5101:3-2-09 **Payment policies for disproportionate share and indigent care adjustments for hospital services.**

This rule is applicable for the program year that ends in calendar year ~~2002~~2003, for all medicaid-participating providers of hospital services included in the definition of "hospital" as described ~~in paragraph (A)(3) of rule 5101:3-2-08 of the Administrative~~under section 5112.01 of the Revised Code.

(A) Definitions.

(1) "Total medicaid costs" for each hospital means the sum of the amounts reported in JFS 02930, schedule H, section I, columns 1 and 3, line 1 and section II, ~~columns~~column 1 ~~and 3~~, line 13.

(2) "Total medicaid managed care plan inpatient costs" for each hospital means the amount on JFS 02930 schedule I, column 3, line 101.

(3) "Total medicaid managed care plan outpatient costs" for each hospital means the amount on JFS 02930 schedule I, column 5, line 101.

(4) "Total Title V costs" for each hospital means the amount on JFS 02930, schedule H, section I, column 2, line 1 and section II, column 2, line 13.

(5) "Total inpatient disability assistance medical costs" for each hospital means the amount on the JFS 02930, schedule F, columns 4 and 5, line 8.

(6) "Total inpatient uncompensated care costs under one hundred percent" for each hospital means the amount on the JFS 02930, schedule F, columns 4 and 5, line 9.

(7) "Total inpatient uncompensated care costs above one hundred per cent without insurance" for each hospital means the amount on the JFS 02930, schedule F, column 5, line 10.

(8) "Total outpatient disability assistance medical costs" for each hospital means the amount on the JFS 02930, schedule F, columns 4 and 5, line 12.

(9) "Total outpatient uncompensated care costs under one hundred per cent" for each hospital means the amount on the JFS 02930, schedule F, columns 4 and 5, line 13.

(10) "Total outpatient uncompensated care costs above one hundred per cent without insurance" for each hospital means the amount on the JFS 02930,

schedule F, column 5, line 14.

(11) "Total disability assistance medical costs" means the sum of total inpatient disability assistance costs as described in paragraph (A)(5) of this rule, and total outpatient disability assistance costs as described in paragraph (A)(8) of this rule.

(12) "Total uncompensated care costs under one hundred per cent" means the sum of total inpatient uncompensated care costs under one hundred per cent as described in paragraph (A)(6) of this rule, and total outpatient uncompensated care costs under one hundred per cent as described in paragraph (A)(9) of this rule.

(13) "Total uncompensated care costs above one hundred per cent without insurance" means the sum of total inpatient uncompensated care costs above one hundred per cent without insurance as described in paragraph (A)(7) of this rule, and total outpatient uncompensated care costs above one hundred per cent without insurance as described in paragraph (A)(10) of this rule.

(14) "Managed care plan days" (MCP days) means for each hospital the amount on the JFS 02930, schedule I, column 1, line 103.

(15) "High federal disproportionate share hospital" means a hospital with a ratio of total medicaid days plus MCP days to total facility days greater than the statewide mean ratio of total medicaid days to total facility days plus one standard deviation.

(16) "Total medicaid payments" for each hospital means the sum of the amounts reported on the JFS 02930, schedule H, column 1, lines 8, 19, 24, and 25, and column 3, lines 8~~, 19,~~and 24 ~~and 25~~, minus the amounts on schedule H, column 1, lines 6 and 18.

(17) "Total medicaid days" means for each hospital the amount on the JFS 02930, schedule C, column 6, line 35 and column 10, line 35.

(18) "Total facility days" means for each hospital the amount reported on the JFS 02930, schedule C, column 4, line 35.

(19) "Medicaid inpatient payment-to-cost ratio" for each hospital means the sum of the amounts reported on the JFS 02930, schedule H, columns 1 and 3, line 8, divided by the sum of the amounts reported on the JFS 02930, schedule H, section I, columns 1 and 3, line 1.

(20) "Medicaid outpatient payment-to-cost ratio" for each hospital means ~~the sum of~~ the ~~amounts~~amount reported on the JFS 02930, schedule H, ~~columns~~column 1 ~~and 3~~, line 19, divided by ~~the sum of~~ the ~~amounts~~amount reported on the JFS 02930, schedule H, section II, ~~columns~~column 1 ~~and 3~~, line 13.

(21) "Total medicaid managed care plan (MCP) costs" means the actual cost to the hospital of care rendered to medical assistance recipients enrolled in a managed care plan that has entered into a contract with the department of job and family services and is the amount on JFS 02930, schedule I, column 3, line 101 and column 5, line 101.

