TO BE RESCINDED

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

(A) Definitions.

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

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

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

(4) "Total medicaid inpatient payments" for each hospital means the sum of the amounts reported on the JFS 02930, schedule H, column 1, lines 8 and 24, and column 3, lines 8 and 24, minus the amount on schedule H, column 1, line 6.

(5) "Medicaid disproportionate share payment for medicaid inpatient shortfall" means for each state hospital the portion of the hospital's disproportionate share adjustment made for medicaid inpatient shortfall as calculated in this paragraph and received by the hospital in the hospital's fiscal year corresponding to the cost reporting period described in paragraph (B) of this rule.

(a) Calculate each state hospital's medicaid inpatient shortfall by subtracting medicaid inpatient costs from medicaid inpatient payments.

(b) Calculate each state hospital's disproportionate share limit as described in rule 5101:3-2-07.5 of the Administrative Code.

(c) Subtract each state hospital's medicaid inpatient shortfall as described in paragraph (A)(5)(a) of this rule from the hospital's disproportionate share limit as described in paragraph (A)(5)(b) of this rule.

(d) For each state hospital subtract the amount calculated in paragraph (A)(5)(c) of this rule from each hospital's total disproportionate share payment for the disproportionate share program year corresponding to

the cost reporting period described in paragraph (B) of this rule. The result of this calculation is the hospital's disproportionate share payment for medicaid inpatient shortfall. For hospitals with a negative disproportionate share payment for medicaid inpatient shortfall, the disproportionate share payment for medicaid inpatient shortfall is equal to zero.

(6) "Total medicaid inpatient discharges" means for each state hospital the sum of the amounts reported on the JFS 02930, schedule C, columns 2 and 3, line 40.

(7) "Medicaid inpatient case mix" is calculated using the hospital's claim records for discharges occurring during the hospital's fiscal year corresponding to the cost reporting period described in paragraph (B) of this rule. 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 as 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) Add the result of each computation in paragraph (A)(7)(a) of this rule.

(c) Divide the total from paragraph (A)(7)(b) of this rule by the number of cases in the hospital's sample as described in paragraph (A)(7)(a) of this rule. Round the result to five decimal places. This produces a hospital-specific medicaid inpatient case mix index.

(8) "Medicare hospital inpatient discharges" means the amount on the HCFA 2552-96, worksheet S-3, part I, column 13, line 12.

(9) "Medicare subprovider inpatient discharges" means the sum of the amounts reported on the HCFA 2552-96, worksheet S-3, part I, column 13, lines 14 and 14.01.

(10) "Medicare subprovider inpatient payments" means the sum of the amounts reported on the HCFA 2552-96, worksheet E-3, part I, line 4 for each subprovider.

(11) "Medicare inpatient DRG payments" means the sum of the amounts reported

on the HCFA 2552-96, worksheet E, part A, lines 1 and 1.01 and 1.02.

(12) "Medicare inpatient outlier payments" means the sum of the amounts reported on the HCFA 2552-96, worksheet E, part A, lines 2 and 2.01.

(13) "Medicare inpatient indirect medical education" means the amount reported on the HCFA 2552-96, worksheet E, part A, line 3.24.

(14) "Medicare inpatient disproportionate share payments" means the amount reported on the HCFA 2552-96, worksheet E, part A, line 4.04 .

(15) "Medicare inpatient hospital capital payments means" the amount reported on the HCFA 2552-96, worksheet E, part A, line 9.

(16) "Medicare inpatient direct medical education" means the amount reported on the HCFA 2552-96, worksheet E, part A, line 11.

(17) "Medicare inpatient hospital payments - other" means the sum of the amounts reported on the HCFA 2552-96, worksheet E, part A, lines 12, 13, 14 and 15.

(18) "Medicare inpatient hospital case mix" means the case mix values for the federal fiscal year corresponding to the cost reporting period described in paragraph (B) of this rule as made available as a public use file by the centers for medicare and medicaid services (CMS).

(B) Source data for calculations.

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

(C) Calculation of available inpatient payment gap for state hospitals subject to medicaid prospective payment and subject to prospective payment under medicare.

(1) For each state hospital, divide the medicare inpatient payment for DRG amount as described in paragraph (A)(11) of this rule by the hospital's medicare inpatient hospital case mix as described in paragraph (A)(18) of this rule.

(2) For each state hospital, calculate the sum of all other medicare inpatient

payments that are not subject to a case mix adjustment by adding the amounts described in paragraphs (A)(10), (A)(12), (A)(13), (A)(14), (A)(15), (A)(16) and (A)(17) of this rule.

(3) For each state hospital, calculate the total medicare inpatient discharges by adding the amounts described in paragraphs (A)(8) and (A)(9) of this rule.

(4) For each state hospital, calculate the estimated medicare inpatient per discharge payment amount subject to case mix adjustment by dividing the amount described in paragraph (C)(1) of this rule by the total medicare inpatient discharges described in paragraph (C)(3) of this rule.

