03
	PEER GROUP AVG COST PER DISCHARGE			$1,233.78
0641336	Berger Hospital	02	1.03080	$ 977.57
1373115	Grady Memorial Hospital	02	0.93208	$1,909.72
2229636	Doctors Hospital-Cols	02	1.04067	$1,114.85
3359253	Grant Medical Center	02	1.07010	$1,345.75
4939179	Lancaster-Fairfield Comm. Hosp	02	0.92885	$ 992.42
5172389	Licking Memorial Hospital	02	0.90520	$1,007.82
5417178	Madison County Hospital	02	0.87810	$1,324.69
5874808	Memorial Hospital of Union Co	02	1.02553	$1,424.21
5887189	Mercy Hospital-Cols	02	1.36956	$1,477.22
6196165	Mount Carmel Health	02	1.08691	$1,382.75
7392469	Riverside Methodist Hosp-Cols	02	1.10471	$1,475.10
7643394	St Ann's Hospital	02	0.70055	$1,577.72
7643527	Saint Anthony Medical Center	02	1.43472	$1,595.85
	PEER GROUP AVG COST PER DISCHARGE			$1,279.65
0787662	Bluffton Community Hospital	03	0.86498	$ 854.34
4434508	Joint Township District Memorial	03	0.85844	$1,159.68
5184518	Lima Memorial Hospital	03	0.93902	$1,100.26
5489663	Mansfield General Hospital	03	0.93821	$1,209.28
6827483	Peoples Hospital Inc	03	1.16783	$ 994.53
7648503	St Rita's Medical Center	03	1.05321	$1,272.21
8013509	Shelby Memorial Hospital	03	0.79816	$ 870.85
	PEER GROUP AVG COST PER DISCHARGE			$1,170.27
0127508	Alliance City Hospital	04	0.89317	$1,030.70
0318758	Aultman Hospital	04	0.97429	$1,207.42
2229770	Doctor's Hospital-Stark Co	04	0.92180	$1,171.49
5589420	Massillon Community Hospital	04	0.87769	$1,188.46
8802602	Timken Mercy Med Ctr	04	0.97619	$1,731.76
	PEER GROUP AVG COST PER DISCHARGE			$1,295.80
0117402	Allen Memorial Hospital	05	0.92753	$1,339.27
0158752	Amherst Hospital	05	0.79744	$1,539.11

2527500	Elyria Memorial Hospital	05	0.87524	$1,362.05
2875330	Fort Hamilton Hughes Mem Hosp	05	0.77776	$1,462.31
5281350	Lorain Community Hospital	05	1.14210	$ 741.57
5887278	Mercy Hospital-Hamilton	05	1.24212	$1,539.12

