Supplemental Payments to Children's Hospitals for Inpatient Outliers

A. Notwithstanding paragraph (C)(5) of rule 5101:3-2-07.9 of the Ohio Administrative Code, children's hospitals that meet the criteria in paragraphs (E)(1) and (E)(2) of rule 5101:3-2-07.9 of the Administrative Code, 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 of the Administrative Code, 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 of the Administrative Code, 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 (D) on page 29 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 of the Administrative Code 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. Up to $38.7 million in SFY 2010 and $31.6 million in FFY 2011 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 29 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 limits as described in rule 5101:3-2-07.5 of the Ohio Administrative Code.

Supplemental Inpatient Hospital Upper Limit Payments For Children's Hospitals

A. For each Ohio hospital owned or operated by an entity other than a governmental entity, 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 29 of Attachment 4.19-A, is the aggregate inpatient upper limit payment gap for all private hospitals.

B. The resulting amount calculated in paragraph (A) on page 29 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. 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 29 of Attachment 4.19-A through (C) on page 29 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 29 of Attachment 4.19-A through (C) on page 29 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, subject to the provisions in paragraph (B) on page 29 of Attachment 4.19-A. 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.

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 children's 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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5101:3-2-53 **Supplemental inpatient hospital payments for children's hospitals.**

This rule sets forth the methodology used to determine the supplemental inpatient hospital payments to children's hospitals required by Section ~~309.30.13~~ 309.30.15 of Amended Substitute House Bill ~~119~~ 1 of the ~~127th~~ 128th General Assembly.

(A) Definitions.

(1) "Childrens hospital", for the purpose of this rule, means an Ohio hospital as defined in section 3702.51 of the Revised Code that is owned and operated by a private entity and is subject to prospective payment as described in rule 5101:3-2-07.1 of the Administrative Code.

(2) "Private hospital" means an Ohio hospital other than as defined in rules 5101:3-2-50 and 5101:3-2-51 of the Administrative Code.

(3) "Available inpatient payment gap" means the difference between what is estimated using the methodology described in paragraphs (C) and (D) 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.

(4) "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.

(5) "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.

(6) "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.

(7) "Medicare inpatient payments for hospitals exempt from medicare ~~diagnostic~~ - diagnosis related ~~groups~~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.

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

(9) "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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(10) "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.

(11) "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.

(12) "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.

(13) "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.

(14) "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.

(15) "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.

(16) "Total medicaid days" means for each children's 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.

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

(18) "Medicaid inpatient cost-to-charge ratio" means the historic medicaid inpatient cost-to-charge ratio applicable to a hospital as described in paragraph (B)(2) of rule 5101:3-2-22 of the Administrative Code.

(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 all hospitals, and the medicare cost report for the corresponding cost reporting period.

(C) Calculation of available inpatient payment gap for private hospitals.

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

(a) For each private hospital, calculate the total medicare inpatient payment by adding the amounts described in paragraphs (A)(7) to (A)(14) of this rule.

(b) For each private 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)(15) of this rule.

(c) For each private 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)(6) of this rule.

(d) For each private 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)(4) of this rule.

(e) For each private 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)(5) 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 hospitals, 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 hospitals.

~~(1) For each private hospital, calculate the total medicare inpatient payment by adding the amounts described in paragraphs (A)(7) to (A)(14) of this rule.~~

~~(2) For each private hospital, calculate the medicare payment-to-charge ratio by dividing the amount calculated in paragraph (C)(1) of this rule by the total medicare inpatient charges as described in paragraph (A)(15) of this rule.~~

~~(3) For each private hospital, calculate the total estimated medicare inpatient payment for medicaid inpatient discharges by multiplying the amount calculated in paragraph (C)(2) of this rule by the total medicaid inpatient charges as described in paragraph (A)(6) of this rule.~~

~~(4) For each private hospital, calculate the available inpatient payment gap by taking total estimated medicare inpatient payments for medicaid inpatient discharges as calculated in paragraph (C)(3) of this rule and subtracting actual total medicaid inpatient payments as described in paragraph (A)(4) of this rule.~~

~~(5) For all private hospitals, sum the amounts calculated in paragraph (C)(3) of this rule. This is the aggregate inpatient upper limit for all private hospitals.~~