In the event the hospital cannot identify the costs associated with recipients enrolled in a health maintenance organization, the department shall add the payments made or charges incurred for the recipient, as reported by the health maintenance organization and verified by the department, to total medicaid managed care costs.

(22) "Medicaid managed care plan (MCP) inpatient payments" for each hospital means the amount defined in paragraph (A)(2) of this rule multiplied by the ratio calculated in paragraph (A)(19) of this rule.

(23) "Medicaid managed care plan (MCP) outpatient payments" for each hospital means the amount defined in paragraph (A)(3) of this rule multiplied by the ratio calculated in paragraph (A)(20) of this rule.

(24) "Total medicaid managed care plan (MCP) payments" for each hospital is the sum of the amount calculated in paragraph (A)(22) of this rule, and the amount calculated in paragraph (A)(23) of this rule.

(25) "Adjusted total facility costs" means the amount described in paragraph ~~(D)(1)~~ (A) of rule 5101:3-2-08 of the Administrative Code.

(26) "Rural hospital" means a hospital that is classified as a rural hospital by the ~~health care financing administration, or that is classified as a rural hospital in accordance with paragraphs (A)(3) and (A)(5) of rule 5101:3-2-07.2 of the Administrative Code, and reconciled with the Ohio department of health's, annual hospital registration report~~centers for medicare and medicaid services.

(27) "Critical Access Hospital (CAH)" means a hospital that is certified as a critical access hospital by the ~~health care financing administration~~centers for medicare and medicaid services, and that has notified the Ohio department of

health and the Ohio department of job and family services of such certification. Beginning in the program year that ends in calendar year 2004, the Ohio department of job and family services must receive notification of critical access hospital certification by the first day of October, the start of the program year, in order for the hospital to be considered a critical access hospital for disproportionate share payment purposes.

(28) "Hospital-specific disproportionate share limit" means the limit on disproportionate share and indigent care payments made to hospitals as defined in paragraph (D) of rule 5101:3-2-07.5 of the Administrative Code.

(B) Applicability.

The requirements of this rule apply as long as the United States ~~health care financing administration~~center for medicare and medicaid services determines that the assessment imposed under section 5112.06 of the Revised Code is a permissible health care related tax. ~~pursuant to section 1903(W) of the Social Security Act, 49 Stat 620 (1935), 42 U.S.C.A. 1396b(W), as amended.~~ Whenever the department of job and family services is informed that the assessment is an impermissible health care-related tax, the department shall promptly refund to each hospital the amount of money currently in the hospital care assurance program fund that has been paid by the hospital, plus any investment earnings on that amount.

(C) Source data for calculations.

(1) The calculations described in this rule will be based on cost-reporting data described in rule 5101:3-2-23 of the Administrative Code which reflect the hospital's cost reporting period ending in state fiscal year ~~2001~~2002.

(2) For new hospitals, the first available cost report filed with the department in accordance with rule 5101:3-2-23 of the Administrative Code will be used until a cost report which meets the requirements of this paragraph is available. If, for a new hospital, there is no available or valid cost report filed with the department, the hospital will be excluded until valid data is available. For hospitals which have changed ownership, the cost reporting data filed by the previous owner which reflects that hospital's completed interim settled medicaid cost report and the cost reporting ~~period ending in state fiscal year 2001 will be used.~~ data filed by the new owner which reflects that hospital's completed interim settled medicaid cost report, will be combined and annualized by the department to reflect one full year of operation. If there is no available or valid cost report from the previous owner, the department shall annualize the cost report from the new owner to reflect one full year of operation. Cost reports for hospitals involved in mergers during the program

year that result in the hospitals using one provider number will be combined and annualized by the department to reflect one full year of operation.

(3) Closed hospitals with unique medicaid provider numbers.

For a hospital facility, identifiable to a unique medicaid provider number, that closes during the program year defined in paragraph (A) of rule 5101:3-2-08 of the Administrative Code, the cost report data used shall be adjusted to reflect the portion of the year the hospital was open during the current 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 ~~(H)~~ (G) of this rule.

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 ~~(H)~~ (G) of this rule.

(4) Replacement hospital facilities.

If a new hospital facility is opened for the purpose of replacing an existing (original) hospital facility identifiable to a unique medicaid provider number and the original facility closes during the program year defined in paragraph (A) of rule 5101:3-2-08 of the Administrative Code, the cost report data from the original facility shall be used to determine the distribution to the new replacement facility if the following conditions are met: (a) both facilities have the same ownership, (b) there is appropriate evidence to indicate that the new facility was constructed to replace the original facility, (c) the new replacement facility is so located as to serve essentially the same population as the original facility, and (d) the new replacement facility has not filed a cost report for the current program year.