(5) For each state hospital, calculate the estimated medicare inpatient per discharge payment amount not subject to case mix adjustment by dividing the amount described in paragraph (C)(2) of this rule by the total medicare inpatient discharges described in paragraph (C)(3) of this rule.

(6) For each state hospital, multiply the estimated medicare inpatient per discharge payment amount subject to case mix adjustment calculated in paragraph (C)(4) of this rule by the hospital's medicaid inpatient case mix value as described in paragraph (A)(7) of this rule.

(7) For each state hospital, calculate the total estimated medicare inpatient payment per medicaid inpatient discharge by adding the amounts calculated in paragraphs (C)(6) and (C)(5) of this rule.

(8) For each state hospital, calculate the total estimated medicare inpatient payment for medicaid inpatient discharges by multiplying the amount in paragraph (C)(7) of this rule by the total medicaid inpatient discharges as described in paragraph (A)(6) of this rule.

(9) For each state hospital, calculate the available inpatient payment gap by taking total estimated medicare inpatient payments for medicaid inpatient discharges as calculated in paragraph (C)(8) of this rule and subtracting actual total medicaid inpatient payments as described in paragraph (A)(4) of this rule. In the year in which the plan becomes effective through December thirty first of that year, subtract each hospital's medicaid disproportionate share payment for medicaid inpatient shortfall as described in paragraph (A)(5) of this rule from the available inpatient payment gap.

(10) For each state hospital that has an available inpatient payment gap greater than zero resulting from the calculations in paragraph (C)(9) of this rule, calculate

the available per discharge supplemental inpatient hospital payment amount by dividing the amount in paragraph (C)(9) of this rule by the amount in paragraph (A)(6) of this rule.

(D) Calculation of available inpatient payment gap for state hospitals subject to medicaid prospective payment and excluded from prospective payment under medicare.

(1) For each state hospital described in this paragraph, "medicaid inpatient costs" means the amount reported on the JFS 02930, schedule H, column 1, line 1.

(2) For each state hospital described in this paragraph, "medicaid inpatient payments" means the amount reported on the JFS 02930, schedule H, column 1, line 12.

(3) For each state hospital described in this paragraph, medicaid discharges means the sum of the amounts reported on the JFS 02930, schedule C-1, column 2, line 25.

(4) "Medicaid disproportionate share payment for medicaid inpatient shortfall" means for each state hospital described in this paragraph the portion of the hospital's disproportionate share adjustment made for medicaid inpatient shortfall as calculated in this paragraph and received by the hospital in the hospital's fiscal year corresponding to the cost reporting period described in paragraph (B) of this rule. For hospitals with a negative disproportionate share payment for medicaid inpatient shortfall, the disproportionate share payment for medicaid inpatient shortfall is equal to zero.

(a) Calculate each state hospital's medicaid inpatient shortfall by subtracting medicaid inpatient costs from medicaid inpatient payments.

(b) Calculate each state hospital's disproportionate share limit as described in rule 5101:3-2-10 of the Administrative Code.

(c) Subtract each state hospital's medicaid inpatient shortfall as described in paragraph (D)(4)(a) of this rule from the hospital's disproportionate share limit as described in paragraph (D)(4)(b) of this rule.

(d) For each state hospital subtract the amount calculated in paragraph (D)(4)(c) of this rule from each hospital's total disproportionate share payment for the disproportionate share program year corresponding to the cost reporting period described in paragraph (B) of this rule. The result of this calculation is the hospital's disproportionate share payment

for medicaid inpatient shortfall.

(5) For each state hospital described in this paragraph, calculate the available inpatient payment gap by subtracting the amounts in paragraphs (D)(2) and (D)(4)(d) of this rule from the amount in paragraph (D)(1) of this rule.

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

(E) For each state owned and operated hospital not subject to medicaid prospective payment and excluded from medicare prospective payment hospitals are paid allowable cost and therefore the available payment gap is zero.

(F) For the first supplemental upper payment limit program year, the resulting per discharge supplemental payment amount calculated in paragraphs (C), (D) and (E) of this rule will be in effect from the effective date of the state plan amendment through December thirty first of that year. For each supplemental upper payment limit program year after, the resulting per discharge supplemental payment amount calculated in paragraphs (C), (D), and (E) of this rule will be in effect from January first through December thirty first of each year.

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

(1) In January and July of each year after the effective date of the plan, the department will notify state hospitals of the available per discharge supplemental inpatient hospital payment amount as described in paragraph (C)(10) or (D)(6) of this rule, the number of actual medicaid inpatient discharges paid for through the department's MMIS for each state hospital in the six months prior to the month of notification, and the maximum supplemental payment that the state hospital is eligible to receive for the prior six months. The maximum amount is the product of the actual number of medicaid discharges paid during the prior six months and the available per discharge supplemental inpatient hospital payment amount as described in paragraph (C)(10) or (D)(6) of this rule, subject to the limitations described in paragraph (G)(3) of this rule. The first six month payment will be prorated from the effective date of the state plan amendment to the end of the six month period from which the actual medicaid inpatient discharges were obtained.

(2) State hospitals electing to receive supplemental inpatient hospital payments

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

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

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

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