CSI - Ohio
The Common Sense Initiative

Business Impact Analysis

Agency Name: Department of Medicaid

Regulation/Package Title: HCAP 2013 BHPP DH

Rule Number(s): 5101:3-2-08.1 'Assessment Rates'

Date: 07/29/2013

Rule Type:

- ☐ New
- X Amended
- ☐ 5-Year Review
- ☐ Rescinded

The Common Sense Initiative was established by Executive Order 2011-01K and placed within the Office of the Lieutenant Governor. Under the CSI Initiative, agencies should balance the critical objectives of all regulations with the costs of compliance by the regulated parties. Agencies should promote transparency, consistency, predictability, and flexibility in regulatory activities. Agencies should prioritize compliance over punishment, and to that end, should utilize plain language in the development of regulations.

Regulatory Intent

1. **Please briefly describe the draft regulation in plain language.**
   This rule sets forth the assessment rates for the Hospital Care Assurance Program.

   The amendment updates paragraph (B) to specify to which program year the rule

77 SOUTH HIGH STREET | 30TH FLOOR | COLUMBUS, OHIO 43215-6117
CSIOhio@governor.ohio.gov

applies. Paragraph (C) establishes an assessment rate of 0.008336554 of a hospital's adjusted total facility costs up to $216,372,500 and 0.00665 for any amount in excess of $216,372,500.

2. **Please list the Ohio statute authorizing the Agency to adopt this regulation.**

   Sections 5111.02, 5112.03, 5112.06 of the Revised Code.

3. **Does the regulation implement a federal requirement? Is the proposed regulation being adopted or amended to enable the state to obtain or maintain approval to administer and enforce a federal law or to participate in a federal program?**
   Yes. Section 1923 of the of the Social Security Act requires states to make Disproportionate Share Hospital payments to hospitals that provide care to a disproportionate share of indigent patients (Medicaid consumers, people below poverty, and the uninsured). Each year the Centers for Medicare and Medicaid Services make federal allotments to states. To fund the state share needed to match these federal funds, ORC 5112.06 requires acute care general hospitals (non-psychiatric hospitals) to pay an assessment that in total cannot exceed the amount needed to match the federal funds. In addition, ORC 5112.06 requires some assessment revenues to be transferred to the Legislative Budget Services Fund and the Health Care Services Administration Fund.

4. **If the regulation includes provisions not specifically required by the federal government, please explain the rationale for exceeding the federal requirement.**

   Federal law does not directly require this regulation but does require that states provide matching funds. ORC 5112.06 provides for these matching funds through an assessment on hospitals, and this regulation implements ORC 5112.06.

5. **What is the public purpose for this regulation (i.e., why does the Agency feel that there needs to be any regulation in this area at all)?**

   The public purpose of this regulation is to provide federally mandated state matching funds for the federally required disproportionate share hospital payment program. The disproportionate share hospital payment program makes payments to hospitals that are intended to help hospitals cover the cost of providing care to the uninsured.

6. **How will the Agency measure the success of this regulation in terms of outputs and/or outcomes?**

   Success of this regulation is measured by the distribution of approximately $577.2 million to Ohio hospitals to help mitigate some of the cost of care to the uninsured.

Development of the Regulation

7. **Please list the stakeholders included by the Agency in the development or initial review of the draft regulation.**
   Staff from the Ohio Hospital Association and ODM reviewed the available data to determine the necessary assessment rates prior to the rule being placed into clearance. The rule was made available for public comment to stakeholders and the general public during the ODM policy clearance process from 8/8/2013 – 8/22/2013.

8. **What input was provided by the stakeholders, and how did that input affect the draft regulation being proposed by the Agency?**

   The Ohio Hospital Association commented with support for the draft regulation. In their comments, OHA has requested that the department modify the assessment rate in order to take full advantage of a recently announced increase in the 2013 federal DSH allotment available to Ohio. The Centers for Medicare and Medicaid Services has also revised the DSH allotment that is available for the 2012 program year. These are additional federal dollars that were not available to Ohio during that program year. OHA has also requested that the department modify the assessment rates applicable to the 2012 program year and distribute the additional funds to eligible hospitals. These changes will allow the department to set the necessary assessment rate to receive the funds necessary to maximize federal funding in a fair and equitable fashion.

   OHA has also commented that it would like to see changes to this rule that would allow the rule to not be filed each year solely for purpose of updating the assessment rates, in order to draw the available federal funds. As the federal allotment and Federal Medical Assistance Percentage (FMAP) change each year and since one parameter of the program (as prescribed by ORC 5112.06) is to only assess the hospitals the amount necessary to fund the required state share, it is then necessary to amend the rule simply to adjust the assessment rate.

   OHA supports the finalization of this rule and hopes that assessments and payments under HCAP can move forward as soon as possible.

