

**Methods and Standards for Establishing Payment Rates**

**Inpatient Hospital Services**

The State has in place a public process which complies with the requirements of Section 1902 (a)(13)(A) of the Social Security Act. Except as noted below, all hospital services provided by Medicaid providers of inpatient hospital services ~~are~~are reimbursed under a DRG based prospective payment system (PPS).

**A. Hospital Services Subject to Reasonable Cost Reimbursement**

For hospital services subject to reasonable cost reimbursement, providers are paid on an interim basis by applying the hospital's cost to charge ratio to allowed charges. Billing must reflect the hospital's customary charge for the service rendered. Payments are subject to retrospective settlement and providers are paid the lesser of reasonable costs or total allowed charges. Payment is made for those items and services recognized as reasonable and allowable under Title XVIII standards and principles. Rules 5101:3-2-22, 5101:3-2-23 and 5101:3-2-24 of Appendix A detail provisions related to reasonable cost reimbursement. Hospital services subject to reasonable cost reimbursement include:

1. Freestanding rehabilitation hospitals which are excluded from the Medicare PPS.
2. Freestanding long-term hospitals which are excluded from the Medicare PPS.
3. Hospitals that are excluded from Medicare's PPS due to providing services, in total, which are excluded due to a combination of long-term care and rehabilitative services.
4. Hospitals licensed as ~~HMOS~~Health Insuring Corporations which limit services to Medicaid recipients to those enrolled in an ~~HMO~~a health insuring corporation or to short-term services provided on an emergency basis.
5. Heart/lung and pancreas transplantation services, single/double lung transplantation services provided on or after January 1, 1991 and prior to february 1, 2000, and liver/small bowel transplantation services.
6. For all hospitals, capital-related costs are subject to reasonable cost related reimbursement.
7. Hospitals recognized by Medicare as cancer hospitals beginning with discharges

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on or after July 1, 1992.

**B. Hospital Services Subject to Prospective Reimbursement:**

For hospital services other than those described in (A), payments are made on a prospective per discharge basis. Although the payment rate is fixed in terms of not being subject to cost reconciliation (with the exception of capital-related costs), payment amounts will vary according to: the DRG to which the case is assigned; the peer group to which the hospital is assigned; the size and cost (as applicable) of a hospital's medical education program, where applicable; ~~whether Norplant was provided~~; and finally, the degree to which a particular case is excessively lengthy or costly (outlier cases for which additional payments are made). The payment rate for a discharge is calculated as follows:

$$\begin{matrix} \text{Average} & & \text{Relative} & & \text{Add-On} & & \text{Add-On} & & \text{Add-On} \\ \text{Cost Per} & \times & \text{Weight} & + & \text{Amount} & + & \text{Amount for} & + & \text{Amount} \\ \text{Discharge} & & \text{for the} & & \text{for} & & \text{Medical} & & \text{for} \\ \text{Amount} & & \text{DRG} & & \text{Capital} & & \text{Education} & & \text{Norplant} \end{matrix}$$

Additional payments for outlier cases are made for cases which exceed outlier thresholds (see Section 5).

**1. Calculation of the Average Cost per Discharge**

The average cost per discharge (ACD) is calculated using inflated hospital base year cost report data (generally either calendar year 1985 or fiscal year 1986), subject to certain adjustments and limitations.

A hospital's Medicaid inpatient costs are standardized to include Medicaid's portion of malpractice costs reported on the 1986 Medicare cost report and to exclude a number of "non-operating" costs. Costs excluded are Medicaid inpatient capital, indirect medical education, and direct medical education. Capital and direct medical education costs are removed from total Medicaid inpatient costs by subtraction; indirect medical education costs are removed by dividing by 1 plus the hospital's indirect percentage. An additional standardization step is taken for hospitals in the major teaching hospital peer group to remove the effect of varying wage rates since these hospitals are dispersed geographically throughout the state. These wage-sensitive costs are then brought back into payment rates using a wage factor specific to each wage area.

For hospitals with an ACD that exceeds cost-increase limits determined by the

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department, the ACD is reduced by 3 percent. The ACD is then inflated to account for varying hospital fiscal year ends and then divided by the hospital's base year DRG case mix index.

Finally a peer group average cost per discharge is determined for all hospitals other than children's hospitals. The PGACD is an average (weighted by Medicaid discharges) of the hospital-specific ACD of all hospitals in a peer group. Children's hospitals are priced on a hospital-specific basis, not subject to peer grouping. The Ohio peer groups are:

- a. MSA Wage Related Peer Groups (9): Using Metropolitan Statistical Areas and wage indices published by the federal government, nine peer groups were identified by combining hospitals located in MSA's that carried wage indices within .01 of each other.
- b. Non-MSAs (2): One peer group includes non-MSA area hospitals with less than 100 beds. A second non-MSA peer group includes non-MSA area hospitals with 100 beds or greater.
- c. Teaching (1): One peer group includes hospitals with major/heavy teaching emphasis and hospitals recognized by Medicare as cancer hospitals until a cost report for the hospital has been reviewed. For State Fiscal years 1993 and 1994, the cancer hospital will be reimbursed on a reasonable cost basis.
- d. Rural Referral Centers (1): Those hospitals which are recognized by Medicare as Rural Referral Centers are assigned to a separate peer group.
- e. Non-Ohio Hospitals: Non-Ohio hospitals are classified into one of the three non-Ohio peer groups:
  - 1. Non-Ohio hospitals with a major heavy teaching emphasis;
  - 2. Non-Ohio Children's hospitals; or
  - 3. All other non-Ohio hospitals. Rule 5101:3-2-07,2 in Appendix A describes the changes made to the non-Ohio payment policies.

Rule 5101:3-2-07,2 details provisions regarding classification of hospitals.

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2. **Adjustments to the Peer Group Average Cost per Discharge (Or Hospital-specific Average Cost per Discharge for Childrens Hospitals)**

- a. **Outlier Set-Aside:** An outlier set-aside is calculated on a hospital-specific basis for children's hospitals and hospitals in the major teaching peer group and on a peer group basis for all other hospitals. The set-aside amount is calculated by first repricing all of a hospital's claims during the period 7/1/85 through 6/30/86 using current prices, relative weights and outlier thresholds. Once claims are repriced, the sum of amounts of additional payments for outliers is divided by the sum of total payments for all cases (less payments for capital and medical education) plus payments for day outliers. In order to reduce the magnitude of the outlier set-aside for hospitals that experience a high volume of outlier cases, the sum of amounts of additional payments for outliers for any hospital with an outlier set-aside value greater than the statewide mean outlier set-aside value is reduced to 75 percent for the purpose of calculating a reduced set-aside.

The outlier set-aside adjustment is made by subtracting from the PGACD the product of the outlier set-aside percentage multiplied by the unadjusted ACD.