For a replacement hospital facility that opened in the immediate prior program year, the distribution for that facility will be based on the cost report data for that facility and the cost report data for the original facility, combined and annualized by the department to reflect one full year of operation.

(5) Cost report data used in the calculations described in this rule will be the cost report data described in this paragraph subject to any adjustments made upon departmental review prior to final determination which is completed each year and subject to the provisions of ~~paragraphs (G) and (H) of~~ rule

5101:3-2-08 of the Administrative Code.

(D) Determination of indigent care pool.

(1) The "indigent care pool" means the sum of the following:

(a) The total assessments paid by all hospitals less the assessments deposited into the legislative budget services fund and the health care services administration fund described in ~~paragraph (F) and (G) of~~ rule 5101:3-2-08 of the Administrative Code.

(b) The total amount of intergovernmental transfers required to be made by governmental hospitals less the amount of transfers deposited into the legislative budget services fund and the health care services administration fund described in ~~paragraph (F) and (G) of~~ rule 5101:3-2-08 of the Administrative Code.

(c) The total amount of federal matching funds that will be made available in the same program year as a result of payments made under paragraph (J)(4) of this rule.

(E) Distribution of funds through the indigent care payment pools

The funds are distributed among the hospitals according to indigent care payment pools described in paragraphs (E)(1) to (E)(3) of this rule.

(1) Hospitals meeting the high federal disproportionate share hospital definition described in paragraph (A)(15) of this rule shall receive funds from the high federal disproportionate share indigent care payment pool.

(a) For each hospital which meets the high federal disproportionate share definition, calculate the ratio of the hospital's total medicaid costs and total medicaid MCP costs to the sum of total medicaid costs and total medicaid MCP costs for all hospitals which meet the high federal disproportionate share definition.

(b) For each hospital which meets the high federal disproportionate share definition, multiply the ratio calculated in paragraph (E)(1)(a) of this rule by $41,441,812.00. This amount is the hospital's federal high disproportionate share hospital payment amount.

(2) Hospitals shall receive funds from the medicaid indigent care payment pool.

(a) For each hospital, calculate medicaid shortfall by subtracting from total medicaid costs, as defined in paragraph (A)(1) of this rule, the total medicaid payments, as defined in paragraph (A)(16) of this rule. For hospitals with a negative medicaid shortfall, the medicaid shortfall amount is equal to zero.

(b) For each hospital, calculate medicaid MCP inpatient shortfall by subtracting from the total medicaid managed care plan inpatient costs, as defined in paragraph (A)(2) of this rule, medicaid MCP inpatient payments, as defined in paragraph (A)(22) of this rule. For hospitals with a negative medicaid MCP inpatient shortfall, the medicaid MCP inpatient shortfall amount is equal to zero.

(c) For each hospital, calculate medicaid MCP outpatient shortfall by subtracting from the total medicaid managed care plan outpatient costs, as defined in paragraph (A)(3) of this rule, medicaid MCP outpatient payments, as defined in paragraph (A)(23) of this rule. For hospitals with a negative medicaid MCP outpatient shortfall, the medicaid MCP outpatient shortfall amount is equal to zero.

(d) For each hospital, calculate medicaid MCP shortfall as the sum of the amount calculated in paragraph (E)(2)(b) of this rule, and the amount calculated in paragraph (E)(2)(c) of this rule.

(e) For each hospital, sum the hospital's medicaid shortfall as calculated in paragraph (E)(2)(a) of this rule, medicaid MCP shortfall as calculated in paragraph (E)(2)(d) of this rule, total medicaid costs, total medicaid MCP costs, and total Title V costs.

(f) For all hospitals, sum all hospitals medicaid shortfall as calculated in paragraph (E)(2)(a) of this rule, medicaid MCP shortfall as calculated in paragraph (E)(2)(d) of this rule, total medicaid costs, total medicaid MCP costs, and total Title V costs.

(g) For each hospital, calculate the ratio of the amount in paragraph (E)(2)(e) of this rule to the amount in paragraph (E)(2)(f) of this rule.

(h) For each hospital, multiply the ratio calculated in paragraph (E)(2)(g) of this rule by ~~$90,810,067.00~~$76,009,499 to determine each hospital's medicaid indigent care payment amount.

(3) Hospitals shall receive funds from the disability assistance medical and

uncompensated care indigent care payment pool.

(a) For each hospital, sum total disability assistance medical costs defined in paragraph (A)(11) of this rule and total uncompensated care costs under one hundred per cent defined in paragraph (A)(12) of this rule.