9. **What scientific data was used to develop the rule or the measurable outcomes of the rule? How does this data support the regulation being proposed?**

   Not Applicable, however financial data reported by hospitals to the Department of Medicaid on their Cost Reports (JFS 02930) is used to develop the assessment rates and also used to measure hospitals' reported cost levels for their uncompensated care burden in relation to all other hospitals' uncompensated care costs.

10. **What alternative regulations (or specific provisions within the regulation) did the Agency consider, and why did it determine that these alternatives were not appropriate? If none, why didn't the Agency consider regulatory alternatives?**

    None – ORC 5112.06 is very prescriptive about the program, including how the assessment rates are to be established and the schedule for assessments.

11. **Did the Agency specifically consider a performance-based regulation? Please explain. *Performance-based regulations define the required outcome, but don't dictate the process the regulated stakeholders must use to achieve compliance.***

    No, this rule was developed to comply with the requirements of Section 5112.06 of the Revised Code.

12. **What measures did the Agency take to ensure that this regulation does not duplicate an existing Ohio regulation?**

    This rule was developed specifically for the hospital disproportionate share payment program and reviewed by the Bureau of Health Plan Policy, Department of Medicaid and ODM Legal Services to ensure that duplication does not exist.

13. **Please describe the Agency's plan for implementation of the regulation, including any measures to ensure that the regulation is applied consistently and predictably for the regulated community.**

    All hospitals in Ohio that serve Medicaid consumers are assessed. Also, the financial model used to determine the assessment rates are checked in great detail for accuracy by the department and the Ohio Hospital Association. In accordance with R.C. 5112.09, a hospital may seek reconsideration of its assessment amount, and a public hearing is held for any hospital to have the opportunity to ask for reconsideration. This rule sets forth the process for such requests.

Adverse Impact to Business

14. **Provide a summary of the estimated cost of compliance with the rule. Specifically, please do the following:**
    a. **Identify the scope of the impacted business community;**
       All Ohio Hospitals.
    b. **Identify the nature of the adverse impact (e.g., license fees, fines, employer time for compliance); and**
       All hospitals are expected to pay the assessment on or before the specified dates. Failure to comply results in a penalty as required by ORC 5112.99 and implemented by OAC rule 5101:3-2-09(L)(2).

c. **Quantify the expected adverse impact from the regulation.**
This rule requires hospitals to pay an assessment of 0.0083584 on their adjusted total facility costs up to $216,372,500 and 0.00665 for any amount in excess of $216,372,500. Total program assessment revenues are approximately $211,223,098 for program year 2013. This is an increase of approximately $12,097,384, compared to HCAP 2012, due to a combination of a decrease in Ohio's Federal Medical Assistance Percentage (FMAP) and an increase in Ohio's federal allotment as provide in the Balanced Budget Act of 1997. These funds will be used to make Disproportionate Share Hospital (DSH) payments to Ohio hospitals totaling $577.9 million through rule 5101:3-2-0, which is more than the assessment amount.

This rule will also require hospitals to pay an additional assessment for the 2012 program year. The additional assessment for2012 is $454,100 and will allow for an additional $1.2 million to be distributed to hospitals.

With regards to the penalty – we anticipate that hospitals will comply with the due dates of the assessment and thus will not be subject to any penalties.

15. **Why did the Agency determine that the regulatory intent justifies the adverse impact to the regulated business community?**

Without this regulation/assessment, the state will be unable to generate $367 million in federal funding that will be distributed to Ohio hospitals to help mitigate some of their uncompensated care costs, which enables some hospitals to keep their doors open to the uninsured.

Regulatory Flexibility

16. **Does the regulation provide any exemptions or alternative means of compliance for small businesses? Please explain.**

No. Compliance is required by the Revised Code.

17. **How will the agency apply Ohio Revised Code section 119.14 (waiver of fines and penalties for paperwork violations and first-time offenders) into implementation of the regulation?**

Not applicable.

18. **What resources are available to assist small businesses with compliance of the regulation?**

Questions may be directed to the Cost Reporting Unit and the Hospital Services Section of ODM.

77 SOUTH HIGH STREET | 30TH FLOOR | COLUMBUS, OHIO 43215-6117
CSIOhio@governor.ohio.gov

5101:3-2-08.1 **Assessment rates.**

The provisions of this rule are applicable for the program year(s) specified in this rule for all hospitals as defined under section 5112.01 of the Revised Code.

(A) Applicability.

The requirements of this rule apply as long as the United States centers for medicare and medicaid services (CMS) determines that the assessment imposed under section 5112.06 of the Revised Code is a permissible health care related tax. Whenever the ~~office~~department of ~~medical assistance~~medicaid is informed that the assessment is an impermissible health care-related tax, the ~~office~~department shall promptly refund to each hospital the amount of money currently in the hospital care assurance match fund that has been paid by the hospital, plus any investment earnings on that amount.

