Calculation of Supplemental Inpatient Hospital Upper Limit Payments For Public Hospitals

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

1. Using the Medicare cost report as described in paragraph (C), 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 public 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.

4. For each public hospital that has an available inpatient payment gap greater than zero resulting from the calculations in paragraph (A)(3), calculate the available per discharge supplemental inpatient hospital payment amount by dividing the amount in paragraph (A)(3) by the public hospital's Medicaid discharges.

B. The resulting amount calculated in paragraph (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, an appendix to Attachment 4.19-A which reflects the most recent completed interim settled Ohio Medicaid cost report (JFS 02930) for all hospitals, and the Medicare cost report (HCFA 2552-96) for the corresponding cost reporting period.

D. Payments will be made on a semiannual basis, based upon actual Medicaid discharges paid during the prior six-month period, subject to the provisions in paragraph (B). If the total funds that will be paid to all public hospitals electing to participate exceeds the aggregate upper payment limit for public hospitals, then the amount paid to all public hospitals electing to participate will be limited to their proportion of the aggregate upper payment limit.

E. Supplemental payments to cost-based providers will be excluded from the cost settlement process.

F. 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.

G. The total supplemental inpatient hospital payments paid to each public hospital from the department as described in paragraph (D) will be included in the calculation of disproportionate share limit.

Calculation of Supplemental Inpatient Hospital Upper Limit Payments For State Hospitals

A. Non-psychiatric Ohio hospitals owned and operated by the state as of October 1 of the year preceding payments (state hospitals) shall be paid supplemental amounts for the provision of hospital inpatient services set forth in paragraphs (B) through (E) of this section. The supplemental amounts shall be in addition to any other amounts payable to hospitals with respect to those services.

B. Data sources used in calculating supplemental payments to state owned hospitals include the Medicare Cost Report (CMS 2552-96) and Medicaid MMIS inpatient fee-for-service date of service claims data. For state fiscal year (SFY) 2012 and SFY 2013, the Hospital fiscal year ending in SFY 2010 Medicare cost reports retrieved from the Hospital Cost Report Information System and the Medicaid MMIS data and Ohio Medicaid cost reports (JFS 02930) from the SFY prior to the month of payment will be utilized unless otherwise noted.

C. The total supplemental payments shall not exceed the amount calculated using the following methodology:

1. For each non-psychiatric Ohio hospital, total Medicare costs are divided by total Medicare charges to establish the Cost to Charge Ratio.

2. Ohio Medicaid payments for the portion of the hospital fiscal year preceding 10/1/2009 were inflated by 5% to account for an increase in Medicaid payment rates effective 10/1/2009.

3. Ohio Medicaid charges derived from the cost report described in paragraph (B) were multiplied by the Cost to Charge Ratio in paragraph (C)(1) to establish estimated Ohio Medicaid costs.

4. Ohio Medicaid costs from (C)(3) were inflated using a hospital specific 5-year average of Medicaid costs per patient day. The average is determined using Medicaid cost reports filed in state fiscal years 2005-2009. This hospital specific inflation factor was applied to individual hospital costs at a discounted rate for the partial year for all hospitals with fiscal year end before the 2010 state fiscal year end of 6/30/2010, plus two years to determine the UPL for SFY 2012 and for a third year to determine the UPL for SFY 2013. In the event in which hospital data did not exist for any hospital in years 2005-2009, the state average of 4.43% was utilized. Ohio Medicaid costs were multiplied by a factor of 1.01 for the Critical Access Hospitals.

5. Ohio Medicaid payments from paragraph (C)(2) were then subtracted from the total in paragraph (C)(4) to find the inpatient upper payment limit gap for the state hospitals. The sum of the differences for these hospitals represents the UPL gap.

D. Each non-psychiatric Ohio hospital that is state owned and operated and paid under the prospective payment system shall receive payments based upon the following hospital-specific calculation:

1. Calculate a Medicare payment to charge ratio by dividing total Medicare inpatient payments by total Medicare inpatient charges.

2. Calculate the total estimated Medicare inpatient payment for Medicaid inpatient discharges by multiplying the amount calculated in paragraph (D)(1) by the total Medicaid inpatient charges.

