Business Impact Analysis

Agency Name: Department of Medicaid

Regulation/Package Title: BHPP Hospital DSH (ERF 120497)

Rule Number(s): 5160-2-07.5, 5160-2-07.17, 5160-2-08, 5160-2-08.1, 5160-2-09, 5160-2-10

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Date:

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Rule 5160-2-07.17 sets forth the requirement that hospitals shall provide, without charge, basic, medically necessary hospital-level services to the individual who is a resident of this state, is not a recipient of the Medicaid program, and whose income is at or below the federal poverty line. The rule is being proposed in order to comply with Ohio's five-year rule review requirements. The proposed changes include updates of references to the rule, to sections of the Ohio Administrative Code, and to the Ohio Revised Code.

Rule 5160-2-08 sets forth the policies for data used to determine disproportionate share and indigent care adjustments in the Hospital Care Assurance Program (HCAP). The rule is being proposed in order to comply with Ohio's five-year rule review requirements. The proposed changes include updates of references to the rule, to sections of the Ohio Administrative Code, to the Ohio Revised Code, and to the Hospital Cost Report (ODM 02930).

Rule 5160-2-08.1 describes the calculation used to determine the assessment rate applied to all hospitals. The rule is being proposed for amendment to establish the assessment rates and the cost levels that fund HCAP for the 2014 program year. The amendment updates paragraph (B) to specify to which program year(s) the rule applies and allows Ohio to access additional Federal funds. Paragraph (C) establishes an assessment rate of 0.8401502% of a hospital's adjusted total facility costs up to $216,372,500 and 0.663% for any amount in excess of $216,372,500. In addition, the rule is being proposed in order to comply with Ohio's five-year rule review requirements, which includes updates of references to the rule, to sections of the Ohio Administrative Code, and to the Ohio Revised Code.

Rule 5160-2-09 sets forth the conditions, requirements, and operation of HCAP as well as the distribution formula. This rule is being proposed for amendment to update the distribution formula for Disproportionate Share Hospital Payment Program (DSH) payment policies for program year 2014 and to incorporate the determination of the hospital-specific disproportionate share limit (OAC rule 5160-2-07.5, proposed for rescission). The proposed distribution formula is updated to reflect more current hospital data. In addition, the proposed amendment removes the uncompensated care for persons above one hundred percent of poverty from the Disability Assistance (DA) and Uncompensated Care Indigent Care Payment Pool, and updates to the percentages being allocated to the remaining payment policy pools. Furthermore, the rule is being proposed in order to comply with Ohio's five-year rule review requirements, which includes updates of references to the rule, to sections of the Ohio Administrative Code, to the Ohio Revised Code, and to the Hospital Cost Report (ODM 02930).

Rule 5160-2-10 sets forth the conditions, requirements, and operation of the disproportionate share and indigent care program adjustment for psychiatric hospitals as well as the distribution formula. The rule is being proposed in order to comply with Ohio's five-year rule review requirements. The proposed changes include updates of references to the rule, to sections of the Ohio Administrative Code, to the Ohio Revised Code, and to the Hospital Cost Report (ODM 02930).

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

   5164.02, 5168.02, 5168.06

3. **Does the regulation implement a federal requirement?** Yes. **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. ***If yes, please briefly explain the source and substance of the federal requirement.***

   As the state Medicaid agency, the Department is required by Section 1923 of the Social Security Act to implement a DSH program to help offset the cost of Medicaid shortfall and the cost of care to the uninsured population that is incurred by hospitals.

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

   Section 1923 of the Social Security Act requires states to implement a DSH program and make additional payments to hospitals, but the federal statutes provide states with broad flexibility in distributing payments. Therefore, these rules specify requirements and regulations for Ohio's DSH program.

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 Department believes that these regulations are important as they provide hospitals with additional funds to offset the cost of Medicaid shortfall and the cost of care to the uninsured. Without these regulations, hospitals that have a high volume of uninsured and/or Medicaid patients may struggle to maintain services to the general public.

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

   The success of this regulation in terms of outputs is determined by examining the distribution of approximately $500-550 million to hospitals in each program year. The distributed amount is used to offset the Medicaid shortfall and 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.**

   The Ohio Hospital Association (OHA) took part in the development of these regulations.

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

   On June 20, 2014, OHA submitted a proposal to the Department to update the distribution formula so that it reflects more current hospital data and to update the predetermined percentage of the total funds available for distribution allocated to each pool. The Department accepted OHA's proposal, which is incorporated into these regulations.

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?**

   Financial data reported by hospitals to the Department of Medicaid on the Hospital Cost Report (ODM 02930) is used to develop the assessments 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. Section 5168.06 of the Revised Code is very specific 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; these rules were developed to comply with the requirements of Section 5168.06 of the Revised Code.

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

    These rules were developed specifically for the DSH program and were reviewed by the Bureau of Health Plan Policy, OMA, 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.**

    The Department assesses all hospitals in Ohio. Also, the financial model used to determine the assessment rates are examined in great detail for accuracy by the Department and OHA. In accordance with Section 5168.08 of the Revised Code, 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; these rules set 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;**

       OAC rule 5160-2-08.1 imposes a HCAP assessment on 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 OAC rule 5160-2-09.

c. Quantify the expected adverse impact from the regulation.

OAC rule 5160-2-08.1 requires acute care hospitals to pay an assessment of 0.8401502 percent of their adjusted total facility costs up to $216,372,500 and 0.663 percent for any amount in excess of $216,372,500. Hospitals will be required to pay approximately $8.8 million more than was needed to fund HCAP 2013; this is due to an increase in Ohio's federal allotment. However, these funds will be used to make DSH payments to acute care hospitals totaling $594 million through OAC rule 5160-2-09, and will outweigh the total assessments paid by the hospitals.

With regards to the penalty – we anticipate that hospitals will comply with the assessment 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?

These regulations will provide approximately $422 million in federal funds to Ohio, which will be distributed to Ohio hospitals to help mitigate some of their uncompensated care costs.

Regulatory Flexibility

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

No. Compliance is required by Revised Code sections 5168.20 to 5168.28.

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 Hospital Services Section (Hospital_Policy@medicaid.ohio.gov) of ODM.

TO BE RESCINDED

5160-2-07.5 **Disproportionate share adjustment.**

This rule describes the disproportionate share definition and limitations on payment methods described in rule ~~5101:3-2-09~~5160-2-09 of the Administrative Code for the program year specified in paragraph (A)(9) of rule ~~5101:3-2-08~~5160-2-08 of the Administrative Code.

(A) For the program year specified in paragraph (A)(9) of rule ~~5101:3-2-08~~5160-2-08 of the Administrative Code, paragraphs (B) to (D) of this rule set forth the definition of disproportionate share as well as other procedures and data used for the disproportionate share calculations as described in rule ~~5101:3-2-09~~5160-2-09 of the Administrative Code.

(B) Source data for calculations.

The source data used for the calculations made in paragraphs (C) and (D) of this rule will be the hospital's cost-reporting period ending in the state fiscal year as specified in paragraph (B) of rule ~~5101:3-2-08~~5160-2-08 of the Administrative Code.

(C) Determination of disproportionate share qualification.

(1) For each hospital calculate the medicaid utilization rate by dividing the sum of total fee for service (FFS) medicaid days and managed care plan (MCP) days as defined in paragraph (A) of rule ~~5101:3-2-09~~5160-2-09 of the Administrative Code by total facility days as defined in paragraph (A) of rule ~~5101:3-2-09~~ 5160-2-09of the Administrative Code.

