Supplemental Inpatient Hospital Upper Limit Payments For Private Hospitals

A. For each Ohio hospital owned or operated by an entity other than a governmental Entity, paid under the prospective payment system for inpatient services, calculate the estimated amount that Medicare would have paid for an inpatient discharge if Medicare were paying the care for Medicaid consumers.

a. Inpatient upper payment limit gap calculation for private hospitals excluding private free standing psychiatric hospitals.

1. Divide the total Medicare inpatient hospital payment by the hospital's Medicare inpatient hospital charges to calculate the hospital specific Medicare payment to charge ratio.

2. Multiply the hospital specific Medicare payment to charge ratio by Medicaid charges to calculate the estimated Medicare payment for Medicaid consumers.

3. For each private hospital, calculate the available payment gap by taking total estimated Medicare payment for Medicaid discharges as calculated in paragraph (A)(2) and subtracting actual Medicaid payments.

b. Inpatient upper payment limit gap calculation for private free standing psychiatric hospitals.

1. Identify inpatient Medicaid costs for each private free standing psychiatric hospitals.

2. Identify inpatient Medicaid payments for each private free standing psychiatric hospitals

3. For each free standing private psychiatric hospital, calculate the inpatient upper payment limit gap by subtracting the amount in paragraph (A)(b)(2) from the amount in (A)(b)(1).

c. For all private hospitals, the sum of the amounts calculated in paragraph (A)(a)(3) and (A)(b)(3) on page 31 of Attachment 4.19-A, is the aggregate inpatient upper limit payment gap for all private hospitals. The available inpatient gap for private hospitals calculated in this paragraph is the same as the inpatient gap calculated in paragraphs (A) of page 29 of Attachment 4.19 A.

B. The resulting amount calculated in paragraph (A) on page 31 of Attachment 4.19-A will be in effect from the effective date of the state plan amendment through December 31 of that year, and from January 1 through December 31 of each year after.

C. The source data for calculations described in this amendment will be based on cost reporting data described in rule 5101:3-2-23 of the Ohio Administrative Code which reflects the most recent completed interim settled Medicaid cost report (JFS 02930) for all hospitals, and the Medicare cost report (CMS 2552-96) for the corresponding cost reporting period.

D. The department will make supplemental payments to private hospitals upto the amount described by paragraphs (A) on page 31 of Attachment 4.19-A through (C) on page 31 of

Attachment 4.19-A as follows: Payments will be made to private hospitals on an annual basis, based upon the ratio of each private hospital's actual inpatient Medicaid fee-for-service days derived from actual Medicaid discharges paid during the state fiscal year to the total Medicaid fee-for-service days for all private hospitals derived from actual inpatient discharges paid for through the department's MMIS in the state fiscal year prior to the month of payment, subject to the provisions in paragraph (B) on page 31 of Attachment 4.19-A. If the total funds that would be paid to all private hospitals exceeds the aggregate upper payment limit for all private hospitals, then the amount paid to all private hospitals will be limited to their proportion of the aggregate upper payment limit.

E. Hospital payments made under this section, when combined with other payments made under the State plan shall not exceed the limit specified in 42 CFR 447.271.

F. The total funds that will be paid to each private hospital will be included in the calculation of disproportionate share limits as described in rule 5101:3-2-07.5 of the Ohio Administrative Code.

Supplemental Inpatient Hospital Upper Limit Payments For Private Hospitals

A. For each Ohio hospital owned or operated by an entity other than a governmental Entity, paid under the prospective payment system for inpatient services, calculate the estimated amount that Medicare would have paid for an inpatient discharge if Medicare were paying the care for Medicaid consumers.

a. Inpatient upper payment limit gap calculation for private hospitals excluding private free standing psychiatric hospitals.

1. Divide the total Medicare inpatient hospital payment by the hospital's Medicare inpatient hospital charges to calculate the hospital specific Medicare payment to charge ratio.

2. Multiply the hospital specific Medicare payment to charge ratio by Medicaid charges to calculate the estimated Medicare payment for Medicaid consumers.