- b. **Coding:** A coding adjustment is made by dividing the ACD (adjusted for outlier set-aside), by 1.005.
- c. **Inflation:** The ACD (previously adjusted for varying fiscal year ends by inflating calendar year hospital's data through June 30, 1986) is inflated further at the beginning of each rate year as described in Rule 5101:3-2-07.4 of Appendix A.

3. **Calculation of Add-on Amounts**

- a. **Medical Education:** Medical education costs, both direct and indirect, are paid on a prospective basis. Calculation of both components of the medical education add-on include a test-of-reasonableness ceiling.

For direct medical education, the hospital's reported cost for interns and residents is divided by its reported number of FTE interns and residents. A statewide mean cost per intern/resident plus one standard/deviation is then

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statewide mean cost per intern/resident plus one standard deviation is then determined using data from all hospitals with approved teaching programs. This value is the statewide ceiling of allowable reimbursable direct medical education costs. A hospital's allowable direct medical education costs are then divided by its number of Medicaid discharges in the base year to determine this portion of the medical education add-on.

Indirect medical education costs for a hospital are identified by applying the Medicare logarithmic formula to the hospital's resident-to-bed ratio. This formula produces a percentage which, when added to 1.0, is divided into Medicaid inpatient costs to standardize for indirect percentage (multiplied first by 100 to bring it to a whole number). This result, called the indirect "unit cost," is then used to determine a statewide mean unit cost plus one standard deviation. This amount is the ceiling for the allowable and reimbursable indirect medical education unit cost. The indirect add-on is then the allowable-indirect medical education percentage (multiplied again by 100 to bring it to a whole number) times the allowable unit cost. The direct and indirect medical education add-ons are summed and inflated for some hospitals for varying fiscal year ends. The total medical education add-on is then subject to the same inflation rates used to update the PGACD at the beginning of each rate year. For discharges on or after January 20, 1995, hospitals total medical education add-on is adjusted to remove the effects of case mix by dividing the hospital's inflated medical education add-on amount by the hospital's overall case mix as calculated in rule 5101:3-2-07.3. The adjusted medical education add-on is then adjusted for resource intensity of the inpatient admission by multiplying it by the corresponding DRG relative weight.

Rule 5101:3-2-07.7 of Appendix A details provisions regarding Medical Education.

- b. Capital: Capital-related costs are subject to reasonable cost reimbursement. Interim rates are calculated by dividing base year capital-related costs by base year Medicaid discharges.

Rule 5101:3-2-07.6 details provisions regarding capital-related costs.

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#### 4. Determination of Relative Weights and Associated DRG Data

a. Relative weights for DRGs and associated DRG values are calculated following methodology described in Rules 5101:3-2-07.3 and 5101:3-2-07.9 of Appendix A. All claims were grouped using the version of Medicare Grouper in effect during federal fiscal year 1998. Effective for discharges on January 1, 2006 through ~~June 30, 2008~~ December 31, 2009: For the purposes of determining the relative weight for each DRG, the sample includes all claims associated with discharges on or after July 1, 2001 through June 30, 2003 and paid by December 31, 2003. ~~Effective for discharges from July 1, 2008 through December 31, 2009: For the purposes of determining the relative weight for each DRG, the sample includes all claims associated with discharges on or after January 1, 2006 through December 31, 2006 and paid by June 30, 2007. Effective for discharges on or after January 1, 2010 occurring during calendar year 2010, and every calendar year thereafter, relative weights shall be determined on an annual basis, unless otherwise determined by the director of the Ohio department of job and family services. For the purposes of determining the relative weight for each DRG, the sample includes all claims associated with discharges during the state fiscal year ending in the calendar year preceding the immediate past calendar year prior to January 1st of the calendar year to which the new relative weights shall apply.~~

Relative weights for all DRGs except those with fewer than 10 cases are determined by first calculating:

- The average charge for a DRG and two standard deviations above the average.
- The average length of stay for a DRG and two standard deviations above the average.

Cases which are two standard deviations (one for neonatal DRGs) above either mean charge or length of stay are "removed" in order to recalculate:

- DRG average charge, without outliers
- DRG average length of stay, without outliers.

The relative weight for a DRG is calculated by dividing average charge for a given DRG by average charges across all DRGs. Charge outlier thresholds are set by adding, for each DRG, the value of two standard

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deviations (one for neonatal DRGs) above the average Charge to the average Charge calculated without outliers. Day outlier thresholds are calculated by adding, for each DRG, the value of two standard deviations (one for neonatal DRGs) above the average length of stay to the average length of stay calculated without outliers.

- b. Ohio Medicaid calculates relative weights and associated data for certain subsets of DRGs not classified in the Medicare Grouper as follows:
  - i. For DRGs 425 through 437, two sets of relative weights are calculated for each DRG. One set is calculated using data from hospitals which do not operate Medicare-approved psychiatric distinct part units while the other set is calculated using data from hospitals which do operate such units.
  - ii. For DRGs 388, 389 and 390, three subgroups are used for each DRG. For example, for DRG 388, one subgroup represents cases from hospitals with no Level II or III nursery, a second for cases from hospitals with a Level II nursery, and a third for cases from hospitals with a Level III nursery. Using this subgrouping criteria, three subgroups are created for each of DRGs 388, 389 and 390.
  - iii. For DRG 386, three subgroups are created, as follows:
    - a. Cases which have ICD-9-CM code 7650 (extreme immaturity);
    - b. Cases which don't have ICD-9-CM code 7650 from hospitals with Level I or II nurseries;
    - c. Cases which don't have ICD-9-CM code 7650 from hospitals with Level III nurseries.
  - iv. For DRG 387, four subgroups are created, as follows:
    - a. Cases with a birthweight 0 to 1750 grams from hospitals with Level I or II nurseries;
    - b. Cases with a birthweight of 0 to 1750 grains from hospitals

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with Level III nurseries;

c. Cases with a birthweight of 1751 grams and above from hospitals with Level I or II nurseries;

d. Cases with a birthweight of 1751 grams and above from hospitals with Level III nurseries.

c. For DRGs with fewer than 10 cases, the relative weights are calculated by multiplying the percentage change in the case mix of the remaining DRGs, ~~resulting from the change from the Medicare grouper in effect during federal fiscal year 1993 as implemented on January 20, 1995 to the Medicare grouper in effect during federal fiscal year 1998~~ using the claims described in item 4 (a) of this plan, by the relative weight calculated using the grouper in effect during federal fiscal year 1998. ~~The resulting values are identified in rule 5101:3-2-07.3.~~

For DRGs with more than ~~no cases~~ one case but fewer than 10 cases, outlier trims and mean lengths of stay are calculated as described. For DRGs with no cases grouped in the federal fiscal year 1998 grouper, previously calculated trims are used.