3. Subtract total inpatient Medicaid payments from the amount calculated in paragraph (D)(2).

4. For each hospital, sum the amount calculated in paragraph (D)(3).

5. Each hospital for which the amount calculated in (D)(3) is greater than zero shall receive an amount of the pool based on the ratio of hospital specific Medicaid discharges to the total state hospital Medicaid discharges.

E. From a pool of funds calculated in (C)(5), less the payments made in (D)(5), resulting in a remaining pool amount, state hospitals shall receive a percentage increase in inpatient Medicaid payments. The percentage increase on SFY 2010 total inpatient hospital Medicaid payments will be equal to the remaining pool amount divided by state hospital Medicaid inpatient hospital fee-for-service payments.

F. Using the source data described in paragraph (B), for each free standing psychiatric state hospital owned or operated by the state, calculate the estimated amount that Medicare would have paid for an inpatient discharge if Medicare were paying the care for Medicaid consumers by subtracting Medicaid inpatient payments from Medicaid inpatient costs.

G. For each state psychiatric hospital that has an inpatient payment gap greater than zero resulting from the calculations in paragraph (F), calculate the per discharge supplemental inpatient hospital payment amount by dividing the amount in paragraph (F) by the state hospital's Medicaid discharges. Payments will be made on a semiannual basis, based upon the product of each psychiatric hospital per discharge gap amount and Medicaid discharges paid during the prior six-month period.

H. Payments in paragraph (D) will be paid semiannually and payments in paragraph (E) will be paid in four installments within the state fiscal year. If the total funds that will be paid to all state hospitals electing to participate exceeds the aggregate upper payment limit for state hospitals, then the amount paid to all state hospital electing to participate will be limited to their proportion of the aggregate upper payment limit.

I. Supplemental payments to cost-based providers will be excluded from the cost settlement process.

J. 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 and 42 CFR 447.272.

K. The total funds that will be paid to each hospital will be included in the calculation of disproportionate share limit.

Supplemental Payments to Children's Hospitals for Inpatient Outliers

A. Notwithstanding paragraph (C)(5) of rule 5101:3-2-07.9 in the appendix to Attachment 4.19-A of the State Plan, children's hospitals that meet the criteria in paragraphs (E)(1) and (E)(2) of rule 5101:3-2-07.9, will be paid for each cost outlier claim made in fiscal years 2010 and 2011, an amount that is the product of the hospital's allowable charges and the hospital's Medicaid inpatient cost-to-charge ratio. The cost-to-charge ratio is based on the Medicaid charges as reported on the hospital's Medicaid cost report (JFS 02930) and the costs attributable to Medicaid as calculated based on the proportion of Medicaid charges to total charges on the hospital's interim settled cost report as applied to the claim year.

B. A Children's hospital shall cease being paid for a cost outlier claim under the methodology described in paragraph (A) on page 28 of Attachment 4.19-A and revert to being paid for such a claim according to methodology in paragraph (A)(6) or (C)(5) of rule 5101:3-2-07.9, as applicable, when the difference between the total amount paid according to the methodology described in paragraph (A) on page 28 of Attachment 4.19-A for such claims and the total amount the Director would have paid according to the methodology in paragraph (A)(6) or (C)(5) of rule 5101:3-2-07.9, as the applicable paragraph existed on June 30, 2007, for such claims, exceeds the amount available as described in paragraph (D) on page 28 of Attachment 4.19-A for the applicable fiscal year.

C. Payments shall be made under paragraph (A) on page 30 of Attachment 4.19-A, Supplemental Inpatient Hospital Upper Limit Payments For Children's Hospitals, if the difference between the total amount the Director has paid according to the methodology in paragraph (A) on page 28 of Attachment 4.19-A for cost outlier claims and the total amount the Director would have paid according to the methodology in paragraph (A)(6) or (C)(5) of rule 5101:3-2-07.9 for such claims, as the applicable paragraph existed on June 30, 2007, does not require the expenditure of the total amount available as described in paragraph (D) on page 28 of Attachment 4.19-A for the applicable fiscal year.