(b) Each hospital's disability assistance medical and uncompensated care under one hundred per cent payment amount is equal to the amount calculated in paragraph (E)(3)(a) of this rule, subject to the following limitations:.

(i) If the sum of a hospital's payment amounts calculated in paragraphs (E)(1) and (E)(2) of this rule is greater than or equal to its hospital-specific disproportionate share limit defined in paragraph (A)(28) of this rule, 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 amounts calculated in paragraphs (E)(1) and (E)(2) of this rule and the amount calculated in paragraph (E)(3)(a) of this rule is less than its hospital-specific disproportionate share limit defined in paragraph (A)(28) of this rule; the hospital's disability medical and uncompensated care under one hundred per cent payment amount is equal to the amount calculated in paragraph (E)(3)(a) of this rule.

(iii) If a hospital does not meet the condition described in paragraph (E)(3)(b)(i) of this rule, and the sum of its payment amounts calculated in paragraphs (E)(1) and (E)(2) of this rule and the amount calculated in paragraph (E)(3)(a) of this rule is greater than its hospital-specific disproportionate share limit defined in paragraph (A)(28) of this rule; 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 (E)(1) and (E)(2) of this rule.

(c) For all hospitals, sum the amounts calculated in paragraph (E)(3)(b) of this rule.

(d) For each hospital except those meeting either condition described in paragraph (E)(3)(b)(i) or (E)(3)(b)(iii) of this rule, multiply a factor of 0.30 by the hospital's total uncompensated care costs above one hundred percent without insurance, as described in paragraph (A)(13)

of this rule. For hospitals meeting the conditions described in paragraph (E)(3)(b)(i) or (E)(3)(b)(iii) of this rule, multiply the hospital's total uncompensated care costs above one hundred percent by zero.

(e) For all hospitals, sum the amounts calculated in paragraph (E)(3)(d) of this rule.

(f) For each hospital, calculate the ratio of the amount in paragraph (E)(3)(d) of this rule to the amount in paragraph (E)(3)(e) of this rule.

(g) Subtract the amount calculated in paragraph (E)(3)(c) of this rule from ~~$316,441,812.00~~$273,877,827.00.

(h) For each hospital, multiply the ratio calculated in paragraph (E)(3)(f) of this rule~~,~~ by the amount calculated in paragraph (E)(3)(g) of this rule~~,~~ to determine each hospital's uncompensated care above one hundred per cent without insurance payment, subject to the following limitations:~~-~~.

(i) If the sum of a hospital's payment amounts calculated in paragraphs (E)(1), (E)(2) and (E)(3)(b) of this rule is greater than or equal to its hospital-specific disproportionate share limit defined in paragraph (A)(28) of this rule, 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 (E)(1), (E)(2), and (E)(3)(b) of this rule is less than the hospital's disproportionate share limit defined in paragraph (A)(28) of this rule, 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 (E)(3)(f) of this rule by the amount calculated in paragraph (E)(3)(g) of this rule.

(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 (E)(1), (E)(2), and (E)(3)(b) of this rule is greater than the hospital's disproportionate share limit defined in paragraph (A)(28) of this rule, 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 (E)(1), (E)(2), and (E)(3)(b) of

this rule.

(i) For each hospital, sum the amount calculated in paragraph (E)(3)(b) of this rule, and the amount calculated in paragraph (E)(3)(h) of this rule. This amount is the hospital's disability assistance medical and uncompensated care indigent care payment amount.

~~(F) Distribution of funds through the disproportionate share limit pool.~~

~~(1) For each hospital, calculate the hospital's specific disproportionate share limit as defined in paragraph (D) of rule 5101:3-2-07.5 of the Administrative Code.~~

~~(2) For each hospital, sum the hospital's total payments allocated in paragraphs (E)(1)(b), (E)(2)(h), and (E)(3)(i) of this rule.~~

~~(3) For each hospital, multiply a factor of 0.50 by the amount calculated in paragraph (D)(2) of rule 5101:3-2-08 of the Administrative Code.~~

~~(4) For each hospital, sum the amounts calculated in paragraphs (F)(2) and (F)(3) of this rule.~~

~~(5) Funds in the disproportionate share limit pool will be distributed as described in paragraphs (F)(5)(a) to (F)(5)(c) of this rule.~~

~~(a) For each hospital, if the amount calculated in paragraph (F)(2) of this rule is greater than the amount calculated in paragraph (F)(1) of this rule, the hospital will receive no payment from the disproportionate share limit pool.~~

