

**TRANSMITTAL AND NOTICE OF APPROVAL OF  
STATE PLAN MATERIAL**  
FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: <u>02-0000</u>	2. STATE: <u>Ohio</u>
3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
4. PROPOSED EFFECTIVE DATE <u>April 1, 2002</u>	

TO: REGIONAL ADMINISTRATOR  
HEALTH CARE FINANCING ADMINISTRATION  
DEPARTMENT OF HEALTH AND HUMAN SERVICES

5. TYPE OF PLAN MATERIAL (Check One):

NEW STATE PLAN       AMENDMENT TO BE CONSIDERED AS NEW PLAN       AMENDMENT

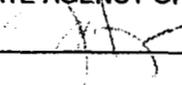
COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)

6. FEDERAL STATUTE/REGULATION CITATION: <u>42 CFR 447.272</u>	7. FEDERAL BUDGET IMPACT: a. FFY <u>2002</u> \$ <u>8,012,877</u> b. FFY <u>2003</u> \$ <u>15,995,563</u>
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: <u>4.19- Page 26 and 27</u>	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable):

10. SUBJECT OF AMENDMENT:  
Supplemental inpatient hospital upper limit payments for state hospitals

11. GOVERNOR'S REVIEW (Check One):

GOVERNOR'S OFFICE REPORTED NO COMMENT       OTHER, AS SPECIFIED:  
 COMMENTS OF GOVERNOR'S OFFICE ENCLOSED      Governor has delegated approval to  
 NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL      OHHS Director

12. SIGNATURE OF STATE AGENCY OFFICIAL:  


13. TYPED NAME:  
Thomas J. Hayes

14. TITLE:  
Director

15. DATE SUBMITTED:

16. RETURN TO:

Decky Jackson  
OHHS/DIRPP  
30 S. Broad St., 27th Fl.  
Columbus, Oh 43215-3414

<b>FOR REGIONAL OFFICE USE ONLY</b>	
17. DATE RECEIVED: <u>5/10/02</u>	18. DATE APPROVED: <u>4/13/02</u>
PLAN APPROVED - ONE COPY ATTACHED	
19. EFFECTIVE DATE OF APPROVED MATERIAL: <u>4/1/02</u>	20. SIGNATURE OF REGIONAL OFFICIAL: 
21. TYPED NAME: <u>Gheryl A. Harris</u> <b>CHARLENE BROWN</b>	22. TITLE: <u>Deputy Director, OHHS</u> Associate Regional Administrator Division of Medicaid and Children's Health

23. REMARKS:

**RECEIVED**  
**MAY 16 2002**  
**DMCH - IL/IN/OH**

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**Calculation of Supplemental Inpatient Hospital Upper Limit Payments For State Hospitals**

- A. For each Ohio state hospital owned or operated by the state, that is not a psychiatric hospital, calculate the estimated amount that Medicare would have paid for an inpatient discharge if Medicare were paying the care for Medicaid consumers.
1. Divide the total Medicare inpatient hospital payment, including a reduction to Medicare IME payments of 15.4% in the year in which the plan becomes effective, 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 state 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 state 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)(10) by the state hospital's Medicaid discharges.
- 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.
1. Calculate the available inpatient payment gap by subtracting Medicaid inpatient payments from Medicaid inpatient costs.
  2. For each state hospital that has an available inpatient payment gap greater than zero resulting from the calculations in paragraph (B)(1), calculate the available per discharge supplemental inpatient hospital payment amount by dividing the amount in paragraph (B)(1) by the state hospital's Medicaid discharges.
- C. The resulting amounts calculated in paragraph (A) and (B) 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.
- D. 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 (HCFA 2552-96) for the corresponding cost reporting period.
- E. 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 (C). 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 hospitals electing to participate will be limited to their proportion of the aggregate upper payment limit.
- F. Hospital payments made under this section, when combined with other payments made under

TN No. 02-006

Approval Date: APR 3 2003

Supersedes

TN No. NEWEffective Date: 04-01-02

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the State plan shall not exceed the limit specified in 42 CFR 447.271.

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

TN No. 02-006

Approval Date:

APR 3 2003

Supersedes

TN No. NEW

Effective Date: 04-01-02