D. $28,642,247 in SFY 2012 and $27,540,622 in FFY 2013 shall be used to pay the amounts described in paragraph (A) on page 28 of Attachment 4.19-A.

E. The source data for calculations described in paragraphs (A) on page 28 of Attachment 4.19-A through (C) on page 28 of Attachment 4.19-A will be based on claims paid for outliers during the prior state fiscal year.

F. Payments will be made to children's hospitals on an annual basis, based upon children's hospitals' actual inpatient Medicaid fee-for-service outliers derived from actual Medicaid discharges paid during the prior state fiscal year and upon the difference between what each hospital would be paid according to the methodology described in paragraph (A) on page 28 of Attachment 4.19-A the amount the hospital had been paid.

G. Hospital payments made under this section shall not exceed the amount available as described in paragraph (D) on page 28 of Attachment 4.19-A for the applicable fiscal year nor, when combined with other payments made to private hospitals under the State plan, the limit specified in 42 CFR 447.272. If the total funds that would be paid to all children's hospitals exceeds either of those amounts, then the amount paid to each children's hospital would be its proportion of the lesser of: the amount described by paragraphs (A) through (C) on page 28 of Attachment 4.19-A; or the amount described in paragraph (D) on page 28 of Attachment 4.19-A. Each hospital's proportion would be equal to the difference between the total amount the Director would pay according to the methodology described in paragraph (A) for such claims minus the total amount the

Director paid for such claims for that hospital divided by the sum of that amount for all children's hospitals.

H. 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.

I. The total funds that will be paid to each children's hospital will be included in the calculation of disproportionate share limit.

Supplemental Inpatient Hospital Upper Limit Payments For Children's Hospitals

A. If the Supplemental Payments to Children's Hospitals for Inpatient Outliers do not require the expenditure of the amount described under paragraph (D) on page 28 of Attachment 4.19-A for the supplemental outlier payments and available under the upper payment limit as described by paragraphs (A) on page 28 of Attachment 4.19-A, the department would make additional supplemental payments to children's hospitals up to the lesser of the amount described in paragraph (D) on page 28 of Attachment 4.19-A or the amount described by paragraphs (A) on page 28 of Attachment 4.19-A through (C) on page 28 of Attachment 4.19-A as follows: Payments will be made to children's hospitals on a annual basis, based upon children's hospitals actual inpatient Medicaid fee-for service days derived from actual Medicaid discharges paid during the prior twelve-month period,. If the total funds that would be paid to all children's hospitals exceeds the aggregate upper payment limit for all private hospitals, then the amount paid to all children's hospitals will be limited to their proportion of the aggregate upper payment limit.

B. 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.

C. For all private hospitals, the sum of the amounts calculated in paragraph (C)(5) on page 31 of Attachment 4.19-A, is the aggregate inpatient upper limit payment gap for all private hospitals.

D. The total funds that will be paid to each children's hospital will be included in the calculation of disproportionate share limit.

Supplemental Inpatient Hospital Upper Limit Payments For Private Hospitals

A. All privately owned Ohio hospitals as of October 1 of the year preceding payments (private hospitals) shall be paid supplemental amounts for the provision of hospital inpatient services set forth in this section. The supplemental amounts shall be in addition to any other amounts payable to hospitals with respect to those services.

B. Data sources used in calculating supplemental payments to private hospitals include the Medicare Cost Report (CMS 2552-96) and Medicaid MMIS inpatient fee-for-service date of service claims data. For state fiscal year (SFY) 2012 and SFY 2013, the Hospital fiscal year ending in SFY 2010 Medicare cost reports retrieved from the Hospital Cost Report Information System and the Medicaid MMIS discharges and days data and Ohio Medicaid cost report (JFS 02930) payment data from SFY 2010 will be utilized unless otherwise noted.