3. For each private hospital, calculate the available payment gap by taking total estimated Medicare payment for Medicaid discharges as calculated in paragraph (A)(2) and subtracting actual Medicaid payments.

b. Inpatient upper payment limit gap calculation for private free standing psychiatric hospitals.

1. Identify inpatient Medicaid costs for each private free standing psychiatric hospitals.

2. Identify inpatient Medicaid payments for each private free standing psychiatric hospitals

3. For each free standing private psychiatric hospital, calculate the inpatient upper payment limit gap by subtracting the amount in paragraph (A)(b)(2) from the amount in (A)(b)(1).

c. For all private hospitals, the sum of the amounts calculated in paragraph (A)(a)(3) and (A)(b)(3) on page 31 of Attachment 4.19-A, is the aggregate inpatient upper limit payment gap for all private hospitals. The available inpatient gap for private hospitals calculated in this paragraph is the same as the inpatient gap calculated in paragraphs (A) of page 29 of Attachment 4.19 A.

B. The resulting amount calculated in paragraph (A) on page 31 of Attachment 4.19-A will be in effect from the effective date of the state plan amendment through December 31 of that year, and from January 1 through December 31 of each year after.

C. The source data for calculations described in this amendment will be based on cost reporting data described in rule 5101:3-2-23 of the Ohio Administrative Code which reflects the most recent completed interim settled Medicaid cost report (JFS 02930) for all hospitals, and the Medicare cost report (CMS 2552-96) for the corresponding cost reporting period.

D. The department would make supplemental payments to private hospitals up to the amount described by paragraphs (A) on page 31 of Attachment 4.19-A through (C) on page 31 of

Attachment 4.19-A as follows: Payments will be made to private hospitals on an annual basis, based upon the ratio of each private hospital's actual inpatient Medicaid fee-for-service days derived from actual Medicaid discharges paid during the state fiscal year to the total Medicaid fee-for-service days for all private hospitals derived from actual inpatient discharges paid for through the department's MMIS in the state fiscal year prior to the month of payment, subject to the provisions in paragraph (B) on page 31 of Attachment 4.19-A. If the total funds that would be paid to all private hospitals exceeds the aggregate upper payment limit for all private hospitals, then the amount paid to all private hospitals will be limited to their proportion of the aggregate upper payment limit.

E. Hospital payments made under this section, when combined with other payments made under the State plan shall not exceed the limit specified in 42 CFR 447.271.

F. The total funds that will be paid to each private hospital will be included in the calculation of disproportionate share limits as described in rule 5101:3-2-07.5 of the Ohio Administrative Code.

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5101:3-2-52 **Supplemental inpatient hospital payments for private hospitals.**

This rule sets forth the methodology used to determine the supplemental inpatient hospital payments to private hospitals required by Section 309.30.17 of Amended Substitute House Bill 1 of the 128th General Assembly.

(A) Definitions.

(1) "Private hospital" means an Ohio hospital, other than a public hospital as defined in rule 5101:3-2-50 or a state hospital as defined in 5101:3-2-51 or a children's hospital as defined in rule 5101:3-2-53 of the Administrative Code, which is subject to prospective payment as described in rule 5101:3-2-07.1 of the Administrative Code.

(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) "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.

(4) "Total medicaid inpatient discharges" means for each 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.

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

(6) "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.

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

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

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(9) "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.

(10) "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.

(11) "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.

(12) "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.

(13) "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.

(14) "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.

(15) "Total medicaid days" means for each private hospital the number of days reported from the facility for medicaid fee-for-service patients, as reported on the medicaid cost report, as specified in paragraph (B) of this rule.

(16) "Program year" means the twelve month period beginning on the first day of January and ending on the thirty first day of December.

(B) Source data for calculations.

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

(C) Calculation of available inpatient payment gap for private hospitals and private children's hospitals as defined in rule 5101:3-2-53.

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

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(a) For each private and private children's hospital, calculate the total medicare inpatient payment by adding the amounts described in paragraphs (A)(6) to (A)(13) of this rule.