~~(6) For all private hospitals, the sum of the amounts calculated in paragraph (C)(4) of this rule, is the aggregate inpatient upper limit payment gap for all private hospitals~~

(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) Notwithstanding paragraph (C)(5) of rule 5101:3-2-07.9 of the Administrative Code and except as provided in paragraph (F) of this rule, the director of the Ohio

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department of job and family services (ODJFS) shall pay a children's hospital that meets the criteria in paragraphs (E)(1) and (E)(2) of rule 5101:3-2-07.9 of the Administrative Code, for each cost outlier claim made in fiscal years ~~2008 and 2009~~ 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. These payments shall be made as supplemental inpatient outlier payments as follows:

(1) In July of each year after the effective date of the medicaid state plan amendment implementing this payment program, the director shall calculate for each eligible children's hospital the difference between the total amount the director would have paid according to the methodology in paragraph (E) of this rule for such claims for services incurred during the prior state fiscal year using the same cost-to-charge ratio as the ratio used to calculate cost outlier payments in accordance with rule 5101:3-2-07.9 of the Administrative Code for services incurred during that time period and the total amount the director paid according to the methodology in paragraph (A)(6) or (C)(5) of rule 5101:3-2-07.9 of the Administrative Code, as the applicable paragraph existed on June 30, 2007, for such claims as reflected in actual medicaid inpatient claims paid through the department's medicaid management information system (MMIS) in the prior state fiscal year.

(2) If the sum of the amounts calculated in paragraph (E)(1) of this rule for all eligible children's hospitals is less than or equal to the available amount for each fiscal year as provided in Section ~~309.30.13~~ 309.30.15 of Amended Substitute House Bill ~~119~~ 1 of the ~~127th~~ 128th General Assembly, then the supplemental inpatient outlier payment for each children's hospital shall be the amount calculated in paragraph (E)(1) of this rule. Otherwise, the supplemental inpatient outlier payment for each children's hospital shall be the amount calculated in paragraph (F) of this rule.

(F) The director shall cease paying a children's hospital for a cost outlier claim under the methodology in paragraph (E) of this rule and revert to paying the hospital for such a claim according to methodology in paragraph (A)(6) or (C)(5) of rule 5101:3-2-07.9 of the Administrative Code, as applicable, when the difference between the total amount the director would pay according to the methodology in paragraph (E) of this rule for such claims and the total amount the director paid according to the methodology in paragraph (A)(6) or (C)(5) of rule 5101:3-2-07.9 of the Administrative Code, as the applicable paragraph existed on June 30, 2007, for such claims, exceeds the available amount for each fiscal year as provided in Section ~~309.30.13~~309.30.15 of Amended Substitute House Bill ~~119~~1 of the ~~127th~~ 128th General Assembly. If the sum of the amounts calculated in paragraph (E)(1) of this rule for all eligible children's hospitals is greater than the available amount for each fiscal year as provided in Section ~~309.30.13~~309.30.15 of Amended Substitute House Bill ~~119~~1 of the ~~127th~~ 128th General Assembly, then the supplemental inpatient outlier payment for each children's hospital shall be the amount calculated as follows:

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(1) For each eligible children's hospital, the director shall calculate the ratio equal to the amount described in paragraph (E)(1) of this rule divided by the sum of the amount described in paragraph (E)(1) of this rule for all children's hospitals. For children's hospitals that did not have an outlier claim paid in that period, this figure shall be zero.

(2) The supplemental inpatient outlier payment for each children's hospital shall be the product of the ratio described in paragraph (F)(1) of this rule multiplied by the available amount for each fiscal year as provided in Section ~~309.30.13~~ - 309.30.15 of Amended Substitute House Bill ~~1191~~ of the ~~127th~~ 128th General Assembly.

(G) If the total funds that would be paid to all children's hospitals under paragraph (E) or (F) of this rule exceeds the aggregate inpatient upper limit payment gap for all private hospitals as described in paragraphs (C) and (D) of this rule, then the amount paid to each children's hospital will be the product of the ratio of the amount described in paragraph (F)(1) of this rule multiplied ~~times~~by the aggregate inpatient upper limit payment gap for all private hospitals as described in paragraphs (C) and (D) of this rule.