(2) Each hospital with a medicaid utilization rate greater than or equal to one per cent qualifies as a disproportionate share hospital for the purposes of rule ~~5101:3-2-09~~5160-2-09 of the Administrative Code.

(3) Each hospital with a medicaid utilization rate less than one per cent qualifies as a nondisproportionate share hospital for the purposes of rule ~~5101:3-2-09~~5160-2-09 of the Administrative Code.

(D) Limitations on disproportionate share and indigent care payments made to hospitals.

(1) For purposes of this rule, for each hospital, calculate medicaid ~~fee-for-service~~

(FFS) shortfall by subtracting from total medicaid FFS costs, as defined in paragraph (A) of rule ~~5101:3-2-09~~5160-2-09 of the Administrative Code, total medicaid FFS payments, as described in paragraph (A) of rule ~~5101:3-2-09~~5160-2-09 of the Administrative Code. For those hospitals exempt from the prospective payment system as described in rule ~~5101:3-2-07.1~~5160-2-07.1 of the Administrative Code, the medicaid FFS shortfall equals zero.

(2) For each hospital, calculate the total medicaid shortfall by adding the medicaid FFS shortfall as defined in paragraph (D)(1) of this rule to the medicaid MCP shortfall as defined in paragraph (E)(2)(d) of rule ~~5101:3-2-09~~5160-2-09 of the Administrative Code.

(3) For each hospital, determine the total cost of uncompensated care for people without insurance ~~as~~by taking the sum of the amounts described in paragraphs (D)(3)(a) to (D)(3)~~(c)~~(b) of this rule.

(a) For each hospital, "total inpatient uncompensated care costs for people without insurance" means ~~the sum of the inpatient disability assistance medical costs, uncompensated care costs below the poverty level, and uncompensated care costs above the poverty level amounts from~~ the value in ~~JFS~~ ODM 02930, schedule F, column 5~~, line 11~~ which represents the sum of the inpatient disability assistance medical costs, uncompensated care costs below the poverty level, and uncompensated care costs above the poverty level amounts.

(b) For each hospital, "total outpatient uncompensated care costs for people without insurance" means the value in ODM 02930, schedule F, column 5 which represents the sum of the outpatient disability assistance medical costs, uncompensated care costs below the poverty level, and uncompensated care costs above the poverty level amounts ~~from the JFS 02930, schedule F, column 5, line 15~~.

~~(c) For each hospital, total uncompensated care costs for patients without insurance is equal to the sum of paragraphs (D)(3)(a) and (D)(3)(b) of this rule.~~

(4) For each hospital, determine the amount received under section 1011 - federal reimbursement of emergency health services furnished to undocumented aliens from the ~~JFS~~ ODM02930, schedule E, line 7b.

(5) For each hospital, calculate the hospital disproportionate share limit by adding the total medicaid shortfall as described in paragraph (D)(2) of this rule and

total uncompensated care costs for people without insurance as described in paragraph (D)(3)~~(c)~~ of this rule and subtracting section 1011 payments as described in paragraph (D)(4) of this rule.

(6) The hospital will receive the lesser of the disproportionate share limit as described in paragraph (D)(5) of this rule or the disproportionate share and indigent care payment as calculated in rule ~~5101:3-2-09~~5160-2-09 of the Administrative Code.

Effective:

Five Year Review (FYR) Dates:

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Certification

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Date

Promulgated Under:	119.03
Statutory Authority:	5164.02, 5168.02
Rule Amplifies:	5164.02, 5164.70, 5168.01, 5168.02
Prior Effective Dates:	10/19/87, 7/1/88 (Emer), 9/29/88, 7/2/92 (Emer), 9/20/92, 7/16/93 (Emer), 9/30/93, 7/24/94, 3/10/95 (Emer), 5/18/95, 3/16/96, 8/7/96 (Emer), 10/21/96, 8/25/97 (Emer), 11/1/97, 8/6/98 (Emer), 9/18/98, 9/15/99, 8/2/01, 9/15/06, 12/25/10

5160-2-07.17 **Provision of basic, medically necessary hospital-level services.**

Under the provisions of section ~~5112.17~~5168.14 of the Revised Code, each hospital that receives payment under the provisions of Chapter ~~5112~~5168. of the Revised Code, shall provide, without charge to the individual, basic, medically necessary hospital-level services to the individual who is a resident of this state, is not a recipient of the medicaid program and whose income is at or below the federal poverty line. Residence is established by a person who is living in Ohio voluntarily and who is not receiving public assistance in another state. Current recipients of the disability assistance (DA) program as defined in Chapter 5115. of the Revised Code or its successor program, qualify for services under the provisions of this rule.

(A) Definitions.

(1) "Basic, medically necessary hospital level services" are defined as all inpatient and outpatient services covered under the medicaid program in Chapter ~~5101:3-2~~5160-2 of the Administrative Code with the exception of transplantation services and services associated with transplantation. These covered services must be ordered by an Ohio licensed physician and delivered at a hospital where the physician has clinical privileges, and where such services are permissible to be provided by the hospital under its certificate of authority granted under Chapters 3711., 3727., and/or 5119. of the Revised Code. Hospitals will be responsible for providing basic, medically necessary hospital-level services to those persons described in paragraph (B) of this rule.

(2) "Third-party payer" means any private or public entity or program that may be liable by law or contract to make payment to or on behalf of an individual for health care services. Third-party payer does not include a hospital.

(B) Determination of eligibility.

A person is eligible for basic, medically necessary hospital-level services under the provisions of this rule if the person is a current recipient of the ~~disability assistance (~~DA~~)~~ program or its successor program, or the person's individual or family income is at or below the current poverty guideline issued by the department of health and human services (available at: ~~http://aspe.hhs.gov/poverty/figures-fed-reg.shtml~~http://www.medicaid.ohio.gov/FOROHIOANS/Fi ~~that applies to the individual or family when calculated by either of the methods described in paragraphs (B)(2)(a) and (B)(2)(b) of this rule on the date these services were provided~~. The current poverty guideline that applies to the individual or family is calculated using either of the methods described in paragraphs (B)(2)(a) and (B)(2)(b) of this rule on the date these services were provided.

(1) For purposes of this rule, a "family" shall include the patient, the patient's spouse (regardless of whether they live in the home), and all of the patient's children, natural or adoptive, under the age of eighteen who live in the home. If the patient is under the age of eighteen, the "family" shall include the patient, the patient's natural or adoptive parent(s) (regardless of whether they live in the home), and the parent(s)' children, natural or adoptive, under the age of eighteen who live in the home. If the income of a spouse or parent who does not live in the home cannot be obtained, or the absent spouse or parent does not contribute income to the family, determination of eligibility shall proceed with the available income information. If the patient is the child of a minor parent who still resides in the home of the patient's grandparents, the "family" shall include only the parent(s) and any of the parent(s)' children, natural or adoptive, who reside in the home.

(2) "Income" shall be defined as total salaries, wages, and cash receipts before taxes; cash receipts that reflect reasonable deductions for business expenses shall be counted for both farm and non-farm self-employment. Income will be calculated by:

(a) Multiplying ~~by four~~ the person's or family's income by four, as applicable, for the three months preceding the date hospital services were provided;

(b) Using the person's or family's income, as applicable, for the twelve months preceding the date hospital services were provided.

(3) For outpatient hospital services, a hospital may consider an eligibility determination to be effective for ninety days from the initial service date, during which a new eligibility determination need not be completed. Eligibility for inpatient hospital services must be determined separately for each admission, unless the patient is readmitted within forty-five days of discharge for the same underlying condition. Eligibility for recipients of the ~~disability assistance (~~DA~~)~~ program or its successor program must be verified on a monthly basis.