Attachment 1

Provider #	Provider Name	Peer Group	B2 BaseCasemix	B2 Base Hospital-Specific Avg. Cost Per Discharge
5948505	Middletown Regional Hospital	05	0.94630	$1,110.26
7647407	St Joseph Hospital-Lorain	05	0.93568	$1,247.77
8294359	Wellington Community hospital	05	0.99998	$1,095.57
	PEER GROUP AVG COST PER DISCHARGE			$1,342.90
7645338	St Elizabeth Hospital	06	1.20905	$1,405.96
7647729	St Joseph Riverside Hospital	06	0.81718	$1,233.25
8895843	Trumbull Memorial Hospital	06	0.89367	$1,567.26
9209752	Warren General Hospital	06	0.95699	$1,454.61
9736361	Youngstown Hospital Association	06	1.02364	$1,929.47
9736816	Youngstown Osteopathic Hospital	06	0.96823	$1,464.82
	PEER GROUP AVG COST PER DISCHARGE			$1,570.13
0069161	Akron City Hospital	07	1.03400	$1,456.02
0069483	Akron General Medical Center	07	1.02554	$1,280.29
0171362	Providence Hospital Cincinnati	07	1.35195	$1,526.90
0217447	Clermont Mercy Hospital	07	1.14365	$1,660.56
0414206	Sycamore Hospital	07	1.45468	$1,644.99
0438600	Barberton Citizen's Hospital	07	0.92184	$1,181.78
0684504	Bethesda Hospital-Cincinnati	07	0.96205	$1,466.59
1485503	The Christ Hospital	07	1.13474	$1,398.28
2054502	Deaconess Hospital-Cincinnati	07	1.42023	$1,417.16
2151255	Dettmer Hospital	07	1.14792	$ 684.02
2560509	Otto C Epp. Memorial Hospital	07	1.38463	$1,690.48
3293485	Good Sam-Cinci	07	1.12342	$1,215.22
3293565	Good Sam-Dayton	07	1.07277	$1,877.47
3354525	Grandview Hospital	07	1.02169	$1,746.72
3389506	Cuyahoga Falls General Hospital	07	0.87954	$1,518.09
3409501	Greene Memorial Hospital	07	1.15907	$1,259.31
4366805	The Jewish Hospital	07	0.87762	$2,126.05
4666259	Kettering Medical Center	07	1.77763	$1,879.43
5874480	Piqua Memorial Medical Center	07	0.86832	$1,099.55
5887634	Mercy Med Ctr-Springfield	07	1.09310	$1,568.96
5935608	Miami Valley Hospital	07	1.01462	$1,614.31
6639409	Our Lady of Mercy Hospital	07	0.78748	$1,395.37
7428859	Robinson Memorial Hospital	07	1.03157	$1,221.84
7645221	St Elizabeth Med Ctr	07	0.98455	$1,822.19
7645883	St Francis/St George Hospital	07	1.24159	$1,468.03
7649601	Saint Thomas Hospital Medical Center	07	1.18157	$ 994.98
8348569	Community Hospital of Springfield	07	0.83554	$1,370.27

8502258	Stouder Memorial Hospital	07	0.86810	$1,170.87
	PEER GROUP AVG COST PER DISCHARGE			$1,494.91
0089998	Hillcrest Hospital	08	0.71397	$3,074.66
0452675	St John and West Shore Hospital	08	0.84712	$2,016.33
0563751	Community Hosp of Bedford	08	0.93731	$1,300.90
0964602	Brentwood Hospital	08	1.01450	$1,466.51
2593420	Euclid General Hospital	08	1.14306	$1,983.97
2596338	Deaconess Hosptial-Cleveland	08	0.00676	$1,977.07
2633565	Fairview General Hospital	08	0.82771	$1,562.18

Attachment 1

Provider #	Provider Name	Peer Group	B2 BaseCasemix	B2 Base Hospital-Specific Avg. Cost Per Discharge
3106758	Geauga Community Hospital	08	0.86943	$1,581.86
3337400	Grace Hospital	08	0.97303	$1,307.09
4195517	Huron Road Hospital	08	1.38205	$2,038.77
4922507	Lake County Memorial Hospital	08	0.90697	$1,421.61
4923882	Lakewood Hospital	08	1.25186	$1,729.27
5243669	Lodi Community Hospital	08	1.18203	$1,242.23
5345406	Lutheran Medical Center	08	1.41210	$2,101.69
5575800	Marymount Hospital Inc	08	0.90686	$1,684.55
5850968	Medina Community Hospital	08	0.86502	$1,057.63
6456508	Northeastern Ohio General Hosp	08	1.22363	$1,383.10
6725100	Parma Community Genrl Hospital	08	0.77160	$1,766.57
7344190	Richmond Hts General Hospital	08	1.15578	$1,565.33
7643134	St Alexis Hospital	08	0.88260	$1,474.74
7647167	St John Hosp-Cleveland	08	1.24003	$1,845.01
7648406	St Lukes Hosp-Cleveland	08	0.90486	$2,078.86
7649709	St Vincent Charity Hospital	08	1.45626	$2,021.87
8295509	Southwest General Hospital	08	0.98819	$1,551.20
8552507	Suburban Community Hospital	08	1.38653	$1,710.17
9112347	Wadsworth-Rittman Hospital	08	1.12515	$1,052.29
	PEER GROUP AVG COST PER DISCHARGE			$1,755.62
1508256	University Hospital-Cinci	09	1.06671	$1,606.90
1563562	Cleveland Clinic Hospital	09	1.71870	$1,749.48
1564543	Cleveland Metro General Hospital	09	1.02210	$1,392.45
5616506	Medical College of Ohio Hospital	09	1.39831	$2,273.67
6196647	The Mt. Sinai Medical Ctr	09	0.96276	$1,952.94
6543682	Ohio State University Hospital	09	1.56280	$1,616.51
8962421	University Hosp-Cleveland	09	0.95907	$1,648.53
	PEER GROUP AVG COST PER DISCHARGE			$1,622.57
2077729	Fulton County Health Center	10	0.84924	$1,390.98
2834339	Flower Memorial Hospital	10	1.05536	$1,651.17
5887812	Mercy Hospital-Toledo	10	0.95162	$2,309.32