5. Calculation of Outlier Payments

a. Day and Cost Outliers - If a claim qualifies for additional day and cost outlier payments, day-cost outlier payment takes precedence. ~~except for DRGs 385, 388, 389, and 892 through 898 (where cost outlier takes precedence over day outlier), and except for the special outlier payment policy described in 5.c below.~~

Day outliers are paid as follows:

$$\frac{(\text{Average Cost Per Discharge} \times \text{Relative Weight for DRG})}{\text{Average length of stay for DRG}} = \text{Per Diem Amount}$$

$$[\text{Per Diem Amount} \times \text{Number of Days Above Day Threshold} \times .60 \text{ (.80 for Neonatal DRGs)}] = \text{Day Outlier Additional Payment}$$

$$\text{Day Outlier Additional Payment} + \text{Regular DRG Payment} = \text{Total Reimbursement}$$

Cost outliers are paid the lesser of the following:

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(Billed Allowable Charges-Cost Outlier Threshold)~~X.60~~ Hospital Specific Cost to Charge Ratio  
~~= Cost Outlier Additional Payment~~

~~(.80 for Neonatal DRGs) = Cost Outlier Additional Payment~~

Cost Outlier Additional Payment + Regular DRG Payment = Total Reimbursement

OR

Billed Allowable Charges X Hospital Specific Cost-To-Charge Ratio = Cost Outlier Payment =  
 Total Reimbursement

To determine a cost outlier for discharges on or after January 20, 1995, total allowable charges must be compared to the charge high trim.

For both day and cost outliers, if charges are less than the sum of regular DRG payment and the additional outlier payment, total payment is limited to billed charges.

- b. **Extraordinary Outliers:** Hospitals that previously qualified for extraordinary outlier payments as such policy was in effect on July 3, 1986 may continue to be paid under that policy for stays exceeding 60 days with an admission date between July 3, 1986 and October 18, 1987. For admissions on or after October 19, 1987, a revised extraordinary outlier payment policy is in effect.

This payment policy effective ~~February 1, 2002~~ January 1, 2005 provides that any hospital with a Medicaid claim exceeding ~~\$443,463~~ \$493,098 (\$477,346 from 1/1/04 to 12/31/04, \$460,758 from 1/1/03 to 12/31/03, \$443,463 from 8/1/02 to 12/31/02, and \$250,000 prior to August 1, 2002) in cost will be paid on a cost-to-charge ratio basis. This threshold amount will be inflated on an annual basis on January 1 of each year by using the inflation factor described in rule 5101:3-2-07.4 of Appendix A. Cost is determined by applying the hospital's cost-to-charge ratio to allowed charges.

- c. **Special Outlier Payment Policy** - Hospitals with outlier set-aside percent greater than one standard deviation above the statewide mean outlier percent and whose ratio of Medicaid, General Assistance and Title V inpatient days-to-total days, as described in Rule 5101:3-2-07.9 of Appendix A, is greater than one standard deviation above the statewide mean ratio qualify for special outlier payment policies. For such hospitals, cost outliers take precedence over day outliers in all cases and payment for cost outliers is based on 85 percent of cost. Cost is

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determined by applying the hospital's cost-to-charge ratio to allowed claim charges.

For hospital serving an AIDS patient population two standard deviations above the statewide mean ratio of hospital AIDS cases to total aids cases, cost outlier will take precedence over day outlier for DRGs 488-490. Payment for those cost outliers will be 85 percent of total allowable claim cost.

Rule 5101:3-2-07.9 details provisions regarding outlier payments.

6. **Special Payment Provisions**

- a. **Transfers and Partial Eligibility:** In cases when a patient is transferred from one hospital to another, payment is made to each hospital on a per diem basis. Similarly, when a patient is Medicaid eligible for only a portion of an inpatient stay, payment is made on a per diem basis, calculated as follows:

$$\frac{(\text{Average Cost Per Discharge} \times \text{Relative Weight For DRG})}{\text{Average Length of Stay for DRG}} = \text{Per Diem Amount}$$

$$[(\text{Per Diem Amount} \times \text{Number of Covered Days}) + \text{Medical Education Add-On} + \text{Capital Add-On}] = \text{Total Per Diem DRG Payment}$$

If total per diem DRG payment exceeds regular DRG payment, reimbursement is limited to the regular DRG amount.

- b. **Readmissions Within One Day:** All readmissions within one day of discharge are considered as one discharge for payment purposes.

Rule 5101:3-2-07.11 of Appendix A details special payment provisions.

7. **Rate Redetermination**

At the start of each succeeding state fiscal year, payment rates are inflated unless other revised payment methods are introduced (e.g., rebasing of prices and/or recalibration of weights).

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example hospitals are reclassified among peer groups, the peer group ACD will be recalculated if such recalculation would result in a two percent change. Similarly, if the use of revised or corrected hospital data would result in a two percent change, the peer group ACD will be recalculated.

Rule 5101:3-2-07<sub>8</sub> details provisions regarding rate redetermination.

### C. Audits and Appeals

Audits are performed for hospital services subject to reasonable cost reimbursement to determine reasonable and allowable costs. Under payments or overpayments are adjusted through settlement. For hospital services subject to PPS, audits are performed to determine reasonable and allowable base year costs and discharge statistics; to determine whether, overall, payments exceeded charges; to verify that services billed were provided and provided to eligible recipients; and to determine whether third party payments received were reported.

In general, hospitals may request reconsideration of payment rates if they believe source data used by the department is inaccurate. Certain components of rate calculation are excluded from reconsideration in order to preserve the predictability of the prospective payment system (e.g., statewide calculation of means used to set thresholds for medical education disallowance and peer group ACD calculations after the end of the second rate year following implementation of revised peer group ACDs).

Rule 5101:3-2-24 of Appendix A details audit provisions for hospital services subject to and excluded from PPS.

Rules 5101:3-2-07<sub>8</sub>, 5101:3-2-07<sub>12</sub> and 5101:3-2-24 of Appendix A detail appeal and reconsideration procedures for hospitals related to auditing and rate-setting determinations.

### D. Cost Reports

All Ohio hospitals and all non-Ohio hospitals with grossoutpatient billings exceeding ~~\$500,000~~\$300,000 within a reporting period are required to submit cost reports.

Rule 5101:3-2-23 of Appendix A describes cost reporting requirements.

### E. Appendix A

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In general Appendix A details the provisions summarized in Section (1) of this Attachment and provides additional detail on related policies which can affect reimbursement.

**Provider Preventable Conditions (PPCs)**

The Medicaid agency meets the requirements of 42 CFR Part 447, Subpart A, and sections 1902(a)(4), 1902(a)(6), and 1903 with respect to non-payment for provider-preventable conditions (PPCs).

The State identifies the following Health Care-Acquired Conditions (HCACs) for non-payment: Hospital-Acquired Conditions as identified by Medicare other than Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE) following total knee replacement or hip replacement surgery in pediatric and obstetric patients. Non-payment of HCACs applies to all inpatient hospitals.

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The State identifies the following OPPCs for non-payment in any health care setting where they may occur: Wrong surgical or other invasive procedure performed on a patient; surgical or other invasive procedure performed on the wrong body part; surgical or other invasive procedure performed on the wrong patient.