(4) A complete application for the hospital care assurance program is required prior to determination of eligibility. Each hospital shall develop an application that, at a minimum, must document income, family size and eligibility for the medicaid ~~Medicaid~~ program. The patient or a legal representative is required to sign the application. An unsigned application can be deemed acceptable if the patient is physically unable to sign the application or does not live in the vicinity of the hospital and is unable to return a signed application by mail. In these situations, the hospital representative ~~should~~shall complete all questions on the application, sign ~~it~~ the application, and must document why the patient

is unable to sign the application.

(5) The hospital shall accept application for services without charge until three years from the date of the follow-up notice, as described in paragraphs (C)(2) and (C)(3) of this rule, has elapsed.

(6) Applicants shall cooperate in supplying information about health insurance or medical benefits available so a hospital may determine any potential third-party resources that may be available.

(7) Nothing in this rule shall be construed to prevent a hospital from assisting and/or requiring an individual to apply for ~~eligibility under the medical assistance program~~medicaid before the hospital processes an application under this rule.

(C) Billing requirements.

Hospitals may bill any third-party payer that has a legal liability to pay for services rendered under the provisions of this rule. Hospitals may bill the medicaid program in accordance with Chapter ~~5111~~5164. of the Revised Code and the rules adopted under that chapter for services rendered under the provisions of this rule if the individual becomes a recipient of the medicaid program. Hospitals may bill individuals for services if all of the following apply:

(1) The hospital has an established post-billing procedure for determining the individual's income and canceling the charges if the individual is found to qualify for services under the provisions of this rule;

(2) The initial bill, and at least the first follow-up bill, is accompanied by a written statement that does all of the following:

(a) Explains that individuals with income at or below the federal poverty guidelines are eligible for services without charge;

(b) Specifies the federal poverty guideline for individuals and families of various sizes at the time the bill is sent; and

(c) Describes the procedure required by paragraph (C)(1) of this rule.

(3) If the written statement as described in paragraph (C)(2) of this rule is printed on the back of the hospital's bill or data-mailer, the hospital must reference the statement on the front of the bill or data-mailer~~.~~; and

(4) Notwithstanding paragraph (B) of this rule, a hospital providing care to an individual under the provisions of this rule is subrogated to the rights of any individual to receive compensation or benefits from any person or governmental entity for the hospital goods and services rendered.

(D) Notice requirements.

Each hospital that receives payment under Chapter ~~5112~~5168. of the Revised Code shall post notices in appropriate areas ~~in~~ of their facility, ~~including but not limited to~~which include the admissions areas, the business office, and the emergency room; the posted notices are not limited to these areas. The posted notices must ~~that~~ specify the rights of persons with incomes at or below the federal poverty line to receive, without charge to the individual, basic, medically necessary hospital-level services at the hospital.

Posted notices must contain all of the following in order to comply with the requirement as described in this paragraph:

(1) At a minimum, the posted notices must specify the rights of these individuals to receive without charge, basic, medically necessary hospital-level services;

(2) The wording of the posted notice must be clear and in simple terms understandable by the population serviced;

(3) Posted notice must be printed in English and other languages that are common to the population of the area serviced;

(4) The posted notice must be clearly readable at a distance of twenty feet or the expected vantage point of the patrons; and

(5) The facility shall make reasonable efforts to communicate the contents of the posted notice to persons it has reason to believe cannot read the notice.

(E) Documentation requirements.

Each hospital shall establish and maintain a written policy outlining its internal policy for administration of the hospital care assurance program in compliance with this rule and with rule ~~5101:3-2-23~~5160-2-23 of the Administrative Code. Each hospital may change its written policy as needed, but policy changes may not be implemented retroactively. The written policy shall include, but is not limited to, the following:

(1) Procedure for taking applications and a copy of the current application in use as described in paragraph (B) of this rule~~.~~; and

(2) Procedure for eligibility determination including the determination of family size and determination of income. If the hospital requires verification of income other than the application, the written policy should describe what constitutes acceptable income documentation.

(F) Reporting requirements.

Each hospital shall collect and report to the department information on the number and categorical identity of persons served under the provisions of this rule.

(1) This information will be reported on the ~~JFS~~ODM 02930, schedule F~~,~~ which must be submitted annually along with a certification of the accuracy of this reported data as required by rule ~~5101:3-2-23~~5160-2-23 of the Administrative Code. The ~~JFS~~ODM 02930 and instructions for completion are available on the Department's website ~~located in appendix A of rule 5101:3-2-23 of the Administrative Code~~.

(2) The use of estimation methods to determine amounts for charges related to non-hospital level services or to determine the health insurance status of patients charges on patient accounts is not permitted.

(3) Each hospital shall maintain, make available for department review and provide to the department on request, any records necessary to document its compliance with the provisions of this rule, including:

(a) Any documents, including medical records of the population served, from which the information required to be reported on the ~~JFS~~ODM 02930 was obtained;

(b) Accounts that clearly segregate the services rendered under the provisions of this rule from other accounts; ~~and~~

(c) Copies of the determinations of eligibility under paragraph (B) of this rule~~.~~; and

(d) A copy of the disability assistance card or other evidence of eligibility for any person who is a recipient of the ~~disability assistance (~~DA~~)~~ program or its successor program at the time the services defined in paragraph

(A) of this rule were delivered.

(4) Hospitals must retain these records for a period of six years from the date of receipt of payment based upon those records or until any audit initiated within the six year period is completed.

(G) This rule in no way alters the scope or limits the obligation of any governmental entity or program, including the program awarding reparations to victims of crime under sections 2743.51 to 2743.72 of the Revised Code and the program for medically handicapped children established under section 3701.023 of the Revised Code, to pay for hospital services in accordance with state or local law.

Effective:

Five Year Review (FYR) Dates:

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Certification

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Date

Promulgated Under:	119.03
Statutory Authority:	5168.02
Rule Amplifies:	5168.02, 5168.14
Prior Effective Dates:	5/22/92 (Emer), 8/20/92, 2/1/93, 7/16/93 (Emer), 9/30/93, 10/1/93 (Emer), 12/30/93, 1/20/95, 3/16/96, 5/22/97, 12/14/00, 1/1/06

5160-2-08 **Data policies for disproportionate share and indigent care adjustments for hospital services.**

This rule sets forth the data used to determine assessments and adjustments, and the data policies that are applicable for each program year for all providers of hospital services included in the definition of "hospital" as described under section ~~5112.01~~5168.01 of the Revised Code.

(A) Definitions.

(1) "Disproportionate share hospital" means a hospital that meets the requirements for disproportionate share status as defined in rule ~~5101:3-2-07.5~~5160-2-09 of the Administrative Code.

(2) "Governmental hospital" means a county hospital with more than five hundred beds or a state-owned and -operated hospital with more than five hundred beds.

(3) "Hospital" means a hospital that is described under section ~~5112.01~~ 5168.01 of the Revised Code.

(4) "Hospital care assurance program fund" means the fund described under section ~~5112.18~~5168.11 of the Revised Code.

(5) "Hospital care assurance match fund" means the fund described under section ~~5112.18~~5168.11 of the Revised Code.

(6) "Intergovernmental transfer" means any transfer of money by a governmental hospital.

(7) "Legislative budget services fund" means the fund described under section ~~5112.19~~5168.12 of the Revised Code.

(8) "Health care services administration fund" means the fund described under section ~~5111.94~~ 5162.54 of the Revised Code.

(9) "Program year" means the twelve-month period beginning on the first day of October and ending on the thirtieth day of September.