6723148	Parkview Hospital	10	1.02019	$1,666.42
7392423	Riverside Hospital-Toledo	10	0.88054	$1,726.87
7644259	St Charles Hospital	10	1.01870	$1,509.93
7648602	St Lukes Hospital Maumee	10	1.22482	$2,770.93
7649905	St Vincent Med Ctr	10	0.97795	$1,969.15
8822662	The Toledo Hospital	10	1.06997	$1,674.11
9626506	Wood County Hospital	10	0.91490	$ 872.54
	PEER GROUP AVG COST PER DISCHARGE			$1,798.59
0135099	Harrison Community Hospital	11	1.05860	$1,090.13
0366134	Potters Medical Center	11	1.19843	$1,564.92
0592336	Bellevue Hosp	11	1.06754	$1,099.80
1058662	Brown Memorial Hosp	11	0.90569	$ 972.11
1112843	Bucyrus Community Hosp	11	0.85758	$1,048.92
1254404	Bryan Community Hosp	11	0.91762	$ 983.92
1677841	Comm Mem Hosp-Hicksville	11	0.87395	$ 935.52
1863809	Crestline Memorial Hosp	11	1.03094	$ 971.49

Attachment 1

Provider #	Provider Name	Peer Group	B2 BaseCasemix	B2 Base Hospital-Specific Avg. Cost Per Discharge
2370250	Dunlap Memorial Hosp	11	0.83664	$ 896.19
2675403	Fayette County Hosp	11	0.93169	$ 896.96
2888924	Fostoria City Hosptial	11	0.86306	$1,296.32
3412855	Greenfield Area Med Ctr	11	1.27446	$1,609.30
3822751	Henry County Hosp	11	1.01238	$ 693.49
3922778	Highland District Hosp	11	0.86562	$1,290.22
4666508	Kettering Hosp	11	1.59419	$ 376.06
5874568	Memorial Hosp of Geneva	11	1.05294	$1,013.36
5887901	Mercy Mem Hosp-Urbana	11	1.24523	$1,157.03
6171566	Morrow County Hosp	11	1.00291	$1,006.99
6196567	Doctors Hosp-Nelsonville	11	1.23294	$ 923.81
6767502	Paulding County Hospital	11	0.90036	$ 577.13
6942509	Pike Community Hospital	11	1.12997	$1,338.48
6999664	Joel Pomerane Mem Hospital	11	0.84571	$1,155.31
7690753	Firelands Community Hospital-Sand Mem	11	0.78258	$ 977.70
8934425	Twin City Hosp	11	0.92052	$1,100.61
9053509	Veterans Memorial Hospital	11	1.14252	$1,074.51
9474500	Willard Area Hospital Inc	11	0.85426	$1,347.04
9687512	Wyandot Memorial Hosp	11	1.07256	$1,137.73
	PEER GROUP AVG COST PER DISCHARGE			$1,069.28
0362129	Knox Community Hosp	12	0.89776	$1,010.97
1037667	Brown County General	12	0.89360	$1,020.38
1575148	Clinton Memorial Hosp	12	0.95958	$1,320.41
1293340	Coshocton City Memorial Hosp	12	0.86405	$ 949.81
2079503	Defiance Hosp	12	0.90521	$1,181.78
2701502	Fisher-Titus Memorial Hosp	12	1.89374	$1,249.27