~~(b) For each hospital, if the amount calculated in paragraph (F)(4) of this rule is less than the amount calculated in paragraph (F)(1) of this rule, the amount in paragraph (F)(3) of this rule will be the hospital's disproportionate share limit pool payment amount.~~

~~(c) For each hospital, if the amount calculated in paragraph (F)(4) of this rule is greater than the amount calculated in paragraph (F)(1) of this rule and the amount calculated in paragraph (F)(2) of this rule is less than the amount calculated in paragraph (F)(1) of this rule, then the hospital's disproportionate share limit pool payment amount will be the difference between the amounts in paragraphs (F)(1) and (F)(2) of this rule.~~

~~(G)~~(F) 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 ~~(G)(1)~~(F)(1) to ~~(G)(2)~~ (F)(2)of this rule.

(1) Hospitals meeting the definition described in paragraph (A)(27) of this rule, shall receive funds from the critical access hospital (CAH) payment pool.

(a) For each hospital with CAH certification, calculate the medicaid shortfall as described in paragraph (E)(2)(a) of this rule.

(b) For each hospital with CAH certification, each hospital's CAH payment amount is equal to the amount calculated in paragraph ~~(G)(1)(a)~~ (F)(1)(a) of this rule.

(c) For all hospitals with CAH certification, sum the amounts calculated in paragraph ~~(G)(1)(b)~~ (F)(1)(b) of this rule.

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

(2) Hospitals meeting the definition described in paragraph (A)(26) of this rule but do not meet the definition described in paragraph (A)(27) of this rule, shall receive funds from the rural access hospital RAH payment pool.

(a) For each hospital with RAH classification, as qualified by paragraphs ~~(G)(2)~~ (F)(2) and ~~(G)(1)(d)~~ (F)(1)(d) of this rule, sum the hospital's total payments allocated in paragraphs (E)(1)(b), (E)(2)(h), and (E)(3)(i)~~, and (F)(5)(c)~~ of this rule.

(b) For each hospital with RAH classification, as qualified by paragraphs ~~(G)(2)~~(F)(2) and ~~(G)(1)(d)~~(F)(1)(d) of this rule subtract the amount calculated in paragraph ~~(G)(2)(a)~~(F)(2)(a) of this rule, from the amount calculated in paragraph ~~(F)(1)~~(A)(28) of this rule. 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 paragraphs ~~(G)(2)~~(F)(2) and ~~(G)(1)(d)~~(F)(1)(d) of this rule, sum the amounts calculated in paragraph ~~(G)(2)(b)~~(F)(2)(b) of this rule.

(d) For each hospital with RAH classification, as qualified by paragraphs ~~(G)(2)~~(F)(2) and ~~(G)(1)(d)~~(F)(1)(d) of this rule, determine the ratio of the amounts in paragraphs ~~(G)(2)(b)~~(F)(2)(b) and ~~(G)(2)(c)~~(F)(2)(c) of

this rule.

(e) Subtract the amount calculated in paragraph ~~(G)(1)(e)~~(F)(1)(c) of this rule from ~~$14,540,726.00~~$12,170,824.

(f) For each hospital with RAH classification, as qualified by paragraphs ~~(G)(2)~~(F)(2) and ~~(G)(1)(d)~~(F)(1)(d) of this rule, multiply the ratio calculated in paragraph ~~(G)(2)(d)~~(F)(2)(d) of this rule, by the amount calculated in paragraph ~~(G)(2)(e)~~(F)(2)(e) of this rule, to determine each hospital's rural access hospital payment pool amount.

(g) For each hospital, sum the amount calculated in paragraph ~~(G)(1)(b)~~(F)(1)(b) of this rule, and the amount calculated in paragraph ~~(G)(2)(f)~~(F)(2)(f) of this rule. This amount is the hospital's rural and critical access payment amount.

~~(H)~~(G) Distribution of funds through the county redistribution of closed hospitals payment pools.

If funds are available in accordance with paragraph (C) of this rule, the funds are distributed among the hospitals according to the county redistribution of closed hospitals payment pools described in paragraphs ~~(H)(1)~~(G)(1) to ~~(H)(3)~~(G)(3) of this rule.

(1) 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 (E), (F), ~~(G)~~ (H), and (I) of this rule for the portion of the year it was closed, less any amounts that would have been paid by the closed hospital under provisions of ~~rule~~rules 5101:3-2-08 and 5101:3-2-08.1 of the Administrative Code 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 (E), (F), ~~(G)~~(H), and (I) of this rule, less any amounts that would have been paid by the closed hospital under provisions of ~~rule~~rules 5101:3-2-08 and 5101:3-2-08.1 of the Administrative Code, 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 (E), (F), ~~(G)~~(H), and (I) of this rule does not result in a net gain, nothing shall be redistributed under paragraphs ~~(H)(2)~~ (G)(2) and ~~(H)(3)~~ (G)(3) of this rule.