C. The total supplemental payments shall not exceed the amount calculated using the following methodology:

1. Fore each privately owned Ohio hospital, total Medicare costs are divided by total Medicare charges to establish the Cost to Charge Ratio.
2. Ohio Medicaid payments for the portion of the hospital fiscal year preceding 10/1/2009 were inflated by 5% to account for an increase in Medicaid payment rates effective 10/1/2009.
3. Ohio Medicaid charges derived from the cost report described in paragraph (B) were multiplied by the Cost to Charge Ratio in paragraph (C)(1) to establish estimated Ohio Medicaid costs.
4. Ohio Medicaid costs from (C)(3) were inflated using a hospital specific 5-year average of Medicaid costs per patient day. The average is determined using Medicaid cost reports filed in state fiscal years 2005-2009. This hospital specific inflation factor was applied to individual hospital costs at a discounted rate for the partial year for all hospitals with fiscal year end before the 2010 state fiscal year end of 6/30/2010, plus two years to determine the UPL for SFY 2012 and for a third year to determine the UPL for SFY 2013. In the event in which hospital data did not exist for any hospital in years 2005-2009, the state average of 4.43% was utilized. Ohio Medicaid costs were multiplied by a factor of 1.01 for the Critical Access Hospitals.
5. Ohio Medicaid payments from (C)(2) were then subtracted from the total in paragraph (C)(5) to find the inpatient upper payment limit gap for the private hospitals. The sum of the differences for these hospitals represents the UPL gap.

D. Privately owned Ohio hospitals that are paid under the inpatient prospective payment system, excluding Children's hospitals, shall receive payments based upon the following hospital-specific calculation:

1. Calculate a Medicare payment to charge ratio by dividing total Medicare inpatient payments by total Medicare inpatient charges.
2. Calculate the total estimated Medicare inpatient payment for Medicaid inpatient discharges by multiplying the amount calculated in paragraph (D)(1) by the total Medicaid inpatient charges.
3. Subtract total inpatient Medicaid payments from the amount calculated in paragraph (D)(2).
4. For each hospital sum the amount calculated in paragraph (D)(3).
5. From the pool of funds, calculated in paragraph (D)(4), payments shall be made to all privately owned Ohio hospitals that are paid under the inpatient prospective payment system, excluding Children's hospitals, based upon the ratio of each

privately owned Ohio hospital that is paid under the inpatient prospective payment system inpatient Medicaid fee-for-service days to the total Medicaid fee-for-service inpatient days for all privately owned Ohio hospitals, excluding Children's hospitals. This ratio will be derived from actual inpatient MMIS Medicaid fee-for-service date of service claims data in the state fiscal year ending prior to the month of payment.

E. From a pool of funds calculated in paragraph (C) less the payments made in paragraph (D), privately owned Ohio hospitals shall receive payments for the provision of inpatient hospital services. These payments will be based on subgroups according to hospital characteristics, that are mutually exclusive and are presented in hierarchical order:

Specialty hospitals – Private hospitals which are reimbursed on a cost basis.
Critical Access hospitals (CAHs) – Private hospitals with critical access designation.
Rural hospitals – Private hospitals that are classified as rural hospitals by the Centers for Medicare and Medicaid Services.
Children's hospitals – Private hospitals centered on providing care to children.
Adult High Disproportionate Share Hospitals (DSH) – Private hospitals with adult high DSH designation as of Federal Fiscal Year 2010.
Magnet education hospitals – Private hospitals with an education component which have received magnet designation by the American Nurses Credentialing Center as of December 31, 2010.
Education hospitals – Private hospitals with a residency program.
General hospitals paid under the inpatient prospective payment system– Private hospitals which do not qualify for any of the preceding categories.

1. From the specialty hospital subgroup, payments shall be made in the form of a percentage increase applied to hospital specific SFY 2010 Medicaid inpatient fee-for-service payments. This percentage increase will be equal to the pool amount of $14,022,012 in SFY 2012 and $13,396,983 in SFY 2013 divided by total private specialty hospital SFY2010 Medicaid inpatient fee-for-service payments.
2. From the critical access and rural subgroup, payments shall be made to all CAHs and rural hospitals in the form of a per diem payment applied to hospital specific SFY 2010 Medicaid fee-for-service days. This payment will be equal to the pool amount of $11,819,200 in both SFY 2012 and SFY 2013 divided by the total CAH and rural hospital SFY 2010 Medicaid fee-for-service days.
3. From the children's hospitals subgroup, payments shall be made to all children's hospitals in accordance with page 28 paragraph B of the State Plan Amendment Section 4.19-A.
4. From the magnet education subgroup, payments shall be made to all magnet education hospitals in the form of a percentage increase applied to hospital specific SFY 2010 Medicaid fee-for-service inpatient payments. This percentage increase will be equal to the pool amount of $12,833,490 in SFY 2012 and $12,282,308 in SFY 2013 divided by total magnet education hospital SFY 2010 Medicaid inpatient fee-for-service payments.