Disproportionate Share and Indigent Care for General Hospitals

This Section applies to all general hospitals eligible to participate in Medicaid who do not meet the criteria in paragraphs (B), (C) and (D) of Rule 5101:3-2-01.

(A) SOURCE DATA FOR CALCULATIONS

The calculations described for determining disproportionate share hospitals and in making disproportionate share and indigent care payments will be based on data provided in annual cost reports submitted to the department under the provisions of Rule 5101:3-2-23. The cost reports used will be for the hospital's cost reporting period ending in the state fiscal year that ends in the federal fiscal year preceding each program year. If specific program data is not available from these reports, the otherwise most recent, reviewed, cost report information will be used. The CMS data used will be as reported by CMS for the prior federal fiscal year.

(B) DETERMINATION OF DISPROPORTIONATE SHARE HOSPITALS

The department makes additional payments to hospitals that qualify for a disproportionate share adjustment. Hospitals that qualify (including Children's and DRG exempt hospitals) are those that meet at least one of the criteria described under (1) and (2) below and that also meet the criteria described under (3) below:

- (1) Have a Medicaid utilization rate greater than or equal to one percent.
- (2) Have a low income utilization rate in excess of 25 percent, where low income utilization rate is:

$$\frac{\text{Medicaid Payments} + \text{Cash subsidies from patient services received directly from state and local government}}{\text{Total hospital revenues (incl. cash subsidies from patient services received directly from state and local government)}}$$

+

$$\frac{\text{Total charges for inpatient services for charity care}}{\text{Total charges for inpatient services}}$$

- (3) Have at least two obstetricians who have staff privileges at the hospital and who have agreed to provide obstetric services to individuals who are entitled to Medicaid, except that:
  - (i) The provisions of (3) do not apply to hospitals the inpatients of which are predominantly individuals under 18 years of age; or
  - (ii) The provisions of (3) do not apply if the hospital does not offer non-emergency obstetric services to the general population as of December 22, 1987; or
  - (iii) In the case of hospitals located in a rural area (as defined for purposes of Section 1886 of the Social Security Act), the term "obstetrician" includes any physician with staff privileges at the hospital to perform non-emergency obstetric procedures.

Hospitals that do not qualify for a disproportionate share adjustment receive additional payments in the form of an indigent care adjustment.

(C) DISPROPORTIONATE SHARE AND INDIGENT CARE POOL

- (1) The disproportionate share and indigent care pool are created in compliance with the Medicaid Voluntary Contribution and Provider Specific Tax Amendments of 1991 and the regulations issued in the August 13, 1993 Federal Register. Furthermore, it is an assurance of this plan that the amount of payments made to disproportionate share hospitals will not exceed, in the aggregate, the limits prescribed under subparagraph (f)(3)(A) of Section 1923.

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(a) The total amount of disproportionate share funds that will be expended for general hospitals in the disproportionate share and indigent care policy pools shall be equal to the state's disproportionate share allotment, as determined by CMS, less amounts reserved for psychiatric hospitals.

(2) The funds available in the indigent care pool shall be distributed through policy payment pools in paragraphs (D) through (H). Policy payment pools shall be allocated a percentage of Ohio's disproportionate share allotment defined in paragraph (C)(1)(a) as described in paragraphs (D)(2)(a) through (D)(2)(f) of this rule.

(a) High federal disproportionate share hospital pool: ~~7.92~~ 7.85%

(b) Medicaid indigent care pool: ~~20.59~~ 20.40%

(c) Disability assistance medical and uncompensated care pool: ~~61.70~~ 61.12%

(d) Uncompensated care for persons above 100% of poverty: ~~5.29~~ 5.24%

(e) Critical access and rural hospitals: ~~3.16~~ 4.06%

(f) Children's hospitals: ~~4.34~~ 1.33%

#### (D) DISTRIBUTION FORMULAS FOR INDIGENT CARE PAYMENT POOLS.

(1) Hospitals meeting the high federal disproportionate share hospital definition are eligible to receive funds from the high federal disproportionate share indigent care payment pool. A high federal disproportionate share hospital is defined as one whose ratio of total Medicaid days and Medicaid MCP days to total days is greater than the statewide mean ratio of total Medicaid days and Medicaid MCP days to total days plus one standard deviation. Funds are distributed to hospitals which meet this definition according to the following formula.

(a) For each hospital that meets the definition of high disproportionate share, calculate the ratio of the hospital's total Medicaid costs and total Medicaid MCP costs to the sum of total Medicaid costs and Medicaid MCP costs for all hospitals which meet the definition of high federal disproportionate share described in paragraph (D)(1).

(b) For each hospital which meets the high federal disproportionate share definition, multiply the ratio calculated in paragraph (D)(1)(a) by the amount allocated in paragraph (C)(2)(a) to determine each hospital's high federal disproportionate share hospital payment amount, subject to the following limitations:

(i) If the hospital's payment amount calculated in paragraph (D)(1)(b) is greater than or equal to its hospital specific disproportionate share limit, defined in paragraph (I), the hospital's high federal disproportionate share hospital payment is equal to its hospital specific disproportionate share limit.

(ii) If the hospital's payment amount calculated in (D)(1)(b) is less than its hospital-specific disproportionate share limit, defined in paragraph (I), the hospital's high federal disproportionate share hospital payment is equal to the amount in paragraph (D)(1)(b).

(iii) If the hospital-specific disproportionate share limit, defined in paragraph (I), is equal to or less than zero, the hospital's high federal disproportionate share hospital payment is equal to zero.

(iv) If any hospital is limited by paragraph (D)(1)(b)(i), reduce the total calculate each hospital's limited payment amount by subtracting its hospital-specific disproportionate share limit from the amount determined in paragraph (D)(1)(b) and sum these amounts for all limited hospital(s). Subtract the sum of the limited payments amounts from the amount allocated in paragraph (C)(2)(a) and repeat the distribution described in paragraph (D)(1) until all funds for this pool are expended. Hospitals that have been limited, shall have their ratio set to zero for subsequent redistributions within the pool.

(iv) For all hospitals, sum the amounts calculated in paragraph (D)(1)(b). This amount is the hospital's high federal disproportionate share hospital payment amount.