(H) The director shall make supplemental inpatient hospital upper limit payments to children's hospitals if the difference between the total amount the director has paid according to the methodology in paragraph (E) of this rule 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 of the Administrative Code for such claims, as the applicable paragraph existed on June 30, 2007, does not require the expenditure of the available amount for each fiscal year as provided in Section - ~~309.30.13~~ 309.30.15 of Amended Substitute House Bill ~~1191~~ of the ~~127th~~ 128th - General Assembly. If the supplemental outlier payments specified in paragraph (E) of this rule do not require the expenditure of the available amount for each fiscal year as provided in Section ~~309.30.13~~ 309.30.15 of Amended Substitute House Bill ~~119~~ 1 of the ~~127th~~ 128th General Assembly, and are less than the aggregate inpatient upper limit payment gap for all private hospitals as calculated for each supplemental payment program year as described in paragraphs (C) and (D) of this rule then supplemental inpatient hospital upper limit payments to children's 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 children's hospital a supplemental inpatient hospital payment amount by multiplying the ratio of each children's 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 children's hospitals derived from actual inpatient discharges paid

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for through the department's MMIS in the state fiscal year prior to the month of payment, by the difference between the available amount for each fiscal year as provided in Section ~~309.30.13~~ 309.30.15 of Amended Substitute House Bill ~~119~~ 1 of the ~~127th~~ 128th General Assembly minus the supplemental payments made pursuant to paragraph (E) of this rule, subject to the limitation described in paragraph (H)(2) of this rule.

(2) If the total funds that would be paid to all children's hospitals under paragraph (H)(1) exceeds the aggregate upper payment limit gap for all private hospitals as calculated for each supplemental inpatient upper limit payment program year as described in paragraphs (C) and (D) of this rule, then the amount paid to each children's hospital will be limited to its proportion, as determined by the ratios described in paragraph (H)(1) of this rule, of the difference between the aggregate upper payment limit gap minus the supplemental payments made pursuant to paragraph (E) of this rule.

(I) 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.

(J) The total funds that will be paid to each children's hospital will be included in the calculation of disproportionate share limits as described in rule 5101:3-2-07.5 of the Administrative Code.

Supplemental Payments to Children's Hospitals for Inpatient Outliers

A. Notwithstanding paragraph (C)(5) of rule 5101:3-2-07.9 of the Ohio Administrative Code, children's hospitals that meet the criteria in paragraphs (E)(1) and (E)(2) of rule 5101:3-2-07.9 of the Administrative Code, 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 of the Administrative Code, 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 of the Administrative Code, 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 (D) on page 29 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 of the Administrative Code 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. Up to $38.7 million in SFY 2010 and $31.6 million in FFY 2011 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 29 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 limits as described in rule 5101:3-2-07.5 of the Ohio Administrative Code.

Supplemental Inpatient Hospital Upper Limit Payments For Children's Hospitals

A. For each Ohio hospital owned or operated by an entity other than a governmental entity, 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 29 of Attachment 4.19-A, is the aggregate inpatient upper limit payment gap for all private hospitals.

B. The resulting amount calculated in paragraph (A) on page 29 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. 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 29 of Attachment 4.19-A through (C) on page 29 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 29 of Attachment 4.19-A through (C) on page 29 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, subject to the provisions in paragraph (B) on page 29 of Attachment 4.19-A. 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.

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 children's 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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5101:3-2-53 **Supplemental inpatient hospital payments for children's hospitals.**

This rule sets forth the methodology used to determine the supplemental inpatient hospital payments to children's hospitals required by Section ~~309.30.13~~ 309.30.15 of Amended Substitute House Bill ~~119~~ 1 of the ~~127th~~ 128th General Assembly.

(A) Definitions.

(1) "Childrens hospital", for the purpose of this rule, means an Ohio hospital as defined in section 3702.51 of the Revised Code that is owned and operated by a private entity and is subject to prospective payment as described in rule 5101:3-2-07.1 of the Administrative Code.

(2) "Private hospital" means an Ohio hospital other than as defined in rules 5101:3-2-50 and 5101:3-2-51 of the Administrative Code.

(3) "Available inpatient payment gap" means the difference between what is estimated using the methodology described in paragraphs (C) and (D) 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.

(4) "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.

(5) "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.

(6) "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.