(10) "Total facility costs" for each hospital means the amount from the ~~JFS~~ ODM

02930, "Hospital Cost Report", for the applicable state fiscal year, schedule B, column 3, line 101. For non-medicaid participating hospitals, total facility costs shall be determined from the medicare cost report.

(11) "Total skilled nursing facility costs" for each hospital means the amount on the ~~JFS~~ODM 02930, schedule B, column 3, line ~~34~~44. For non-medicaid participating hospitals, total skilled nursing facility costs shall be determined from the medicare cost report.

(12) "Total home health facility costs" for each hospital means the amount on the ~~JFS~~ODM 02930, schedule B, column 3, line ~~67~~98. For non-medicaid participating hospitals, total home health facility costs shall be determined from the medicare cost report.

(13) "Total hospice facility costs" for each hospital means the amount on ~~JFS~~ODM 02930, schedule B, column 3, line ~~68~~99. For non-medicaid participating hospitals, total hospice facility costs shall be determined from the medicare cost report.

(14) "Total ambulance costs" for each hospital means the amount on ~~JFS~~ODM 02930, schedule B, column 3, line ~~64~~95. For non-medicaid participating hospitals, total ambulance costs shall be determined from the medicare cost report.

(15) "Total Durable Medical Equipment (DME) rental costs" for each hospital means the amount on ~~JFS~~ODM 02930, schedule B, column 3, line ~~65~~96. For non-medicaid participating hospitals, total DME rental costs shall be determined from the medicare cost report.

(16) "Total DME sold costs" for each hospital means the amount on ~~JFS~~ODM 02930, schedule B, column 3, line ~~66~~97. For non-medicaid participating hospitals, total DME sold costs shall be determined from the medicare cost report.

(17) "Other non-hospital costs" for each hospital means separately identifiable non-hospital operating costs found on worksheet B, Part I of the medicare cost report, as determined by the department upon the request of the hospital, that are permitted to be excluded from the provider tax in compliance with section 1903(w) of the Social Security Act.

(18) "Adjusted total facility costs" means the result of subtracting the sum of the amounts defined in paragraphs (A)(11), (A)(12), (A)(13), (A)(14), (A)(15)

and (A)(16) of this rule from the amount defined in paragraph (A)(10) of this rule.

(B) Source data for calculations.

(1) The calculations described in this rule for each program year will be based on cost-reporting data described in rule ~~5101:3-2-23~~5160-2-23 of the Administrative Code that reflects the completed interim settled medicaid cost report (~~JFS~~ODM 02930) for each hospital's cost reporting period ending in the state fiscal year that ends in the federal fiscal year preceding each program year. For non-medicaid participating hospitals, the calculations will be based on the medicare cost report for the same time period.

(a) For new hospitals, the first available cost report filed with the department in accordance with rule ~~5101:3-2-23~~5160-2-23 of the Administrative Code will be used until a cost report that 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.

(b) Data for hospitals that have changed ownership shall be treated as described in paragraphs (B)(1)(b)(i) to (B)(1)(b)(ii) of this rule.

(i) For a change of ownership that occurs during the program year, the cost reporting data filed by the previous owner that reflects that hospital's most recent completed interim settled medicaid cost report shall be annualized to reflect one full year of operation. The data will be allocated to each owner based on the number of days in the program year the hospital was owned.

(ii) For a change of ownership that occurred in the previous program year, the cost reporting data filed by the previous owner that reflects that hospital's most recent completed interim settled medicaid cost report and the cost reporting data filed by the new owner that reflects that hospital's most recent 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.

(c) For hospitals involved in mergers during the program year that result in the hospitals using one provider number, the cost reports from the

merged providers will be combined and annualized by the department to reflect one full year of operation.

Cost report data used in the calculations described in this rule will be the cost report data described in this paragraph and are subject to any adjustments made upon departmental review that is completed each year and subject to the provisions of paragraph (E) of this rule.

(2) Closed hospitals with unique medicaid provider numbers.

For a hospital facility, identifiable to a unique medicaid provider number, that closes during the current program year as defined in paragraph (A) of this rule, the cost report data shall be adjusted to reflect the portion of the year that the hospital was open during the current program year. That partial year data shall be used to determine the assessment owed by that closed hospital.

Hospitals identifiable to a unique medicaid provider number that closed during the immediate prior program year will not owe an assessment for the current program year.

(3) Replacement hospital facilities.

(a) 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 this rule, the cost report data from the original facility shall be used to determine the assessment for the new replacement facility if the following conditions are met:

(i) Both facilities have the same ownership,

(ii) There is appropriate evidence to indicate that the new facility was constructed to replace the original facility,

(iii) The new replacement facility is so located as to serve essentially the same population as the original facility, and

(iv) The new replacement facility has not filed a cost report for the current program year.

(b) For a replacement hospital facility that opened in the immediate prior program year, the assessment 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.

(C) Deposits into the legislative budget services fund.

From the first installment of the assessments paid under rule ~~5101:3-2-08.1~~5160-2-08.1 of the Administrative Code and intergovernmental transfers made under rule ~~5101:3-2-08.1~~5160-2-08.1 of the Administrative Code during each program year beginning in an odd-numbered calendar year, the department shall deposit into the state treasury to the credit of the legislative budget services fund a total amount equal to the amount by which the biennial appropriation from that fund exceeds the amount of the unexpended, unencumbered monies in that fund.

(D) Deposits into the health care services administration fund.

From the first installment of assessments paid under rule ~~5101:3-2-08.1~~5160-2-08.1 of the Administrative Code and intergovernmental transfers made under rule ~~5101:3-2-08.1~~5160-2-08.1 of the Administrative Code during each program year, the department shall deposit into the state treasury to the credit of the health care services administration fund, a total amount equal to the amount allocated by the appropriations act from assessments paid under section ~~5112.06~~5168.06 of the Revised Code and intergovernmental transfers made under section ~~5112.07~~5168.07 of the Revised Code during each program year.

(E) Finalization of data used for disproportionate share and indigent care adjustments.

During each program year, the department may mail any data the department may choose to use for disproportionate share and indigent care adjustments, described in rule ~~5101:3-2-09~~5160-2-09 of the Administrative Code to each hospital. Not later than thirty days after the department mails the data, any hospital may submit to the department a written request to correct data. Any documents, data, or other information that supports the hospital's request to correct data must be submitted with the request. On the basis of the information submitted to the department, the department may adjust the data.

(1) For each program year, upon the expiration of all hospitals' thirty-day data correction periods, the department shall consider the data correction period closed and all data final, subject to review and acceptance by the department.

(2) Any hospital that requests to correct data after the expiration of its thirty-day correction period but before the data correction period is closed for all hospitals as described in paragraph (E)(1) of this rule, shall be subject to an administrative fee. The administrative late fee shall be 0.03 per cent of the

hospital's adjusted total facility cost as calculated in paragraph (A)(15) of this rule. The hospital shall include payment of the administrative late fee with the written request to correct data.

(3) All amounts received by the department under this paragraph shall be deposited into the state treasury to the credit of the health care services administration fund, described under paragraph (A)(8) of this rule.

(4) The department shall accept at any time, data from any hospital that has misstated its reported data used to make disproportionate share and indigent care adjustments and that resulted in a disproportionate share and indigent care payment that was greater than the payment would have been with the corrected data.

(F) Confidentiality.

Except as specifically required by the provisions of this rule and rule ~~5101:3-2-24~~5160-2-24 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~~ medicaid or by any person under contract with the department who has access to such information.