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- (2) Hospitals are eligible to receive funds from the Medicaid indigent care payment pool according to the following formulas.
- (a) For each hospital, calculate Medicaid shortfall by subtracting from total Medicaid costs total Medicaid payments. For hospitals with a negative Medicaid shortfall, the Medicaid shortfall is equal to zero.
  - (b) For each hospital, Medicaid MCP inpatient payments are as reported on the Medicaid Cost Report.
  - (c) For each hospital, Medicaid MCP outpatient payments are as reported on the Medicaid Cost Report.
  - (d) For each hospital, calculate Medicaid MCP inpatient shortfall by subtracting from the total Medicaid MCP inpatient costs, Medicaid MCP inpatient payments in paragraph (D)(2)(b).
  - (e) For each hospital, calculate Medicaid MCP outpatient shortfall by subtracting from the total Medicaid MCP outpatient costs, Medicaid MCP outpatient payments in paragraph (D)(2)(c).
  - (f) For each hospital, calculate Medicaid MCP shortfall as the sum of the amount calculated in paragraph (D)(2)(d), and the amount calculated in paragraph (D)(2)(e).
  - (g) For each hospital, sum the hospital's Medicaid shortfall, Medicaid MCP shortfall, total Medicaid costs, total Medicaid MCP costs, and total Title V costs.
  - (h) For all hospitals, sum all hospitals Medicaid shortfall, Medicaid MCP shortfall, total Medicaid costs, total Medicaid MCP costs, and total Title V costs.
  - (i) For each hospital, calculate the ratio of the amount in paragraph (D)(2)(g) to the amount in paragraph (D)(2)(h).
  - (j) For each hospital, multiply the ratio calculated in paragraph (D)(2)(i) by the amount allocated in paragraph (C)(2)(b) to determine each hospital's Medicaid indigent care payment amount.
  - (k) Each hospital's indigent care payment amount is equal to the amount calculated in paragraph (D)(2)(j), subject to the following limitations:
    - (i) If the sum of a hospital's payment amounts calculated in paragraph (D)(1)(b) is greater than or equal to its hospital-specific disproportionate share limit, the hospital's Medicaid indigent care payment pool amount is equal to zero.
    - (ii) If the sum of a hospital's payment amounts calculated in paragraph (D)(1)(b) and the amount calculated in paragraph (D)(2)(j) is less than its hospital-specific disproportionate share limit defined in paragraph (I); the hospital's indigent care payment amount is equal to the amount calculated in paragraph (D)(2)(j).
    - (iii) If the sum of a hospital's indigent care and the payment amounts calculated in paragraph (D)(1)(b) is greater than the hospital's disproportionate share limit defined in paragraph (I), then the hospital's indigent care payment amount is equal to the difference between the hospital's disproportionate share limit and the sum of the payment amounts in paragraphs (D)(1)(b) and (D)(2)(j).
    - (iv) If any hospital is limited by paragraph (D)(2)(k)(i), calculate each hospital's limited payment amount by subtracting its hospital-specific disproportionate share limit from the amount determined in paragraph (D)(2)(j) and sum these amounts for all limited hospital(s). Subtract the sum of the limited payments amounts from the amount allocated in paragraph (C)(2)(b) and repeat the distribution described in paragraph (D)(2) until all funds for this pool are expended. Hospitals that have been limited, shall have their ratio set to zero for subsequent redistributions within the pool.
- (3) Hospitals are eligible to receive funds from the disability assistance medical and uncompensated care indigent care payment pool.

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- (a) For each hospital, sum total disability assistance medical costs and total uncompensated care costs under one hundred per cent. For hospitals with total negative disability assistance and uncompensated care costs, the resulting sum is zero.
- (b) For all hospitals, sum the amounts calculated in paragraph (D)(3)(a).
- (c) For each hospital, calculate the ratio of the amount in paragraph (D)(3)(a) to the amount in paragraph (D)(3)(b).
- (d) For each hospital, multiply the ratio calculated in paragraph (D)(3)(c) by the amount calculated in paragraph (C)(2)(c) to determine each hospital's disability assistance medical and uncompensated care under one hundred per cent payment, subject to the following limitations:
- (i) If the sum of a hospital's payment amounts calculated in paragraphs (D)(1) and (D)(2) is greater than or equal to its hospital-specific disproportionate share limit defined in paragraph (I), the hospital's disability assistance medical and uncompensated care under one hundred per cent payment amount is equal to zero.
  - (ii) If the sum of a hospital's payment amount calculated in paragraphs (D)(1) and (D)(2) and the amount calculated in paragraph (D)(3)(d) is less than its hospital-specific disproportionate share limit defined in paragraph (I), the hospital's disability medical and uncompensated care under one hundred per cent payment amount is equal to the amount is equal to the amount calculated in paragraph (I).
  - (iii) If a hospital does not meet the condition described in paragraph (D)(3)(d)(i), and the sum of its payment amounts calculated in paragraph (D)(1) and (D)(2) and the amount calculated in paragraph (D)(3)(d) is greater than its hospital-specific disproportionate share limit defined in paragraph (I), the hospital's disability medical and uncompensated care under one hundred per cent payment amount is equal to the difference between the hospital's disproportionate share limit and the sum of the payment amounts calculated in paragraphs (D)(1) and (D)(2).
  - (iv) If any hospital is limited by paragraph (D)(3)(d)(i), calculate each hospital's limited payment amount by subtracting its hospital-specific disproportionate share limit from the amount determined in paragraph (D)(3)(d) and sum these amounts for all limited hospital(s). Subtract the sum of the limited payments amounts from the amount allocated in paragraph (C)(2)(c) and repeat the distribution described in paragraph (D)(3) until all funds for this pool are expended or all unlimited hospitals have received one hundred per cent of the amount described in paragraph (D)(3)(a). Hospitals that have been limited, shall have their ratio set to zero for subsequent redistributions within the pool.
- (e) For all hospitals, sum the amounts calculated in paragraph (D)(3)(d).
- (f) For each hospital, except those meeting either condition described in paragraph (D)(3)(d)(i) or (D)(3)(d)(iii) multiply a factor of 0.30 by the hospital's total uncompensated care costs above one hundred percent without insurance. For hospitals meeting the conditions described in paragraph (D)(3)(d)(i) or (D)(3)(d)(iii), multiply the hospital's total uncompensated care costs above one hundred percent by zero.
- (g) For all hospitals, sum the amounts calculated in paragraph (D)(3)(f).
- (h) For each hospital, calculate the ratio of the amount in paragraph (D)(3)(f) to the amount in paragraph (D)(3)(g).
- (i) Subtract the amount calculated in paragraph (D)(3)(e) from the amount allocated in paragraph (C)(2)(c) and add the amount calculated in paragraph (C)(2)(d).
- (j) For each hospital, multiply the ratio calculated in paragraph (D)(3)(h) by the amount calculated in paragraph (D)(3)(i), to determine each hospital's uncompensated care above one hundred percent without insurance payment amount, subject to the following limitations:
- (i) If the sum of a hospital's payment amounts calculated in paragraphs (D)(1), (D)(2) and (D)(3)(d) is greater than or equal to its hospital-specific disproportionate share limit defined in paragraph (I), the hospital's uncompensated care above one hundred per cent without insurance amount is equal to zero.

(ii) If the sum of a hospital's uncompensated care above one hundred per cent without insurance payment and the payment amounts calculated in paragraphs (D)(1), (D)(2), and (D)(3)(d) is less than the hospital's disproportionate share limit defined in paragraph (I), then the hospital's uncompensated care above one hundred per cent without insurance payment is equal to the product of multiplying the ratio calculated in paragraph (D)(3)(h) by the amount calculated in paragraph (D)(3)(i).

