Table of Contents

State/Territory Name: OH

State Plan Amendment (SPA) #: 15-011

This file contains the following documents in the order listed:

1) Approval Letter
2) CMS 179 Form/Summary Form (with 179-like data)
3) Approved SPA Pages

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

MAY 11 2016

John McCarthy, Medicaid Director
Office of Ohio Health Plans
Ohio Department of Medicaid
P.O. Box 182709
50 West Town Street, Suite 400
Columbus, Ohio 43218

RE: Transmittal Number (TN) 15-0011

Dear Mr. McCarthy:

The Centers for Medicare and Medicaid Services (CMS) has reviewed the proposed amendment to Attachment 4.19-A of your Medicaid state plan submitted under transmittal number (TN) 15-0011. Effective August 25, 2015, The Ohio Department of Medicaid is requesting approval from the Centers for Medicare and Medicaid Services (CMS) to reauthorize the Upper Payment Limit program for inpatient hospital services

We conducted our review of your submittal according to the statutory requirements at sections 1902(a)(2), 1902(a)(13), 1902(a)(30), 1903(a) and 1923 of the Social Security Act (the Act) and the regulations at 42 CFR 447 Subpart C. We hereby inform you that Medicaid State plan amendment 15-0011 is approved effective August 25, 2015. We are enclosing the CMS-179 and the amended plan pages.

If you have any questions, please contact Fredrick Sebree at (217) 492-4122 or via email at Fredrick.Sebree@cms.hhs.gov.

Sincerely,

[redacted]

Kristin Fan
Director

Enclosure

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL	1. TRANSMITTAL NUMBER: **15-011 Revised**	2. STATE **OHIO**
FOR: CENTERS FOR MEDICARE AND MEDICAID SERVICES	3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
TO: REGIONAL ADMINISTRATOR CENTERS FOR MEDICARE & MEDICAID SERVICES DEPARTMENT OF HEALTH AND HUMAN SERVICES	4. PROPOSED EFFECTIVE DATE **August 25, 2015**	

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ **AMENDMENT**

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:	7. FEDERAL BUDGET IMPACT:
42 CFR part 447, subpart C	a. FFY 2015 $300 thousands b. FFY 2016 $2,960 thousands
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.19-A, Pages 24 through 33	Attachment 4.19-A, Pages 24 through 33 (TN 13-016) 4.19-A, Appendix 5101:3-2-50 (TN 13-016) 4.19-A, Appendix 5101:3-2-51 (TN 13-016) 4.19-A, Appendix 5101:3-2-52 (TN 13-016) 4.19-A, Appendix 5101:3-2-53 (TN 13-016) 4.19-A, Appendix 5101:3-2-54 (TN 13-016)

10. SUBJECT OF AMENDMENT: Inpatient Hospital Supplemental Upper Payment Limit (UPL) Methodology

11. GOVERNOR'S REVIEW *(Check One)*:

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED:
The State Medicaid Director is the Governor's designee

12. SIGNATURE: [redacted]

13. TYPED NAME: **JOHN B. McCARTHY**

14. TITLE: **STATE MEDICAID DIRECTOR**

15. DATE SUBMITTED: September 29, 2015

16. RETURN TO:

Carolyn Humphrey
Ohio Department of Medicaid
P.O. BOX 182709
Columbus, Ohio 43218

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:

18. DATE APPROVED: MAY 11 2016

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: AUG 25 2015

20. SIGNATURE OF REGIONAL OFFICIAL: [redacted]

21. TYPED NAME: Kristin FAN

22. TITLE: Director, FMG

23. REMARKS:

Instructions on Back

FORM CMS-179 (07-92)

Calculation of Inpatient Hospital Upper Payment Limit Supplemental 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. Sum the amount calculated in paragraph (A)(3), across all public hospitals to find the aggregate public hospital upper payment limit.

5. 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. Data sources used in calculating supplemental payments to public hospitals include the Medicare Cost Report (CMS 2552-10), the Hospital Cost Report Information System (HCRIS), the Ohio Medicaid Hospital Cost Report (ODM 02930) and Medicaid MMIS inpatient fee-for-service date of service claims data for a state fiscal year not more than two years prior to the current state fiscal year.

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 exceeds the aggregate upper payment limit for public hospitals calculated in paragraph (A)(4), then the amount paid to all public hospitals 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 447.272.

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 hospital specific DSH limit.

Calculation of Inpatient Hospital Upper Payment Limit Supplemental 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 hospitals include the Medicare Cost Report (CMS 2552-10), the Hospital Cost Report Information System (HCRIS), the Ohio Medicaid Hospital Cost Report (ODM 02930) and Medicaid MMIS inpatient fee-for-service date of service claims data for a state fiscal year not more than two years prior to the current state fiscal year.