Effective:

Five Year Review (FYR) Dates:

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Certification

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Date

Promulgated Under:	119.03
Statutory Authority:	5168.02
Rule Amplifies:	5168.02
Prior Effective Dates:	7/1/94, 2/27/95 (Emer), 5/18/95, 6/26/96 (Emer), 8/13/96, 7/24/97 (Emer), 8/21/97 (Emer), 11/1/97, 6/26/98 (Emer), 9/1/98, 4/16/99 (Emer), 6/10/99 (Emer), 8/26/99, 7/16/00 (Emer), 7/18/00 (Emer), 9/28/00 (Emer), 8/2/01, 7/1/02 (Emer), 9/19/02, 7/28/03, 7/22/05 , 12/25/10

5160-2-08.1 **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 5168.01 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 5168.01 of the Revised Code is a permissible health care related tax. Whenever the department of medicaid 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 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 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 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 ~~2013~~ 2014are specified in paragraph (C) of this rule.

(2) The revised assessment rates applicable to the program year that ends in calendar year 2012 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 5160-2-23 of the Administrative Code that reflect the most 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 5160-2-08 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 ~~0.0083584~~0.008401502. 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 ~~0.0083584~~0.008401502 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 ~~0.00665~~0.00663 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 5160-2-08.1 of the Administrative Code, effective February 21, 2013 are revised in paragraphs (D)(1) to (D)(3) of this rule.

(1) The original adjusted total facility cost threshold of $216,372,500 is unchanged.

(2) The original tier one assessment rate of 0.0083966197575 is increased to 0.0084222.

(3) The original tier two assessment rate of 0.006 is unchanged.

(E) Determination of intergovernmental transfer amounts.

The department may require governmental hospitals, as described in paragraph (A)(2) of rule 5160-2-08 of the Administrative Code, to make intergovernmental transfers each program year.

The 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 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 paragraph (F)(2) of 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 department mails the preliminary determinations as described in paragraph (C) of this rule, any hospital may submit to the 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 department shall hold a public hearing in Columbus, Ohio not later than thirty days after the preliminary determinations have been mailed by the department for the purpose of reconsidering its preliminary determinations. The 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 department or presented at the public hearing, the 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 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 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.

Effective:

Five Year Review (FYR) Dates:

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Certification

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Date

Promulgated Under:	119.03
Statutory Authority:	5164.02, 5168.02, 5168.06
Rule Amplifies:	5164.02, 5168.02, 5168.06
Prior Effective Dates:	7/1/94, 2/27/95 (Emer), 5/18/95, 6/26/96 (Emer), 8/13/96, 7/24/97 (Emer), 8/21/97 (Emer), 11/1/97, 6/26/98 (Emer), 9/1/98, 4/16/99 (Emer), 6/10/99 (Emer), 8/26/99, 7/16/00 (Emer), 7/18/00 (Emer), 9/28/00, 8/2/01, 7/1/02 (Emer), 9/19/02, 7/28/03, 7/1/04, 7/22/05, 10/27/06 (Emer), 11/30/06, 9/17/07, 8/3/08, 8/13/09, 12/25/10, 9/29/11 (Emer), 12/28/11, 11/28/12 (Emer.), 2/21/13, 1/1/14

5160-2-09 **Payment policies for disproportionate share and indigent care adjustments for hospital services.**

This rule is applicable for each program year for all medicaid-participating providers of hospital services included in the definition of "hospital" as described under section ~~5112.01~~5168.01 of the Revised Code.

(A) Definitions.

(1) "Total fee for service (FFS) medicaid costs" for each hospital means the sum of inpatient program costs ~~the amounts~~ reported on ~~in JFS~~ ODM 02930, ~~for the applicable state fiscal year,~~ schedule H, section I, columns 1 and 3, line 1 and outpatient medicaid program costs as reported on ODM 02930 section II, column 1, line 10 for the applicable state fiscal year.

(2) "Total medicaid managed care plan (MCP) inpatient costs" for each hospital means the amount on ~~JFS~~ODM 02930 schedule I, column 3, line ~~101~~201.

(3) "Total medicaid managed care plan (MCP) outpatient costs" for each hospital means the amount on ~~JFS~~ODM 02930 schedule I, column 5, line ~~101~~201.

(4) "Total Title V costs" for each hospital means the sum of the inpatient and outpatient program costs as reported ~~amount~~ on ~~JFS~~ODM 02930, schedule H, section I, column 2, line 1 and section II, column 2, line 10.

(5) "Total inpatient disability assistance medical costs" for each hospital means the sum of inpatient disability assistance costs for patients with and without insurance as reported ~~amount~~ on the ~~JFS~~ODM 02930, schedule F, columns 4 and 5~~, line 8~~.

(6) "Total inpatient uncompensated care costs for people without insurance" for each hospital means the sum of the inpatient disability assistance medical costs, inpatient uncompensated care costs below the poverty level, and inpatient uncompensated care costs above the poverty level amounts as totaled on ODM 02930, schedule F, column 5.

~~(6)~~(7) "Total inpatient uncompensated care costs under one hundred per cent" for each hospital means the ~~amount~~ sum of the inpatient uncompensated care costs under one hundred per cent for patients with and without insurance as reported on the ~~JFS~~ODM 02930, schedule F, columns 4 and 5~~, line 9~~.

~~(7)~~(8) "Total inpatient uncompensated care costs above one hundred per cent without insurance" for each hospital means the ~~amount~~ sum of the inpatient uncompensated care costs over one hundred per cent for patients without insurance as reported on the ~~JFS~~ODM 02930, schedule F, column 5~~, line 10~~.

~~(8)~~(9) "Total outpatient disability assistance medical costs" for each hospital means the ~~amount~~sum of outpatient disability assistance costs for patients with and without insurance as reported on the ~~JFS~~ODM 02930, schedule F, columns 4 and 5~~, line 12~~.

~~(9)~~(10) "Total outpatient uncompensated care costs under one hundred per cent" for each hospital means the sum of the outpatient care costs under one hundred per cent for patients with and without insurance as ~~amount~~ on the ~~JFS~~ODM 02930, schedule F, columns 4 and 5~~, line 13~~.

~~(10)~~(11) "Total outpatient uncompensated care costs above one hundred per cent without insurance" for each hospital means the sum of the outpatient uncompensated care costs above one hundred per cent for patients without insurance as reported ~~the amount~~ on the ~~JFS~~ODM 02930, schedule F, column 5~~, line 14~~.

~~(11)~~(12) "Total disability assistance medical costs" for each hospital 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)~~(9) of this rule.

~~(12)~~(13) "Total uncompensated care costs under one hundred per cent" for each hospital means the sum of total inpatient uncompensated care costs under one hundred per cent as described in paragraph (A)~~(6)~~(7) of this rule, and total outpatient uncompensated care costs under one hundred per cent as described in paragraph (A)~~(9)~~(10) of this rule.

~~(13)~~(14) "Total uncompensated care costs above one hundred per cent without insurance" for each hospital means the sum of total inpatient uncompensated care costs above one hundred per cent without insurance as described in paragraph (A)~~(7)~~(8) of this rule, and total outpatient uncompensated care costs above one hundred per cent without insurance as described in paragraph (A)~~(10)~~(11) of this rule.

(15) "Total outpatient uncompensated care costs for people without insurance" for each hospital means the sum of the outpatient disability assistance medical costs, outpatient uncompensated care costs below the poverty level, and

outpatient uncompensated care costs above the porverty level as represented on the ODM 02930, schedule F.

(16) "Total uncompensated care costs for patients without insurance" for each hospital means the sum of the total inpatient uncompensated care costs for people without insurance in paragraph (A)(6) and the total outpatient uncompensated care costs for people without insurance in paragraph (A)(15).