(iii) If the sum of a hospital's uncompensated care above one hundred per cent without insurance payment and the payment amounts calculated in paragraphs (D)(1), (D)(2), and (D)(3)(d) is greater than the hospital's disproportionate share limit defined in paragraph (I), then the hospital's uncompensated care above one hundred per cent without insurance payment is equal to the difference between the hospital's disproportionate share limit and the sum of the payment amounts calculated in paragraphs (D)(1), (D)(2), and (D)(3)(d).

(iv) If any hospital is limited by paragraph (D)(3)(j)(iii), calculate each hospital's limited payment amount by subtracting its hospital-specific disproportionate share limit from the amount determined in paragraph (D)(3)(d) and sum these amounts for all limited hospital(s). Subtract the sum of the limited payments amounts from the amount allocated in paragraph (D)(3)(i) and repeat the distribution described in paragraph (D)(3)(g) through (D)(3)(j) until all funds for this pool are expended. Hospitals that have been limited, shall have their ratio set to zero for subsequent redistributions within the pool.

(k) For each hospital, sum the amount calculated in paragraph (D)(3)(b), and the amount calculated in paragraph (D)(3)(j). This amount is the hospital's disability assistance medical and uncompensated care indigent care payment amount.

(E) DISTRIBUTION OF FUNDS THROUGH THE RURAL AND CRITICAL ACCESS PAYMENT POOLS

The funds are distributed among the hospitals according to rural and critical access payment pools described in paragraphs (E)(1) to (E)(2).

(1) Hospitals that are certified as critical access hospitals by the Centers for Medicare and Medicaid Services, and that have notified the Ohio Department of Health and the Ohio Department of Job and Family Services of such certification, shall receive funds from the critical access hospital (CAH) payment pool. Hospitals shall notify the Ohio Department of Job and Family Services of any change in their critical access hospital status, immediately following notification from CMS.

(a) For each hospital with CAH certification, calculate the Medicaid shortfall by adding Medicaid FFS shortfall described paragraph (D)(2)(a), to the Medicaid MCP shortfall described in paragraph (D)(2)(f).

(b) For each hospital with CAH certification, calculate the ratio of each CAH hospital's Medicaid shortfall to total Medicaid shortfall for all CAH hospitals.

(c) For each CAH hospital, multiply the ratio calculated in paragraph (E)(1)(b) by ~~26.67~~ 32.01% of the amount allocated in paragraph (C)(2)(e) to determine each hospital's CAH payment amount.

(d) For all hospitals with CAH certification, sum the amounts calculated in paragraph (E)(1)(c).

(e) For each hospital with CAH certification, if the amount described in paragraph (E)(1)(a) of this rule is equal to zero, the hospital shall be included in the RAH payment pool described in paragraph (E)(2)(a).

(2) Hospitals that are classified as rural hospitals by the Centers for Medicare and Medicaid Services, but do not meet the definition described in paragraph (E)(1), shall receive funds from the rural access hospital (RAH) payment pool.

(a) For each hospital with RAH classification, as qualified by paragraph (E)(2) and (E)(1)(d), sum the hospital's total payments allocated in paragraphs (D)(1)(b), (D)(2)(j), and (D)(3)(j).

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- (b) For each hospital with RAH classification, as qualified by paragraph (E)(2) and (E)(1)(e) subtract the amount calculated in paragraph (E)(2)(a), from the hospital's disproportionate share limit defined in paragraph (I). If this difference for the hospital is negative, then for the purpose of this calculation set the difference equal to zero.
- (c) For all hospitals with RAH classification, as qualified by paragraph (E)(2) and (E)(1)(e), sum the amounts calculated in paragraph (E)(2)(b).
- (d) For each hospital with RAH classification, as qualified by paragraph (E)(2) and (E)(1)(e), determine the ratio of the amounts in paragraph (E)(2)(b) and (E)(2)(c).
- (e) Subtract the amount calculated in paragraph (E)(1)(c) from the amount allocated in paragraph (C)(2)(e).
- (f) For each hospital with RAH classification, as qualified by paragraph (E)(2) and (E)(1)(e), multiply the ratio calculated in paragraph (E)(2)(d), by the amount calculated in paragraph (E)(2)(e), to determine each hospital's RAH payment pool amount.
- (g) For each hospital, sum the amount calculated in paragraph (E)(1)(c), and the amount calculated in paragraph (E)(2)(f). This amount is the hospital's rural and critical access payment amount.

(F) DISTRIBUTION OF FUNDS THROUGH THE COUNTY REDISTRIBUTION OF CLOSED HOSPITALS PAYMENT POOLS.

(1) Closed hospitals with unique Medicaid provider numbers.

For a hospital facility, identifiable to a unique Medicaid provider number, that closes during the program year, the cost report data used shall be adjusted to reflect the portion of the year the hospital was open during the program year. That partial year data shall be used to determine the distribution to that closed hospital. The difference between the closed hospital's distribution based on the full year cost report and the partial year cost report shall be redistributed to the remaining hospitals in accordance with paragraph (F)(2).

For a hospital facility identifiable to a unique Medicaid provider number that closed during the immediate prior program year, the cost report data shall be used to determine the distribution that would have been made to that closed hospital. This amount shall be redistributed to the remaining hospitals in accordance with paragraph (F)(2).

If funds are available in accordance with paragraph (F)(1), the funds are distributed among the hospitals according to the county redistribution of closed hospitals payment pools described in paragraphs (F)(2) to (F)(4).

- (2) If a hospital facility that is identifiable to a unique Medicaid provider number closes during the current program year, the payments that would have been made to that hospital under paragraphs (D), (E), (G), and (H) for the portion of the year it was closed, less any assessment amounts that would have been paid by the closed hospital for the portion of the year it was closed, shall be distributed to the remaining hospitals in the county where the closed hospital is located. If another hospital does not exist in such a county, the funds shall be distributed to hospitals in bordering counties within the state.

For each hospital identifiable to a unique Medicaid provider number that closed during the immediate prior program year, the payments that would have been made to that hospital under paragraphs (D), (E), (G), and (H), less any assessment amounts that would have been paid by the closed hospital, shall be distributed to the remaining hospitals in the county where the closed hospital was located. If another hospital does not exist in such a county, the funds shall be distributed to hospitals in bordering counties within the state.

If the closed hospital's payments under paragraphs (D), (E), (G), and (H) does not result in a net gain, nothing shall be redistributed under paragraphs (F)(3) and (F)(4).

- (3) Redistribution of closed hospital funds within the county of closure.