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

(a) For each hospital within a county with a closed hospital as described in paragraph ~~(H)(1)~~(G)(1) of this rule, sum the amount calculated in paragraph (E)(3)(a) of this rule, and the amount calculated in paragraph (E)(3)(d) of this rule.

(b) For all hospitals within a county with a closed hospital, sum the amounts calculated in paragraph ~~(H)(2)(a)~~(G)(2)(a) of this rule.

(c) For each hospital within a county with a closed hospital, determine the ratio of the amounts in paragraphs ~~(H)(2)(a)~~(G)(2)(a) and ~~(H)(2)(b)~~(G)(2)(b) of this rule.

(d) For each hospital within a county with a closed hospital, multiply the ratio calculated in paragraph ~~(H)(2)(c)~~(G)(2)(c) of this rule, by the amount calculated in paragraph ~~(H)(1)~~(G)(1) of this rule, to determine each hospital's county redistribution of closed hospitals payment amount.

(3) 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 ~~(H)(1)~~(G)(1) of this rule, sum the amount calculated in paragraph (E)(3)(a) of this rule, and the amount calculated in paragraph (E)(3)(d) of this rule.

(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 ~~(H)(3)(a)~~(G)(3)(a) of this rule.

(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 paragraphs ~~(H)(3)(a)~~(G)(3)(a) and ~~(H)(3)(b)~~(G)(3)(b) of this rule.

(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 ~~(H)(3)(c)~~(G)(3)(c) of this rule, by the amount calculated in paragraph ~~(H)(1)~~(G)(1) of this rule, to determine each hospital's county redistribution of closed hospitals payment amount.

(H) Distribution of funds through the disproportionate share limit pool.

(1) For each hospital, calculate the hospital's specific disproportionate share limit as defined in paragraph (A)(28) of this rule.

(2) For each hospital, sum the hospital's total payments allocated in paragraphs (E), (F), and (G) of this rule.

(3) For each hospital, multiply a factor of 0.4185 by the hospital's assessment amount calculated in rule 5101:3-2-08.1 of the Administrative Code.

(4) For each hospital, sum the amounts calculated in paragraphs (H)(2) and (H)(3) of this rule.

(5) Funds in the disproportionate share limit pool will be distributed as described in paragraphs (H)(5)(a) to (H)(5)(c) of this rule.

(a) For each hospital, if the amount calculated in paragraph (H)(2) of this rule is greater than the amount calculated in paragraph (H)(1) of this rule, the hospital will receive no payment from the disproportionate share limit pool.

(b) For each hospital, if the amount calculated in paragraph (H)(4) of this rule is less than the amount calculated in paragraph (H)(1) of this rule, the amount in paragraph (H)(3) of this rule will be the hospital's disproportionate share limit pool payment amount.

(c) For each hospital, if the amount calculated in paragraph (H)(4) of this rule is greater than the amount calculated in paragraph (H)(1) of this rule and the amount calculated in paragraph (H)(2) of this rule is less than the amount calculated in paragraph (H)(1) of this rule, then the hospital's disproportionate share limit pool payment amount will be the difference between the amounts in paragraphs (H)(1) and (H)(2) of this rule.

(I) Distribution model adjustments and limitations through the statewide residual pool.

(1) For each hospital, sum the payment amounts as calculated in paragraphs ~~(F)(2), (F)(5), (G)(2)(g), (H)(2)(d) and (H)(3)(d)~~(E), (F), (G), and (H) of this rule. This is the hospital's calculated payment amount.

(2) For each hospital, subtract the hospital's disproportionate share limit as calculated in paragraph ~~(F)(1)~~(H)(1) of this rule from the payment amount as calculated in paragraph (I)(1) of this rule to determine if a hospital's calculated payment amount is greater than its disproportionate share limit. If the hospital's calculated payment amount as calculated in paragraph (I)(1) of this rule is greater than the hospital's disproportionate share limit calculated in paragraph ~~(F)(1)~~(H)(1) of this rule, then the difference is the hospital's residual payment funds.

(3) If a hospital's calculated payment amount, as calculated in paragraph (I)(1) of this rule, is greater than its disproportionate share limit defined in paragraph ~~(F)(1)~~ (H)(1) of this rule, then the hospital's payment is equal to the hospital's disproportionate share limit.