C. The total supplemental payments for non-psychiatric state hospitals shall not exceed the amount calculated using the following methodology:

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

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

3. Ohio Medicaid costs from (C)(2) are inflated using a hospital specific 5-year average of Medicaid costs per patient day. The average is determined using the five most recently filed Medicaid cost reports. In the event in which a hospital does not have a cost report for any of the five most recently filed Medicaid cost reports, the statewide 5-year average of Medicaid costs per patient day will be utilized. Ohio Medicaid costs will be multiplied by a factor of 1.01 for the Critical Access Hospitals.

4. Ohio Medicaid payments are then subtracted from the total in paragraph (C)(3) to find the inpatient upper payment limit gap for the state hospitals. The sum of the differences for these hospitals represents the aggregate non-psychiatric state hospital 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. Sum the amount calculated in paragraph (D)(3), across all non-psychiatric State owned hospitals to find the total non-psychiatric State owned hospital pool.

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 the pool of funds calculated in (C)(4), less the payments made in (D)(5), resulting in a remaining pool amount, non-psychiatric state hospitals shall receive a percentage increase in inpatient Medicaid payments. The percentage increase on total inpatient hospital Medicaid payments will be equal to the remaining pool amount divided by non-psychiatric state hospital Medicaid inpatient hospital fee-for-service payments.

F. For each 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. Using the Medicare cost report as described in paragraph (B), 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. Calculate the available payment gap by taking total estimated Medicare payment for Medicaid discharges as calculated in paragraph (F)(2) and subtracting actual Medicaid payments.

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

G. Payments to state owned psychiatric hospitals calculated in paragraph (F) will be made on a semiannual basis, based upon the product of each psychiatric hospital per discharge gap amount as calculated in paragraph (F)(4) 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 exceeds the aggregate upper payment limit for non-psychiatric state hospitals calculated in paragraph (C)(4), then the amount paid to all state hospitals 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 hospital specific DSH limit.

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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 2552-10), the Hospital Cost Report Information System (HCRIS), the Ohio Medicaid Hospital Cost Report (ODM 02930) and Medicaid MMIS inpatient fee-for-service date of service claims data for a state fiscal year not more than two years prior to the current state fiscal year.

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

1. For each privately owned Ohio hospital, total Medicare costs are divided by total Medicare charges to establish the hospital specific Cost to Charge Ratio.

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

3. Ohio Medicaid costs from (C)(2) are inflated using a hospital specific 5-year average of Medicaid costs per patient day. The average is determined using the five most recently filed Medicaid cost reports. In the event in which a hospital does not have a cost report for any of the five most recently filed Medicaid cost reports, the statewide 5-year average of Medicaid costs per patient day will be utilized. Ohio Medicaid costs are multiplied by a factor of 1.01 for the Critical Access Hospitals.

4. Ohio Medicaid payments are then subtracted from the total in paragraph (C)(3) to find the inpatient upper payment limit gap for the private hospitals. The sum of the differences for these hospitals represents the aggregate private hospital 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 hospital specific 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. Sum the amount calculated in paragraph (D)(3), across all privately owned hospitals, excluding Children's hospitals, that are paid under the inpatient prospective payment system.

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 the pool of funds calculated in paragraph (C)(4) less the payments made in paragraph (D)(5), 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 ending immediately prior to the UPL calculation.
Magnet education hospitals – Private hospitals with an education component which have received magnet designation by the American Nurses Credentialing Center as of the calendar year immediately prior to the UPL calculation..
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 Medicaid inpatient fee-for-service payments. This percentage increase will be equal to the pool amount of $13,572,897 divided by total private specialty hospital Medicaid inpatient fee-for-service payments from the state fiscal year ending prior to the month of payment.

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 Medicaid fee-for-service days. This payment will be equal to the pool amount of $10,002,400 divided by the total CAH and rural hospital Medicaid fee-for-service days from the state fiscal year ending prior to the month of payment.

3. From the children's hospitals subgroup, payments shall be made to all children's hospitals and shall be equal to $27,540,622. The payments to each children's hospital will be made on an 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 in (C)(4).

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 Medicaid fee-for-service inpatient payments. This percentage increase will be equal to the pool amount of $16,911,462 divided by total magnet education hospital Medicaid inpatient fee-for-service payments from the state

fiscal year ending prior to the month of payment.

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 Medicaid fee-for-service inpatient payments. This percentage increase will be equal to the pool amount of $39,022,622 divided by total education hospitals' Medicaid inpatient fee-for-service payments from the state fiscal year ending prior to the month of payment. This amount is in addition to the amount paid to magnet education hospitals in (E)(4).

6. From the pooled amount calculated in (C)(4) 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 MMIS paid discharge data for inpatient Medicaid discharges from the state fiscal year ending prior to the month of payment. This increase will be equal to the pool amount less payments made in (D) and (E)(1) through (E)(5) divided by the total private general acute hospital Medicaid discharges. These payments are in addition to the payments in (D) and (E)(1) through (E)(5).

7. If the amounts distributed in paragraphs (E)(1) through (E)(6) exceed the amount calculated in paragraph (C)(4) less the amount paid in (D)(4), then the amounts available for payment in (E)(1) through (E)(6) shall be reduced proportionally.

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 hospital specific DSH limit.