5. From the total education subgroup, all education hospitals and magnet education hospitals shall receive a percentage increase in Medicaid payments applied to their total hospital specific SFY 2010 Medicaid fee-for-service inpatient payments. This percentage increase will be equal to the pool amount of $40,722,805 in SFY 2012 and $39,534,103 in SFY 2013 divided by total education hospitals' SFY 2010 Medicaid inpatient fee-for-service payments. This amount is in addition to the amount paid to magnet education hospitals in (E)(4).
6. From the pooled amount calculated in (C) less payments made in (D) and (E)(1) through (E)(5), all private hospitals excluding children's hospitals (private general acute hospitals) shall receive a payment. These payments will be in the form of an additional payment per discharge applied to SFY 2010 inpatient Medicaid discharges from the SFY 2010 MMIS date of service claims data. This increase will be equal to the pool amount divided by the total private general acute hospital SFY 2010 Medicaid discharges. These payments are in addition to the payments in (D) and (E)(1) through (E)(5).

F. Supplemental payments in paragraph (D) will be paid semiannually and (E) shall be paid in four installments within the state fiscal year.

G. Supplemental payments to cost-based providers will be excluded from the cost settlement process.

H. 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 447.272.

I. The total funds that will be paid to each hospital will be included in the calculation of disproportionate share limit.

OS Notification

State/Title/Plan Number:	**Ohio 11-024**
Type of Action:	**SPA Approval**
Required Date for State Notification:	**April 12, 2012**
Fiscal Impact:	**FY 2011 $28,650,000** **FY 2012 $122,580,000**

Number of Services Provided by Enhanced Coverage, Benefits or Retainced 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 July 1, 2011, this amendment revises UPL gap calculation payment methodologies for inpatient hospital services. Specifically, this amendment revises the calculation of supplemental payments for public hospitals, State hospitals, children's hospitals for inpatient outliers, children's hospitals, and private hospitals. The State met public process requirements. The non-Federal share of these payments comes from State appropriations and permissible provider tax. There are no issues with the UPL.

For supplemental UPL payments to State hospitals, with this amendment Ohio will calculate the gap using a Medicare cost to charge ratio methodology and will include inflating Medicaid costs using a hospital specific 5-year average of Medicaid costs per patient day. Payments to non-psychiatric Ohio state hospitals are calculated on a hospital specific basis using a Medicare payment to charge ratio methodology. Any remaining UPL gap room is paid to non-psychiatric Ohio state hospitals via a percentage increase applied to their SFY 2010 regular Medicaid rate. The percentage is the amount of remaining gap room divided by total state hospital Medicaid inpatient hospital FFS payments. For state psychiatric hospitals, UPL gap room calculated by taking Medicaid inpatient payments less Medicaid inpatient costs is paid semiannually by applying a per discharge amount to Medicaid discharges for the previous 6 month period.

For supplemental UPL payments to private hospitals, with this amendment Ohio calculates a UPL gap using a Medicare cost to charge ratio methodology and will include inflating Medicaid costs using a hospital specific 5-year average of Medicaid costs per patient day. Payments are made based upon a ratio of inpatient Medicaid FFS days to total Medicaid FFS days. From the amount remaining in the UPL gap less the payments made above, payments are made to private hospitals

depending on provider type. Each provider type is placed in a hierarchical order and each provider type has a separate methodology and proportion of the remaining gap amount that can be paid to each hospital. The proportions are identified in the State plan.

The changes this amendment proposes for the other supplemental payment methodologies involve clarifying that certain hospitals are excluded from the cost settlement process and removing references to Ohio Administrative Code.

Other Considerations: This plan amendment drew interest from Senator Sherrod Brown from Ohio.

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.

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