(17) "Total FFS medicaid days" means, for each hospital, the amount on the ODM 02930, schedule C, column 6, line 49 and column 10, line 49.

~~(14)~~(18) "Managed care plan days" (MCP days) means, for each hospital, the amount on the ~~JFS~~ODM 02930, schedule I, column 2, line ~~103~~204.

(19) "Total medicaid days" for each hospital means the sum of total medicaid FFS days as defined in paragraph (A)(17) and total medicaid MCP days as defined in (A)(18).

~~(15)~~(20) "High federal disproportionate share hospital" means a hospital with a ratio of total medicaid days as defined in paragraph (A)(19) ~~plus MCP days~~ to total facility days as defined in paragraph (A)(22) greater than the statewide mean ratio of the sum of total medicaid days ~~plus MCP days~~ to the sum of total facility days plus one standard deviation.

~~(16)~~(21) "Total FFS medicaid payments" for each hospital means the sum of the total medicaid and medicaid transplant inpatient payments, total medicaid outpatient payments, and the medicaid and medicaid transplant settlement amounts as reported on the ~~JFS~~ODM 02930, schedule H, column 1, lines 7, 15, 26, and column 3, lines 7 and 26.

~~(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)~~(22) "Total facility days" means for each hospital the amount reported on the ~~JFS~~ODM 02930, schedule C, column 4, line ~~35~~49.

(23) "Medicaid utilization rate" for each hospital means the rate calculated by dividing the sum of total medicaid days as defined in paragraph (A)(19) by the total facility days as defined in paragraph (A)(22)

~~(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 7, less the amount described in paragraph (A)(30) of this rule, 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 amount reported on the JFS 02930, schedule H, column 1, line 15, divided by the amount reported on the JFS 02930, schedule H, section II, column 1, line 10.~~

~~(21)~~(24) "Total medicaid managed care plan (MCP) costs" for each hospital 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~~ medicaid and is the amount on ~~JFS~~ODM 02930, schedule I, column 3, line ~~101~~ 202and column 5, line ~~101~~202.

~~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)~~(25) "Medicaid managed care plan (MCP) inpatient payments" for each hospital means the amount on ~~JFS~~ODM 02930 schedule I, column 2, line ~~107~~208.

~~(23)~~(26) "Medicaid managed care plan (MCP) outpatient payments" for each hospital means the amount on ~~JFS~~ODM 02930 schedule I, column 4, line ~~107~~208.

~~(24)~~(27) "Total medicaid managed care plan (MCP) payments" for each hospital is the sum of the amount calculated in paragraph (A)~~(22)~~(25) of this rule, and the amount calculated in paragraph (A)~~(23)~~(26) of this rule.

~~(25)~~(28) "Adjusted total facility costs" for each hospital means the amount described in paragraph (A) of rule ~~5101:3-2-08~~5160-2-08 of the Administrative Code.

~~(26)~~(29) "Rural Access Hospital (RAH)" means a hospital that is classified as a rural hospital by the centers for medicare and medicaid services (CMS).

~~(27)~~(30) "Critical Access Hospital (CAH)" means a hospital that is certified as a critical access hospital by CMS and that has notified the Ohio department of health and the Ohio department of ~~job and family services~~medicaid of such certification. Beginning in the program year that ends in calendar year 2004, the Ohio department of ~~job and family services~~medicaid 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. Hospitals shall notify the Ohio department of ~~job and family services~~medicaid of any change in their critical access hospital status, including continued CAH designations, immediately following notification from CMS.

~~(28)~~(31) "Hospital-specific disproportionate share limit" for each hospital means the limit on disproportionate share and indigent care payments made to a specific ~~hospitals~~hospital as defined in paragraph ~~(D)~~(J)(2) of this rule ~~5101:3-2-07.5 of the Administrative Code~~.

~~(29)~~(32) "Children's hospitals" are those hospitals that meet the definition in paragraph (A)(2) of rule ~~5101:3-2-07.2~~ 5160-2-07.2 of the Administrative Code

~~(30)~~(33) "~~Other medicaid payments~~Inpatient upper limit payment" for each hospital means the amount reported ~~in~~on ~~JFS~~ODM 02930, schedule H, section I, column 1, line 5.

(34) "Outpatient upper limit payment" for each hospital means the amount reported on ODM 02930, schedule H, section II, column 1, line 14.

~~(31)~~(35) "Total program amount" means the sum of the amounts in paragraphs ~~(J)~~(K)(2) and ~~(J)~~(K)(3) of this rule.

(36) "Obstetric services requirements" (OSR) means for each hospital that satisfies the federal statute of having at least two obstetricians who have staff privileges at the hospital that agreed to provide obstetric services to medicaid eligible individuals during the cost-reporting year as defined in paragraph (A) of rule 5160-2-08 of the Administrative Code. For rural hospitals as defined in paragraph (A)(29) of this rule, this requirement includes any physician with staff privileges at the hospital to perform non-emergency obstretic procedures. This requirement shall not apply to a hospital whose inpatients are predominantly individuals under 18 years of age or a hospital which did not offer non-emergency obstretic services to the general population as of December 22, 1987, the date the federal statute was enacted.

(B) Applicability.

The requirements of this rule apply as long as CMS determines that the assessment imposed under section ~~5112.06~~5168.06 of the Revised Code is a permissible health care related tax. Whenever the department of ~~job and family services~~ medicaid 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 paragraph (B)(1) of rule ~~5101:3-2-08~~5160-2-08 of the Administrative Code.

(2) For new hospitals, the first available cost report filed with the department in accordance with rule ~~5101:3-2-23~~5160-2-23 of the Administrative Code will be used until a cost report that 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.

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~~5160-2-08 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 (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 (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~~5160-2-08 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) Hospitals that have changed ownership.

For a change of ownership that occurs during the program year, the cost reporting data filed by the previous owner that reflects that hospital's most recent completed interim settled medicaid cost report shall be annualized to reflect one full year of operation. The data will be allocated to each owner based on the number of days in the program year the hospital was owned.

For a change of ownership that occurred in the previous program year, the cost reporting data filed by the previous owner that reflects that hospital's most recent completed interim settled medicaid cost report and the cost reporting data filed by the new owner that reflects that hospital's most recent 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.

(6) 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 that is completed each year and subject to the provisions of rule ~~5101:3-2-08~~5160-2-08 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 rule ~~5101:3-2-08~~5160-2-08 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 rule ~~5101:3-2-08~~5160-2-08 of the Administrative Code.

(c) The total amount of federal matching funds that will be made available to general acute care hospitals in the same program year as a result of the state's disproportionate share limit payment allotment determined by the United States center for medicare and medicaid services (CMS) for that program year.

(2) The funds available in the indigent care pool shall be distributed through policy payment pools in accordance with paragraphs (E) to (I) of this rule. Policy payment pools shall be allocated a percentage of the indigent care pool as described in paragraphs (D)(2)(a) to (D)(2)(f) of this rule.

(a) High federal disproportionate share hospital pool: ~~7.85~~12.00 per cent.

(b) Medicaid indigent care pool: ~~20.40~~60.38 per cent.

(c) Disability assistance medical and uncompensated care pool below one hundred per cent of poverty: ~~61.12~~16.88 per cent.

~~(d) Uncompensated care for persons above one hundred per cent of poverty: 5.24 per cent.~~

~~(e)~~(d) Critical access and rural hospitals: ~~4.06~~8.76 per cent.

~~(f)~~(e) Children's hospitals: ~~1.33~~1.98 per cent.

(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)~~(20) of this rule shall receive funds from the high federal disproportionate share indigent care payment pool.