(B) The program years to which this rule applies are identified in paragraphs (B)(1) and (B)(2) of this rule. When the ~~office~~department is notified by the centers for medicare and medicaid services that an additional disproportionate share allotment is available for a prior program year, the ~~office~~department may amend the assessment rates for the prior program year.

(1) The assessment rates applicable to the program year that ends in calendar year ~~2012~~2013 are specified in paragraph (C) of this rule.

(2) The revised assessment rates applicable to the program year that ends in calendar year 2009 are specified in paragraph (D) of this rule.

(C) Calculation of assessment amounts.

The calculations described in this rule will be based on cost-reporting data described in rule 5101:3-2-23 of the Administrative Code that reflect the most ~~recent~~recently completed interim settled medicaid cost report for all hospitals. For non-medicaid participating hospitals, the calculations shall be based on the most recent as-filed medicare cost report.

The assessment is calculated as follows:

(1) Determine each hospital's adjusted total facility costs as the amount calculated in paragraph (A)(18) of rule 5101:3-2-08 of the Administrative Code.

(2) For hospitals with adjusted total facility costs, as described in paragraph (C)(1) of this rule, that are less than or equal to $216,372,500, multiply the hospital's adjusted total facility costs as described in paragraph (C)(1) of this rule by ~~0.00839661957~~0.008345216. The product will be each hospital's assessment

amount. For hospitals with adjusted total facility costs, as described in paragraph (C)(1) of this rule, that are greater than $216,372,500, multiply a factor of ~~0.0083966195750~~0.008345216 times the hospital's adjusted total facility costs as described in paragraph (C)(1) of this rule, up to $216,372,500. Multiply a factor of ~~0.006~~0.00665 times the hospital's adjusted total facility costs as described in paragraph (C)(1) of this rule, that are in excess of $216,372,500. The sum of the two products will be each hospital's assessment amount.

(3) The assessment amounts calculated in paragraph (C)(2) of this rule are subject to adjustment under the provisions of paragraph (F) of this rule.

(D) For the program year specified in paragraph (B)(2) of this rule, the assessment rates specified in rule 5101:3-2-08.1 of the Administrative Code, effective August 13, 2009 are revised in paragraphs (D)(1) to (D)(3) of this rule.

(1) The original adjusted total facility cost threshold of $216,374,000 is unchanged.

(2) The original tier one assessment rate of 0.010338 is increased to 0.01040209.

(3) The original tier two assessment rate of 0.00738093 is increased to 0.00738107.

(E) Determination of intergovernmental transfer amounts.

The ~~office~~department may require governmental hospitals, as described in paragraph (A)(2) of rule 5101:3-2-08 of the Administrative Code, to make intergovernmental transfers each program year.

The ~~office~~department shall notify each governmental hospital of the amount of the intergovernmental transfer it is required to make during the program year.

Each governmental hospital shall make intergovernmental transfers in periodic installments, executed by electronic funds transfer.

(F) Notification and reconsideration procedures.

(1) The ~~office~~department shall mail by certified mail, return receipt requested, the results of the determinations made under paragraph (C) of this rule to each hospital. If no hospital submits a request for reconsideration as described in this rule, the preliminary determinations constitute the final reconciliation of the amounts that each hospital must pay under this rule.

(2) Not later than fourteen days after the ~~office~~department mails the preliminary determinations as described in paragraph (C) of this rule, any hospital may submit to the ~~office~~department a written request for reconsideration of the preliminary determination made under paragraph (C) of this rule. The request must be accompanied by written materials setting forth the basis for the reconsideration.

If one or more hospitals submit such a request, the ~~office~~department shall hold a public hearing in Columbus, Ohio not later than thirty days after the preliminary determinations have been mailed by the ~~office~~department for the purpose of reconsidering its preliminary determinations. The ~~office~~department shall mail written notice of the date, time, and place of the hearing to every hospital at least ten days before the date of the hearing.

On the basis of the evidence submitted to the ~~office~~department or presented at the public hearing, the ~~office~~department shall reconsider and may adjust the preliminary determinations. The result of the reconsideration is the final reconciliation of the amounts that each hospital must pay under the provisions of this rule.

(3) The ~~office~~department shall mail each hospital written notice of the amount it must pay under the final reconciliation as soon as practical. Any hospital may appeal the amount it must pay to the court of common pleas of Franklin county.

(4) In the course of any program year, the ~~office~~department may adjust the assessment rate defined in paragraph (C) of this rule or adjust the amount of the intergovernmental transfers required under paragraph (E) of this rule, and, as a result of the adjustment, adjust each hospital's assessment and intergovernmental transfer, to reflect refinements made by the CMS during that program year.