(b) For each private and private children's hospital, calculate the medicare payment-to-charge ratio by dividing the amount calculated in paragraph (C)(1)(a) of this rule by the total medicare inpatient charges as described in paragraph (A)(14) of this rule.

(c) For each private and private children's hospital, calculate the total estimated medicare inpatient payment for medicaid inpatient discharges by multiplying the amount calculated in paragraph (C)(1)(b) of this rule by the total medicaid inpatient charges as described in paragraph (A)(5) of this rule.

(d) For each private and private children's hospital, calculate the available inpatient payment gap by taking total estimated medicare inpatient payments for medicaid inpatient discharges as calculated in paragraph (C)(1)(c) of this rule and subtracting actual total medicaid inpatient payments as described in paragraph (A)(3) of this rule.

(e) For each private and private children's hospital that has an available inpatient payment gap greater than zero resulting from the calculations in paragraph (C)(1)(d) of this rule, calculate the available per discharge supplemental inpatient hospital payment amount by dividing the amount in paragraph (C)(1)(d) of this rule by the amount in paragraph (A)(4) of this rule.

(2) Calculation of available inpatient payment gap for private psychiatric hospitals (PPH) subject to medicaid prospective payment as described in rule 5101:3-2-07.8 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.

(a) For each PPH 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.

(b) For each PPH 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.

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

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(d) For each PPH described in this paragraph, calculate the available inpatient payment gap by subtracting the amount in paragraph (C)(2)(b) of this rule from the amount in paragraph (C)(2)(a) of this rule.

(e) For each PPH described in this paragraph that has an available inpatient payment gap greater than zero resulting from the calculations in paragraph(C)(2)(d) of this rule, calculate the available per discharge supplemental inpatient hospital payment amount by dividing the amount in paragraph (C)(2)(d) of this rule by the amount in paragraph (C)(2)(c) of this rule.

(3) For all private and private children's hospital, sum the amounts calculated in paragraphs (C)(1)(d) and (C)(2)(d) of this rule. This is the aggregate inpatient upper limit for all private and children's hospitals.

(4) The available inpatient gap for private and private children's hospitals calculated in paragraphs (C)(1)(a) to (C)(2)(e) of this rule is the same as the inpatient gap calculated in paragraphs (C)(1)(a) to (C)(2)(e) of rule 5101:3-2-53 of the Ohio Administrative Code. The total available inpatient gap for private and private children's hospitals is the amount described in paragraph (C)(3) of this rule.

(D) For each supplemental payment made after the effective date of this rule, the resulting upper payment limit 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 payment program year.

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

Supplemental inpatient hospital upper limit payments to private hospitals shall be made as follows:

(1) In July of each year after the effective date of the medicaid state plan amendment implementing this payment program, the department will calculate for each eligible private hospital a supplemental inpatient hospital payment amount by multiplying the ratio of each private hospitals' total medicaid fee-for-service days derived from actual medicaid inpatient discharges paid for through the department's medicaid management information system (MMIS) in the state fiscal year prior to the month of payment, to the total medicaid fee-for-service days from all private hospitals derived from actual inpatient discharges paid for through the department's MMIS in the state fiscal year prior to the month of payment in the state fiscal year prior to the month of payment but not earlier than the effective date of the state plan amendment, by the aggregate upper payment limit for all private hospitals calculated each supplemental inpatient upper limit payment program year as described in paragraph (C) of this rule.

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(2) If the total of the funds that will be paid to all private hospitals exceeds the aggregate upper payment limit for all private hospitals calculated each supplemental inpatient upper limit payment program year as described in paragraph (C) of this rule, then the amount paid to each private hospital will be limited to each hospital's proportion of the aggregate upper payment limit.

(3) For each fiscal year the supplemental upper limit payment for private hospitals will not exceed the limits specified in 42 CFR 447.272.

(F) All medicaid payments including payments made under this rule are subject to the limitations described in rule 5101:3-2-24 of the Administrative Code.

(G) The total funds that will be paid to each private hospital 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.