(a) The hospital's residual payment funds as calculated in paragraph (I)(2) of this rule is subtracted from the hospital's calculated payment amount as calculated in paragraph (I)(1) of this rule and is applied to and distributed as the statewide residual payment pool as described in paragraph (I)(4) of this rule.

(b) The total amount distributed through the statewide residual pool will be the sum of the hospital care assurance fund described in paragraph (J)(4) minus the sum of the lesser of each hospital's calculated payment amount calculated in (I)(1) of this rule or the hospital's disproportionate share limit calculated in paragraph ~~(F)(1)~~(H)(1) of this rule.

(4) Redistribution of residual payment funds in the statewide residual payment pool.

(a) For each hospital meeting the high federal disproportionate share hospital definition described in paragraph (A)(15) of this rule, with a calculated payment amount that is not greater than the disproportionate share limit, as described in paragraph (I)(3) of this rule, subtract the amount in paragraph (I)(1) of this rule from the amount in paragraph ~~(F)(1)~~ (H)(1) of this rule.

(b) For ~~all~~ hospitals meeting the high federal disproportionate share definition described in paragraph (A)(15) of this rule, with calculated payment amounts that are not greater than the disproportionate share limit, sum the amounts calculated in paragraph (I)(4)(a) of this rule.

(c) For each hospital meeting the high federal disproportionate share

definition described in paragraph (A)(15) of this rule, with a calculated payment amount that is not greater than the disproportionate share limit, determine the ratio of the amounts in paragraphs (I)(4)(a) and (I)(4)(b) of this rule.

(d) For each hospital meeting the high federal disproportionate share definition described in paragraph (A)(15) of this rule, with a calculated payment amount that is not greater than the disproportionate share limit, multiply the ratio calculated in paragraph (I)(4)(c) of this rule by the total amount distributed through the statewide residual pool described in paragraph (I)(3)(b) of this rule. This amount is the hospital's statewide residual payment pool payment amount.

(J) Payments and adjustments.

(1) Every hospital that must make payments of assessments and/or intergovernmental transfers to the department of job and family services under the provisions of rule ~~5101:3-2-08~~5101:3-2-08.1 of the Administrative Code shall make the payments in accordance with the payment schedule as described in this rule. If the final determination that the hospital must make payments was made by the department, the hospitals shall meet the payment schedule developed by the department after consultation with the hospitals or a designated representative thereof.

If the final determination that the hospital must make payments was made by the court of common pleas of Franklin county, the hospital shall meet the payment schedule developed by the department after consultation with the hospital or a designated representative thereof. Delayed payment schedules for hospitals that are unable to make timely payments under this paragraph due to financial difficulties will be developed by the department.

The delayed payments shall include interest at the rate of ten per cent per year on the amount payable from the date the payment would have been due had the delay not been granted until the date of payment.

(2) Except for the provisions of paragraphs ~~(F) and (G)~~ (C) and (D) of rule ~~5101:3-2-08~~5101:3-2-08.1 of the Administrative Code, all payments of assessments and intergovernmental transfers, when applicable, from hospitals under rule 5101:3-2-08 of the Administrative Code shall be deposited to the credit of the hospital care assurance program fund. All investment earnings of the fund shall be credited to the fund. The department shall maintain records that show the amount of money in the fund at any time that has been paid by each hospital and the amount of any investment earnings on that amount. All moneys credited to the hospital care assurance program fund shall be used

solely to make payments to hospitals under the provisions of this rule.

(3) All federal matching funds received as a result of hospital payments of assessments and intergovernmental transfers the department makes to hospitals under paragraph (J)(4) of this rule shall be credited to the hospital care assurance match fund. All investment earnings of the fund shall be credited to the fund. All money credited to the hospital care assurance match fund shall be used solely to make payments to hospitals under the provisions of this rule.

(4) The department shall make payments to each medicaid participating hospital meeting the definition ~~in paragraph (A)(3) of rule 5101:3-2-08 of the Administrative~~ of hospital as described under section 5112.01 of the Revised Code. The payments shall be based on amounts that reflect the sum of amounts in the hospital care assurance program fund described in paragraph (J)(2) of this rule and the hospital care assurance match fund described in paragraph (J)(3) of this rule. Payments to each hospital shall be calculated as described in paragraphs (E), (F), (G), (H), and (I) of this rule. For purposes of this paragraph, the value of the hospital care assurance match fund is calculated as:

Sum of hospital care assurance program fund/{1-(federal medical assistance percentage/100)}

The payments shall be made solely from the hospital care assurance program fund and the hospital care assurance match fund. If amounts in the funds are insufficient to make the total amount of payments for which hospitals are eligible, the department shall reduce the amount of each payment by the percentage by which the amounts are insufficient. Any amounts not paid at the time they were due shall be paid to hospitals as soon as moneys are available in the funds.