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

(b) For each hospital that meets the high federal disproportionate share definition, multiply the ratio calculated in paragraph (E)(1)(a) of this rule by the amount allocated in paragraph (D)(2)(a) of this rule 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 (E)(1)(b) of this rule is greater than or equal to its hospital-specific disproportionate share limit defined in paragraph (A)~~(28)~~(31) of this rule, the hospital's high federal disproportionate share hospital payment is the amount defined in paragraph (A)~~(28)~~(31).

(ii) If the hospital's payment amount calculated in (E)(1)(b) of this rule is less than its hospital-specific disproportionate share limit defined in paragraph (A)~~(28)~~(31) of this rule, the hospital's high federal disproportionate share hospital payment is equal to the amount in paragraph (E)(1)(b) of this rule and any additional amount provided by paragraph (E)(1)(b)(iv) of this rule.

(iii) If the hospital-specific disproportionate share limit defined in paragraph (A)~~(28)~~(31) of this rule is equal to or less than zero, the hospital's high federal disproportionate share hospital payment is equal to zero.

(iv) For hospitals whose high federal disproportionate share hospital payment is set at the disproportionate share limit defined in paragraph (A)(31)~~If any hospital is limited as described in paragraph (E)(1)(b)(i) of this rule~~, calculate each hospital's limited payment by subtracting the amount defined in paragraph

(A)~~(28)~~ (31) of this rule from the amount determined in paragraph (E)(1)(b) of this rule and sum these amounts for all limited hospital(s). Subtract the sum of the limited payments from the amount allocated in paragraph (D)(2)(a) of this rule and repeat the distribution described in paragraph (E)(1) of this rule until all remaining funds for this pool are expended.

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

(a) For each hospital, subtract the amount distributed in paragraph (E)(1) of this rule from the hospital-specific disproportionate share limit defined in paragraph (A)(31) of this rule ~~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.~~

~~(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.~~

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

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

~~(h)~~(d) For each hospital, multiply the ratio calculated in paragraph (E)(2)~~(g)~~(c) of this rule by the amount allocated in paragraph (D)(2)(b) of this rule to determine each hospital's medicaid indigent care payment amount subject to the following limitations:

(i) If the sum of a hospital's payment amounts calculated in paragraph (E)(1) of this rule is greater than or equal to its hospital-specific disproportionate share limit defined in paragraph (A)~~(28)~~(31) of this rule, 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 paragraphs (E)(1) and (E)(2)~~(h)~~(d) of this rule is less than its hospital-specific disproportionate share limit defined in paragraph (A)~~(28)~~(31) of this rule, then the payment is equal to the amount in paragraph (E)(2)~~(h)~~(d) of this rule and any amount provided by paragraph (E)(2)~~(h)~~(d)(iv) of this rule.

(iii) If the sum of a hospital's payment amounts calculated in paragraphs (E)(1) and (E)(2)~~(h)~~(d) of this rule is greater than its hospital-specific disproportionate share limit defined in paragraph (A)~~(28)~~(31) of this rule, then the payment is equal to the difference between the ~~amount calculated~~ hospital-specific disproportionate share limit defined in paragraph (A)~~(28)~~(31) of this rule and the amount calculated in paragraph (E)(1) of this rule.

(iv) If any hospital is limited as described in paragraph (E)(2)~~(h)~~(d)(iii) of this rule, calculate each hospital's limited payment by subtracting the amount defined in paragraph (A)~~(28)~~(31) of this rule from the amount determined in paragraph (E)(2)~~(h)~~(d) of this rule and sum these amounts for all limited hospital(s). Subtract the sum of the limited payments from the amount allocated in paragraph (D)(2)(b) of this rule and repeat the distribution described in paragraph (E)(2) of this rule until all remaining funds for this pool are expended.

(v) For all hospitals, sum the amounts calculated in paragraph (E)(2)~~(h)~~(d) of this rule. This amount is the hospital's medicaid indigent 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)~~(12) of this rule and total uncompensated care costs under one hundred per cent defined in paragraph (A)~~(12)~~(13) of this rule. For hospitals with total negative disability assistance and uncompensated care costs, the resulting sum is equal to zero.

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

(c) For each hospital, calculate the ratio of the amount in paragraph (E)(3)(a) of the rule to the amount in paragraph (E)(3)(b) of this rule.

(d) For each hospital, multiply the ratio calculated in paragraph (E)(3)(c) of this rule by the amount allocated in paragraph (D)(2)(c) of this rule 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 (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)~~(31) 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 amount calculated in paragraphs (E)(1) and (E)(2) of this rule and the amount calculated in paragraph (E)(3)(d) of this rule is less than its hospital-specific disproportionate share limit defined in paragraph (A)~~(28)~~(31) 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)(d) of this rule and any amount provided by paragraph (E)(3)(d)(iv) of this rule.

(iii) If a hospital does not meet the condition described in paragraph (E)(3)(d)(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)(d) of this rule is greater than its hospital-specific disproportionate share limit defined in paragraph (A)~~(28)~~(31) 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.

(iv) If any hospital is limited as described in paragraph (E)(3)(d)(iii) of this rule, calculate each hospital's limited payment by subtracting the amount defined in paragraph (A)~~(28)~~(31) of this rule from the amount determined in paragraph (E)(3)(d) of this rule and sum these amounts for all limited hospital(s). Subtract the sum of the limited payments from the amount allocated in paragraph (D)(2)(c) of this rule and repeat the distribution described in paragraph (E)(3) of this rule until all funds for this pool are expended ~~or all unlimited hospitals have received one hundred per cent of the amount described in paragraph (E)(3)(a) of this rule~~.

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

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

~~(g) For all hospitals, sum the amounts calculated in paragraph (E)(3)(f) of this rule.~~

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

~~(i) Subtract the amount calculated in paragraph (E)(3)(e) of this rule from the amount allocated in paragraph (D)(2)(c) of this rule and add the amount allocated in paragraph (D)(2)(d) of this rule.~~

~~(j) For each hospital, multiply the ratio calculated in paragraph (E)(3)(h) of this rule by the amount calculated in paragraph (E)(3)(i) 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)(d) 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)(d) 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)(h) of this rule by the amount calculated in paragraph (E)(3)(i) of this rule and any amount provided by paragraph (E)(3)(j)(iv) 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)(d) 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)(d) of this rule.~~

~~(iv) If any hospital is limited as described in paragraph (E)(3)(j)(iii) of this rule, calculate each hospital's limited payment by subtracting the amount defined in paragraph (A)(28) of this rule from the amount determined in paragraph (E)(3)(j) of this rule and sum these amounts for all limited hospital(s). Subtract the sum of the limited payments from the amount calculated in paragraph (E)(3)(i) of this rule and repeat the distribution described in paragraph the distribution described in paragraphs (E)(3)(g) to (E)(3)(j) of this rule until all funds for this pool are expended.~~

~~(k)~~(e) For each hospital, sum the amount calculated in paragraph (E)(3)(d) of this rule~~, and the amount calculated in paragraph (E)(3)(j) 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 rural and critical access payment pools.

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

(1) Hospitals meeting the definition described in paragraph (A)~~(27)~~(30) 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~~remaining hospital-specific disproportionate share limit by subtracting the amounts calculated in paragraphs (E)(1), (E)(2)~~(a)~~ and (E)(3) of this rule from the amount described in paragraph (A)(31) of this rule.

(b) For each hospital with CAH certification:

(i) Calculate the ratio of each CAH hospital's ~~medicaid shortfall~~remaining hospital-specific disproportionate share limit as described in pargraph (F)(1)(a) of this rule to the total ~~medicaid shortfall~~ remaining hospital-specific disproportionate share limit for all CAH hospitals.