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- (a) For each hospital within a county with a closed hospital as described in paragraph (F)(2), sum the amount calculated in paragraph (D)(3)(a), and the amount calculated in paragraph (D)(3)(f).
  - (b) For all hospitals within a county with a closed hospital, sum the amounts calculated in paragraph (F)(3)(a).
  - (c) For each hospital within a county with a closed hospital, determine the ratio of the amounts in paragraph (F)(3)(a) and (F)(3)(b).
  - (d) For each hospital within a county with a closed hospital, multiply the ratio calculated in paragraph (F)(3)(c), by the amount calculated in paragraph (F)(2) of this rule, to determine each hospital's county redistribution of closed hospitals payment amount.
- (4) Redistribution of closed hospital funds to hospitals in a bordering county.
- (a) For each hospital within a county that borders a county with a closed hospital where another hospital does not exist, as described in paragraph (F)(2), sum the amount calculated in paragraph (D)(3)(a), and the amount calculated in paragraph (D)(3)(f).
  - (b) For all hospitals within counties that border a county with a closed hospital where another hospital does not exist, sum the amounts calculated in paragraph (F)(4)(a).
  - (c) For each hospital within a county that borders a county with a closed hospital where another hospital does not exist, determine the ratio of the amounts in paragraph (F)(4)(a) and (F)(4)(b).
  - (d) For each hospital within a county that borders a county with a closed hospital where another hospital does not exist, multiply the ratio calculated in paragraph (F)(3)(c), by the amount calculated in paragraph (F)(2), to determine each hospital's county redistribution of closed hospitals payment amount.

(G) DISTRIBUTION OF FUNDS THROUGH THE CHILDREN'S HOSPITAL POOL.

- (1) For each hospital meeting the children's hospital definition, sum the payment amounts as calculated in paragraphs (D), (E), and (F). This is the hospital's calculated payment amount.
- (2) For each hospital meeting the children's hospital definition, with a calculated payment amount that is not greater than the disproportionate share limit, as described in paragraph (I), subtract the amount in paragraph (G)(1) from the amount described in paragraph (I).
- (3) For hospitals meeting the children's hospital definition, with calculated payment amounts that are not greater than the disproportionate share limit, sum the amounts calculated in paragraph (G)(2).
- (4) For each hospital meeting the children's hospital definition, with a calculated payment amount that is not greater than the disproportionate share limit, determine the ratio of the amounts in paragraphs (G)(2) and (G)(3).
- (5) For each hospital meeting the children's hospital definition, with a calculated payment that is not greater than the disproportionate share limit, multiply the ratio calculated in paragraph (G)(4) by the amount allocated in paragraph (C)(2)(f). This amount is the children's hospital payment pool payment amount.

If the sum of the hospital's payment amounts calculated in paragraphs (D), (E), (F), and (G) is less than the hospital's disproportionate share limit defined in paragraph (I), then the hospital's children's hospital pool payment amount is equal to the amount calculated in paragraph (G)(5), not to exceed the amount defined in paragraph (I).

If any hospital is limited as described in paragraph (G)(5), calculate each hospital's limitation limited amount by subtracting the amount defined in paragraph (I) from the amount determined in paragraph (G)(5) and sum these amounts for all limited hospital(s). Subtract the sum of the limited amounts from the amount calculated in paragraph (C)(2)(f) and repeat the distribution described in paragraph (G) until all funds for this pool are expended. Hospitals that have been limited, shall have their ratio set to zero for subsequent redistributions within the pool.

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## (H) DISTRIBUTION MODEL ADJUSTMENTS AND LIMITATIONS THROUGH THE STATEWIDE RESIDUAL POOL.

- (1) For each hospital, subtract the hospital's specific disproportionate share limit as defined in paragraph (I) from the payment amount as calculated in paragraphs (H)(2), to determine if a hospital's calculated payment amount is greater than its disproportionate share limit.
- (2) For each hospital, sum the hospital's total payments allocated in paragraphs (D)(1)(b), (D)(2)(k), AND (D)(3)(j), (E)(2)(g), (F)(3)(d), (F)(4)(d) and (G)(5).

If a hospital's calculated payment amount is greater than its disproportionate share limit, then the hospital's payment is equal to the hospital's disproportionate share limit. The portion of the calculated amount above the disproportionate share limit, referred to as residual payment funds, is subtracted from the hospital's calculated payment amount and is applied to the statewide residual payment pool as described in paragraph (I)(3).

## (3) RE-DISTRIBUTION OF RESIDUAL PAYMENT FUNDS IN THE STATEWIDE RESIDUAL PAYMENT POOL.

- (a) For each hospital with a calculated payment amount that is not greater than the disproportionate share limit, as described in paragraph (I), subtract the payment amount described in paragraph (H)(1) from the amount of the disproportionate share limit.
- (b) For each hospital with calculated payment amounts that are not greater than the disproportionate share limit, sum the amounts calculated in paragraph (H)(3)(a).
- (c) For each hospital with a calculated payment amount that is not greater than the disproportionate share limit, determine the ratio of the amounts in paragraph (H)(3)(a) and (H)(3)(b).
- (d) For each hospital with a calculated payment amount that is not greater than the disproportionate share limit, multiply the ratio calculated in paragraph (H)(3)(c) of this rule by the total amount distributed through the statewide residual pool described in paragraph (H)(1). This amount is the hospital's statewide residual payment pool payment amount.

## (I) LIMITATIONS ON DISPROPORTIONATE SHARE AND INDIGENT CARE PAYMENTS MADE TO HOSPITALS

- (1) For each hospital calculate Medicaid shortfall by subtracting from total Medicaid costs, total Medicaid payments. (NOTE: FOR HOSPITALS WITH A NEGATIVE MEDICAID SHORTFALL, THE MEDICAID SHORTFALL AMOUNT IS NOT EQUAL TO ZERO). For hospitals exempt from the prospective payment system, Medicaid shortfall equals zero. For each hospital, add Medicaid MCP shortfall as calculated in paragraph (D)(2)(f).
- (2) For each hospital, calculate total inpatient costs for patients without insurance by multiplying the hospitals' inpatient Medicaid cost-to-charge ratio, by the sum of hospital's reported charges for inpatient disability assistance medical, inpatient uncompensated care under one hundred per cent of federal poverty level, and inpatient uncompensated care above one hundred per cent of federal poverty level.
- (3) For each hospital, calculate total outpatient costs for patients without insurance by multiplying the hospitals' outpatient Medicaid cost-to-charge ratio, by the sum of hospital's reported charges for outpatient disability assistance medical, outpatient uncompensated care under one hundred per cent of federal poverty level, and outpatient uncompensated care above one hundred per cent of federal poverty level.
- (4) For each hospital, calculate the hospital disproportionate share limit by adding the Medicaid shortfall and Medicaid MCP shortfall as described in paragraph (I)(1), inpatient uncompensated care as described in paragraph (I)(2), and outpatient uncompensated care as described in paragraph (I)(3).
- (5) The hospital will receive the lesser of the disproportionate share limit as described in paragraph (I)(4) or the disproportionate share and indigent care payment as calculated in paragraphs (D), (E), (F), (G), and (H).

Payments are made to each hospital in installments based on the amount calculated for the annual period. The annual period used in performing disproportionate share/indigent care adjustments is the hospital's fiscal year ending in the state fiscal year that ends in the federal fiscal year preceding each program year. Payments are subject to reconciliation if errors have been made in

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calculating the amount of disproportionate share indigent care adjustments or if adjustments must be made in order to comply with the federal regulations issued under H.R. 3595.