(7) "Medicare inpatient payments for hospitals exempt from medicare ~~diagnostic~~ - diagnosis related ~~groups~~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.

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

(9) "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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(10) "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.

(11) "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.

(12) "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.

(13) "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.

(14) "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.

(15) "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.

(16) "Total medicaid days" means for each children's 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.

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

(18) "Medicaid inpatient cost-to-charge ratio" means the historic medicaid inpatient cost-to-charge ratio applicable to a hospital as described in paragraph (B)(2) of rule 5101:3-2-22 of the Administrative Code.

(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 all hospitals, and the medicare cost report for the corresponding cost reporting period.

(C) Calculation of available inpatient payment gap for private hospitals.

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

(a) For each private hospital, calculate the total medicare inpatient payment by adding the amounts described in paragraphs (A)(7) to (A)(14) of this rule.

(b) For each private 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)(15) of this rule.

(c) For each private 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)(6) of this rule.

(d) For each private 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)(4) of this rule.

(e) For each private 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)(5) 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 hospitals, 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 hospitals.

~~(1) For each private hospital, calculate the total medicare inpatient payment by adding the amounts described in paragraphs (A)(7) to (A)(14) of this rule.~~

~~(2) For each private hospital, calculate the medicare payment-to-charge ratio by dividing the amount calculated in paragraph (C)(1) of this rule by the total medicare inpatient charges as described in paragraph (A)(15) of this rule.~~

~~(3) For each private hospital, calculate the total estimated medicare inpatient payment for medicaid inpatient discharges by multiplying the amount calculated in paragraph (C)(2) of this rule by the total medicaid inpatient charges as described in paragraph (A)(6) of this rule.~~

~~(4) For each private hospital, calculate the available inpatient payment gap by taking total estimated medicare inpatient payments for medicaid inpatient discharges as calculated in paragraph (C)(3) of this rule and subtracting actual total medicaid inpatient payments as described in paragraph (A)(4) of this rule.~~

~~(5) For all private hospitals, sum the amounts calculated in paragraph (C)(3) of this rule. This is the aggregate inpatient upper limit for all private hospitals.~~

~~(6) For all private hospitals, the sum of the amounts calculated in paragraph (C)(4) of this rule, is the aggregate inpatient upper limit payment gap for all private hospitals~~

(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) Notwithstanding paragraph (C)(5) of rule 5101:3-2-07.9 of the Administrative Code and except as provided in paragraph (F) of this rule, the director of the Ohio

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department of job and family services (ODJFS) shall pay a children's hospital that meets the criteria in paragraphs (E)(1) and (E)(2) of rule 5101:3-2-07.9 of the Administrative Code, for each cost outlier claim made in fiscal years ~~2008 and 2009~~ 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. These payments shall be made as supplemental inpatient outlier payments as follows:

(1) In July of each year after the effective date of the medicaid state plan amendment implementing this payment program, the director shall calculate for each eligible children's hospital the difference between the total amount the director would have paid according to the methodology in paragraph (E) of this rule for such claims for services incurred during the prior state fiscal year using the same cost-to-charge ratio as the ratio used to calculate cost outlier payments in accordance with rule 5101:3-2-07.9 of the Administrative Code for services incurred during that time period and the total amount the director paid according to the methodology in paragraph (A)(6) or (C)(5) of rule 5101:3-2-07.9 of the Administrative Code, as the applicable paragraph existed on June 30, 2007, for such claims as reflected in actual medicaid inpatient claims paid through the department's medicaid management information system (MMIS) in the prior state fiscal year.

(2) If the sum of the amounts calculated in paragraph (E)(1) of this rule for all eligible children's hospitals is less than or equal to the available amount for each fiscal year as provided in Section ~~309.30.13~~ 309.30.15 of Amended Substitute House Bill ~~119~~ 1 of the ~~127th~~ 128th General Assembly, then the supplemental inpatient outlier payment for each children's hospital shall be the amount calculated in paragraph (E)(1) of this rule. Otherwise, the supplemental inpatient outlier payment for each children's hospital shall be the amount calculated in paragraph (F) of this rule.