3031507	Galion Comm Hosp	12	0.90923	$1,150.90
3293725	Firelands Comm Hosp-Good sam	12	1.33161	$1,254.67
3486259	Guernsey Memorial Hospital	12	1.00337	$1,204.62
3653756	Hardin Memorial Hosp	12	0.95950	$1,157.42
3978503	Hocking Valley Comm Hosp	12	0.96161	$ 904.10
5430662	HB Magruder Mem Hosp	12	0.85456	$1,042.08
5874728	Memorial Hosp	12	0.87219	$1,026.48
5887545	Mercy Hosp-Portsmouth	12	1.15904	$1,117.45
5887723	Mercy Hosp-Tiffin	12	0.81472	$ 778.93
6639605	Mercer City Jt Twp Comm Hosp	12	0.85059	$1,105.18
7098751	Providence Hosp-Sandusky	12	1.11655	$1,217.44
7608503	Mary Rutan Hospital	12	0.85330	$1,130.21
7664255	Samaritan Hosp	12	0.92510	$ 924.62
8017265	O'Bleness Mem Hosp	12	0.85812	$ 924.16
8294304	Southern Hills Hosp	12	1.24656	$1,306.25
9027663	Van Wert County Hosp	12	0.82623	$1,075.82
9250484	Wayne Hosp Co	12	0.89648	$ 829.50
9548609	Wilson Memorial Hosp	12	1.02477	$ 824.38
9656251	Wooster Comm Hosp	12	0.89481	$1,009.92
	PEER GROUP AVG COST PER DISCHARGE			$1,072.93
0465509	Childrens Medical Center-Dayton	13	1.16857	$2,178.51
1473203	Childrens Hosp-Akron	14	1.30245	$1,966.03
1473276	Childrens Hosp-Cols	15	1.15572	$1,915.24

Attachment 1

Provider #	Provider Name	Peer Group	B2 BaseCasemix	B2 Base Hospital-Specific Avg. Cost Per Discharge
1473285	Childrens Hosp-Cinci	16	1.07091	$1,414.05
0548143	Rainbow Babies and Childrens	17	1.28712	$2,616.75
0560343	100 Babies Hosp	19	1.35268	$1,460.13
1721506	Convalescent Hosp for Children	18	1.12148	$1,888.91
	PEER GROUP AVG COST PER DISCHARGE			$2,016.01
0289343	Ashtabula Co Med Ctr	99	0.80678	$1,024.96
0684755	Bethesda Hosp-Zanesville	99	0.87722	$1,230.73
0759666	Blanchard Valley Hosp	99	0.90536	$1,068.29
1475685	Medical Ctr Hosp-Chillicothe	99	0.99250	$1,149.98
1677850	MedCenter Hosp Inc-Marion	99	1.08543	$1,143.84
2413481	E Liverpool City Hosp	99	0.96815	$1,004.00
3293887	Good Sam -Zanes	99	1.00692	$1,346.20
4046562	Holzer Med Ctr	99	0.94565	$1,071.79
5514803	Marion General Hosp	99	0.82516	$1,587.01
7654408	Salem Comm Hosp-N Col County	99	0.95151	$ 937.44
7892571	Scioto Memorial Hosp	99	0.83219	$ 994.31
8957759	Union Hospital	99	0.93251	$1,086.28
	PEER GROUP AVG COST PER DISCHARGE			$1,126.46

MAR 1 7 2010
TN No. 09-015 Approval Date: _____
SUPERSEDES
TN No. 08-002 Effective Date: 10-01-2009

OS Notification

State/Title/Plan Number: Ohio 09-015

Type of Action: SPA Approval

Required Date for State Notification: March 31, 2010

Fiscal Impact:

FY 2010	$35,900,000
FY 2011	$36,100,000

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: Yes

Delivery System Innovation: No

Number of People Losing Medicaid Eligibility: No

Reduces Benefits: No

Detail: Effective for services on or after October 1, 2009, this amendment revises methodology for inpatient hospital payment rates. Specifically, this amendment adjusts the composite inflation factor for CY's 2010 and 2011 and provides for a one-time five percent increase effective for discharges occurring between October 1, 2009 and June 30, 2011.

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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National Institutional Reimbursement Team