Expenses associated with payment of hospital assessments are allowable as a Medicaid cost for cost reporting purposes.

**Audits of Disproportionate Share Programs**

The state shall contract with an independent audit firm to conduct an audit of the state's DSH programs as they apply to general and psychiatric hospitals in accordance with 42 CFR 447.299 and 42 CFR 455.304, for DSH State Plan years beginning 2005. In the event that the independent auditor determines that any hospital has received a DSH payment in excess of their hospital-specific disproportionate share limit, the state shall:

1. Collect from each hospital which has received payment in excess of their hospital-specific DSH limit, the amount of the overpayment.
2. Redistribute the aggregate amount of the overpayment(s) to all hospitals which, according to the independent auditor, still have room under their hospital-specific DSH limit.
3. The amount to be redistributed to each eligible hospital shall be determined by the Statewide Residual Payment Pool policies for the State Plan Year of the audit. The redistribution shall use the independent auditor's revised hospital-specific DSH limits to ensure that no hospital receives a payment that is in excess of their audited hospital-specific DSH limit.

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Disproportionate share and indigent care payment policies for psychiatric hospitals

This section applies to hospitals eligible to participate in Medicaid only for the provision of inpatient psychiatric services to eligible recipients:

1. Age 65 and older; and
2. Under age 21, or if the recipient was receiving services immediately before he/she reached age 21, services are covered until the earlier of the date he/she no longer requires the services or the date he/she reaches age 22.

The payment policies described below are in accordance with rule 5101:3-2-10. Hospitals eligible to participate only for the provision of inpatient psychiatric services are limited, in accordance with rule 5101:3-2-01, to psychiatric hospitals, and certain alcohol and drug abuse rehabilitation hospitals, that are certified by Medicare for reimbursement of services and are licensed by the Ohio Department of Mental Health or operated under the state mental health authority.

A. Source data for calculations

The calculations described in determining disproportionate share psychiatric and certain alcohol and drug abuse rehabilitation hospitals (hospitals) and in making disproportionate share and indigent care payments will be based on financial data and patient care data for psychiatric inpatient services provided for the hospital fiscal year ending in the state fiscal year that ends in the federal fiscal year preceding each program year.

B. Determination of disproportionate share hospitals

The department makes additional payments to hospitals that qualify for a disproportionate share adjustment. Hospitals that qualify are those that meet at least one of the criteria described under (1) and (2) below, and that also meet the criteria described under (3) below:

- (1) The hospital's Medicaid inpatient utilization rate is at least one standard deviation above the mean Medicaid inpatient utilization rate for all hospitals receiving Medicaid payments in the state.

The Medicaid inpatient utilization rate is the ratio of the hospital's number of inpatient days attributable to patients who were eligible for medical assistance and who are age twenty-one and under or age sixty-five and older, divided by the hospital's total inpatient days.

- (2) The hospital's low-income utilization rate is in excess of twenty-five percent.

The low-income utilization rate is the sum of:

- (a) The sum of total Medicaid revenues for inpatient services and cash subsidies for inpatient services received directly from state and local governments, divided by the sum of total facility inpatient revenues and cash subsidies for patient services received directly from state and local governments, plus
- (b) Total charges for inpatient services for charity care (less cash subsidies above, and not including contractual allowances and discounts other than for indigent patients ineligible for Medicaid) divided by the total charges for inpatient services.

- (3) A Medicaid inpatient utilization rate greater than or equal to one percent.

C. Determination of hospital disproportionate share groups for payment distribution

Hospitals determined to be disproportionate share as described above will be classified into one of four three tiers for payment distribution based on the data described in paragraph a-(A) above. The tiers are described below:

- (1) Tier one includes all hospitals deemed to be disproportionate share hospitals based on a low-income utilization rate greater than 25% but less than 40%, or hospitals with a low-income utilization rate less than or equal to 25% that are deemed a disproportionate share hospital based on a Medicaid inpatient utilization rate that is one standard deviation above the mean Medicaid inpatient utilization rate for all hospitals receiving Medicaid payments in the state.
- (2) Tier two includes all hospitals deemed to be disproportionate share hospitals based on a low-income utilization rate greater than or equal to 40% but less than 50%.

- (3) Tier three includes all hospitals deemed to be disproportionate share hospitals based on a low-income utilization rate greater than or equal to 50% ~~but less than 60%.~~
- ~~(4) Tier four includes all hospitals deemed to be disproportionate share hospitals based on a low-income utilization rate greater than or equal to 60%.~~

D. Distribution of funds within each hospital tier

The funds available in a tier are distributed among hospitals in that tier according to the payment formulas described below. Hospitals will be distributed a payment amount based on the lesser of their uncompensated care costs or their disproportionate share payment. Uncompensated care costs are defined as total inpatient allowable costs less insurance revenues, self-pay revenues, total Medicaid revenues and uncompensated care costs rendered to patients with insurance for the service provided. Each hospital's disproportionate share payment is calculated on a tier-specific basis as follows:

Hospital specific uncompensated care Costs /	X	Disproportionate share funds available for distribution in the tier
Sum of uncompensated care costs for all hospitals in the tier		

(1) Funds available for distribution by tier.

- (a) Tier 1. A maximum of ~~5%~~ 10% of the disproportionate share funds will be distributed to the hospitals in tier one.

If no hospitals fall into tier one, or all funds are not distributed, then undistributed funds from tier one will be added to the funds available for distribution in tier ~~four~~ three.

- (b) Tier 2. A maximum of ~~25%~~ 30% of the disproportionate share funds will be distributed to hospitals in tier two.

If no hospitals fall into tier two, or all funds are not distributed, then undistributed funds will be added to the funds available for distribution in tier ~~four~~ three.

- (c) Tier 3. A ~~maximum~~ minimum of ~~45%~~ 60% of the disproportionate share funds will be distributed to hospitals in tier three.

~~If no hospitals fall into tier three, or all funds are not distributed, then undistributed funds will be added to the funds available for distribution in tier four.~~

- ~~(d) Tier 4. A minimum of 40% of the disproportionate share funds will be distributed to hospitals in tier four.~~

(2) Payment distribution

Each hospital will be distributed a payment amount based on the lesser of their:

- (a) Uncompensated care costs; or
- (b) Disproportionate share payment amount.

E. Disproportionate share funds

The maximum amount of disproportionate share funds available for distribution to psychiatric hospitals will be determined by subtracting the funds distributed in accordance with rule 5101:3-2-09 of the administrative code from the state's disproportionate share limit as described in subparagraph (f) of section 1923 of the Social Security Act, 49 Stat. 620 (1935), 42 USC 1396-r-4 (f), as amended.

**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.

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Supersedes:  
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**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.

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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.

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**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.

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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 2552-96) 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. For 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

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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.

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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.

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