(F) The director shall cease paying a children's hospital for a cost outlier claim under the methodology in paragraph (E) of this rule and revert to paying the hospital for such a claim according to methodology in paragraph (A)(6) or (C)(5) of rule 5101:3-2-07.9 of the Administrative Code, as applicable, when the difference between the total amount the director would pay according to the methodology in paragraph (E) of this rule for such claims and the total amount the director paid according to the methodology in paragraph (A)(6) or (C)(5) of rule 5101:3-2-07.9 of the Administrative Code, as the applicable paragraph existed on June 30, 2007, for such claims, exceeds the available amount for each fiscal year as provided in Section ~~309.30.13~~309.30.15 of Amended Substitute House Bill ~~119~~1 of the ~~127th~~ 128th General Assembly. If the sum of the amounts calculated in paragraph (E)(1) of this rule for all eligible children's hospitals is greater than the available amount for each fiscal year as provided in Section ~~309.30.13~~309.30.15 of Amended Substitute House Bill ~~119~~1 of the ~~127th~~ 128th General Assembly, then the supplemental inpatient outlier payment for each children's hospital shall be the amount calculated as follows:

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(1) For each eligible children's hospital, the director shall calculate the ratio equal to the amount described in paragraph (E)(1) of this rule divided by the sum of the amount described in paragraph (E)(1) of this rule for all children's hospitals. For children's hospitals that did not have an outlier claim paid in that period, this figure shall be zero.

(2) The supplemental inpatient outlier payment for each children's hospital shall be the product of the ratio described in paragraph (F)(1) of this rule multiplied by the available amount for each fiscal year as provided in Section ~~309.30.13~~ - 309.30.15 of Amended Substitute House Bill ~~119~~1 of the ~~127th~~ 128th General Assembly.

(G) If the total funds that would be paid to all children's hospitals under paragraph (E) or (F) of this rule exceeds the aggregate inpatient upper limit payment gap for all private hospitals as described in paragraphs (C) and (D) of this rule, then the amount paid to each children's hospital will be the product of the ratio of the amount described in paragraph (F)(1) of this rule multiplied ~~times~~by the aggregate inpatient upper limit payment gap for all private hospitals as described in paragraphs (C) and (D) of this rule.

(H) The director shall make supplemental inpatient hospital upper limit payments to children's hospitals if the difference between the total amount the director has paid according to the methodology in paragraph (E) of this rule 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 of the Administrative Code for such claims, as the applicable paragraph existed on June 30, 2007, does not require the expenditure of the available amount for each fiscal year as provided in Section - ~~309.30.13~~ 309.30.15 of Amended Substitute House Bill ~~119~~1 of the ~~127th~~ 128th - General Assembly. If the supplemental outlier payments specified in paragraph (E) of this rule do not require the expenditure of the available amount for each fiscal year as provided in Section ~~309.30.13~~ 309.30.15 of Amended Substitute House Bill ~~119~~ 1 of the ~~127th~~ 128th General Assembly, and are less than the aggregate inpatient upper limit payment gap for all private hospitals as calculated for each supplemental payment program year as described in paragraphs (C) and (D) of this rule then supplemental inpatient hospital upper limit payments to children's 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 children's hospital a supplemental inpatient hospital payment amount by multiplying the ratio of each children's 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 children's hospitals derived from actual inpatient discharges paid

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for through the department's MMIS in the state fiscal year prior to the month of payment, by the difference between the available amount for each fiscal year as provided in Section ~~309.30.13~~ 309.30.15 of Amended Substitute House Bill ~~119~~ 1 of the ~~127th~~ 128th General Assembly minus the supplemental payments made pursuant to paragraph (E) of this rule, subject to the limitation described in paragraph (H)(2) of this rule.

(2) If the total funds that would be paid to all children's hospitals under paragraph (H)(1) exceeds the aggregate upper payment limit gap for all private hospitals as calculated for each supplemental inpatient upper limit payment program year as described in paragraphs (C) and (D) of this rule, then the amount paid to each children's hospital will be limited to its proportion, as determined by the ratios described in paragraph (H)(1) of this rule, of the difference between the aggregate upper payment limit gap minus the supplemental payments made pursuant to paragraph (E) of this rule.

(I) 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.

(J) The total funds that will be paid to each children's hospital will be included in the calculation of disproportionate share limits as described in rule 5101:3-2-07.5 of the Administrative Code.