(5) All payments to hospitals under the provisions of this rule are conditional on:

(a) Expiration of the time for appeals under the provisions ~~of paragraphs (G) to (G)(4)~~ of rule ~~5101:3-2-08~~5101:3-2-08.1 of the Administrative Code without the filing of an appeal, or on court determinations, in the event of appeals, that the hospital is entitled to the payments;

(b) The availability of sufficient moneys in the hospital care assurance program fund and the hospital care assurance match fund to make payments after the final determination of any appeals;

(c) The hospital's compliance with the provisions of rule 5101:3-2-07.17 of the Administrative Code.

(d) The payment made to hospitals does not exceed the hospital's disproportionate share limit as calculated in paragraph (D) of rule 5101:3-2-07.5 of the Administrative Code.

(6) If an audit conducted by the department of the amounts of payments made and received by hospitals under the provisions of this rule identifies amounts that, due to errors by the department, a hospital should not have been required to pay but did pay, should have been required to pay but did not pay, should not have received but did receive, or should have received but did not receive, the department shall:

(a) Make payments to any hospital that the audit reveals paid amounts it should not have been required to pay but did pay or did not receive amounts it should have received;

(b) Take action to recover from a hospital any amounts that the audit reveals it should have been required to pay but did not pay or that it should not have received but did receive.

(7) Payments made under paragraph (J)(6)(a) of this rule shall be made from the hospital care assurance program fund. Amounts recovered under paragraph (J)(6)(b) of this rule shall be deposited to the credit of the hospital care assurance program fund. Any hospital may appeal the amount the hospital is to be paid under paragraph (J)(6)(a) of this rule or the amount to be recovered from the hospital under paragraph (J)(6)(b) of this rule to the court of common pleas of Franklin county.

(K) Confidentiality.

Except as specifically required by the provisions of this rule and rule 5101:3-2-24 of the Administrative Code, information filed shall not include any patient-identifying material. Information including patient-identifying information is not a public record under section 149.43 of the Revised Code and no patient-identifying material shall be released publicly by the department of job and family services or by any person under contract with the department who has access to such information.

(L) Penalties for failure to report or make payment.

(1) Any hospital that fails to report the information required under this rule and under paragraph (A) of rule 5101:3-2-23 of the Administrative Code on or before the dates specified in this rule and in rule 5101:3-2-23 of the Administrative Code shall be fined one ~~hundred~~thousand dollars for each day after the due date that the information is not reported.

(2) In addition to any other remedy available to the department under law to collect unpaid assessments and transfers, any hospital that fails to make payments of the assessments and intergovernmental transfers to the department of job and family services on or before the dates specified in this rule or under any schedule for delayed payments established under paragraph (J)(1) of this rule shall be fined one ~~hundred~~thousand dollars for each day after the due date, not to exceed more than twenty thousand dollars.

(3) The director of job and family services shall waive the penalties provided for in paragraphs (L)(1) and (L)(2) of this rule for good cause shown by the hospital.

(M) Payment schedule.

The assessments, intergovernmental transfers and payments made under the provisions of this rule will be made in installments.

(1) On or before the fourteenth day after the department mails the final determination as described in ~~paragraph (G)(3) of~~ rule ~~5101:3-2-08~~5101:3-2-08.1 of the Administrative Code, the hospital must submit its first assessment to the department.

All subsequent assessments and intergovernmental transfers, when applicable, must be made on or before the fifth day after the date on the warrant or electronic funds transfer (EFT) issued as payment by the department as described in paragraph (M)(2) of this rule.

(2) On or before the tenth day after the departments deadline for receiving assessments and intergovernmental transfers, the department must make a payment to each hospital. However, the department shall make no payment to any hospital that has not paid assessments or made intergovernmental transfers that are due until the assessments and transfers are paid in full or a final determination regarding amounts to be paid is made under any request for reconsideration or appeal.

(3) If a hospital closes after the date of the public hearing held in accordance with

~~paragraph (G)(2) of~~ rule ~~5101:3-2-08~~5101:3-2-08.1 of the Administrative Code, and before the last payment is made, as described in this paragraph, the payments to the remaining hospitals will be adjusted in accordance with paragraphs (E) to (J)(7) of this rule.

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R.C. 119.032 review dates: 05/13/2003 and 07/28/2008

CERTIFIED ELECTRONICALLY

Certification

07/18/2003

Date

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