(ii) For each CAH hospital, multiply the ratio calculated in paragraph (F)(1)(b)(i) of this rule by ~~32.01~~38.81 per cent of the amount allocated in paragraph (D)(2)~~(e)~~(d) of this rule to determine each hospital's CAH payment amount.

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

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

(2) Hospitals meeting the definition described in paragraph (A)~~(26)~~(29) of this rule but do not meet the definition described in paragraph (A)~~(27)~~(30) 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 (F)(2) and (F)(1)(d) of this rule, sum the hospital's total payments allocated in paragraphs (E)(1)(b), (E)(2)~~(h)~~(d), and (E)(3)~~(k)~~(e) of this rule.

(b) For each hospital with RAH classification, as qualified by paragraphs (F)(2) and (F)(1)(d) of this rule subtract the amount calculated in

paragraph (F)(2)(a) of this rule, from the amount calculated in paragraph (A)~~(28)~~(31) 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 (F)(2) and (F)(1)(d) of this rule, sum the amounts calculated in paragraph (F)(2)(b) of this rule.

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

(e) Subtract the amount calculated in paragraph (F)(1)(c) of this rule from the amount allocated in paragraph (D)(2)~~(e)~~(d) of this rule.

(f) For each hospital with RAH classification, as qualified by paragraphs (F)(2) and (F)(1)(d) of this rule, multiply the ratio calculated in paragraph (F)(2)(d) of this rule, by the amount calculated in paragraph (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 (F)(1)(b) of this rule, and the amount calculated in paragraph (F)(2)(f) of this rule. This amount is the hospital's rural and critical access payment amount.

(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 (G)(1) to (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), (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 rules ~~5101:3-2-08~~5160-2-08 and ~~5101:3-2-08.1~~5160-2-08.1 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), (H), and (I) of this rule, less any amounts that would have been paid by the closed hospital under provisions of rules ~~5101:3-2-08~~5160-2-08 and ~~5101:3-2-08.1~~5160-2-08.1 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), (H), and (I), of this rule does not result in a net gain, nothing shall be redistributed under paragraphs (G)(2) and (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 (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)(f) of this rule~~ if the sum of a hospital's total payments calculated in paragraphs (E)(1), (E)(2), (E)(3), (F)(1), and (F)(2) of this rule does not exceed the hospital's disproportionate share limit defined in paragraph (A)~~(28)~~(31) of this rule.

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

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

If the sum of a hospital's payment amounts calculated in paragraphs (E)(1), (E)(2), (E)(3)(d), (F)(1), and (F)(2) of this rule is less than the hospital's disproportionate share limit defined in paragraph (A)~~(28)~~(31) of this rule, then the hospital's redistribution of closed hospital funds amount is equal to the amount in paragraph (G)(2)(d) of this rule, not to exceed the amount defined in paragraph (A)~~(28)~~(31) of this rule.

(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 (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)(f) of this rule if the sum of a hospital's total payments calculated in paragraphs (E)(1), (E)(2), (E)(3), (F)(1) and (F)(2) of this rule does not exceed the hospital's disproportionate share limit defined in paragraph (A)~~(28)~~(31) 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 (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 (G)(3)(a) and (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 (G)(3)(c) of this rule, by the amount calculated in paragraph (G)(1) of this rule, to determine each hospital's county redistribution of closed hospitals payment amount subject to the following limitation:

If the sum of a hospital's payment amounts calculated in paragraphs (E)(1), (E)(2), (E)(3)(d), (F)(1), and (F)(2) of this rule is less than the hospital-specific disproportionate share limit defined in paragraph (A)~~(28)~~(31) of this rule, the hospital's redistribution of closed hospital funds amount is the amount defined in paragraph (G)(3)(d) of this rule, not to exceed the amount defined in paragraph (A)~~(28)~~(31) of this rule.

(H) Distribution of funds through the children's hospital pool.

(1) For each hospital meeting the children's hospital definition described in paragraph (A)~~(29)~~(32) of this rule, sum the payment amounts as calculated in paragraphs (E), (F), and (G) of this rule. This is the hospital's calculated payment amount.

(2) For each hospital meeting the children's hospital definition described in paragraph (A)~~(29)~~(32) of this rule, with a calculated payment amount that is

not greater than the disproportionate share limit, as described in paragraph (A)~~(28)~~(31) of this rule, subtract the amount in paragraph (H)(1) of this rule from the amount in paragraph (A)~~(28)~~(31) of this rule.

(3) For hospitals meeting the children's hospital definition described in paragraph (A)~~(29)~~(32) of this rule, with calculated payment amounts that are not greater than the disproportionate share limit, as described in paragraph (A)(31) of this rule, sum the amounts calculated in paragraph (H)(2) of this rule.

(4) For each hospital meeting the children's hospital definition described in paragraph (A)~~(29)~~(32) of this rule, with a calculated payment amount that is not greater than the disproportionate share limit, as described in paragraph (A)(31) of this rule, determine the ratio of the amounts in paragraphs (H)(2) and (H)(3) of this rule.

(5) For each hospital meeting the children's hospital definition described in paragraph (A)~~(29)~~(32) of this rule, with a calculated payment that is not greater than the disproportionate share limit, as described in paragraph (A)(31) of this rule, multiply the ratio calculated in paragraph (H)(4) of this rule by the amount allocated in paragraph (D)(2)~~(f)~~(e) of this rule. This amount is the children's hospital payment pool payment amount, subject to the following limitation.

If the sum of the hospital's payment amounts calculated in paragraphs (E)(1), (E)(2), (E)(3)~~(d)~~, (F)(1), (F)(2), and (G) of this rule is less than the hospital's disproportionate share limit defined in paragraph (A)~~(28)~~(31) of this rule, then the hospital's children's hospital pool payment amount is equal to the amount calculated in paragraph (H)(5) of this rule, not to exceed the amount defined in paragraph (A)~~(28)~~(31) of this rule.

If any hospital is limited as described in paragraph (H)(5) of this rule, calculate each hospital's limited payment by subtracting the amount defined in paragraph (A)~~(28)~~(31) of this rule from the amount determined in paragraph (H)(5) of this rule and sum these amounts for all limited hospital(s). Subtract the sum of the limited payments from the amount in paragraph (D)(2)~~(f)~~(e) of this rule and repeat the distribution described in paragraph (H) of this rule until all funds for this pool are expended.

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

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

(2) For each hospital, calculate the hospital's specific disproportionate share limit as defined in paragraph (A)~~(28)~~(31) of this rule.

(3) For each hospital, subtract the hospital's disproportionate share limit as calculated in paragraph (I)(2) 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 (I)(2) of this rule, then the difference is the hospital's residual payment funds.

(4) 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 (I)(2) 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)(3) 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)(5) 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)~~(K)(4) minus the sum of the lessor of each hospital's calculated payment amount calculated in (I)(1) of this rule or the hospital's disproportionate share limit calculated in paragraph (I)(2) of this rule.

(5) Redistribution 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)(4) of this rule, subtract the amount in paragraph (I)(1) of this rule from the amount in paragraph (I)(2) of this rule.

(b) For hospitals with calculated payment amounts that are not greater than the disproportionate share limit, sum the amounts calculated in paragraph (I)(5)(a) of this rule.

(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 paragraphs (I)(5)(a) and (I)(5)(b) of this rule.

(d) For each hospital with a calculated payment amount that is not greater than the disproportionate share limit, multiply the ratio calculated in paragraph (I)(5)(c) of this rule by the total amount distributed through the statewide residual pool described in paragraph (I)(4)(b) of this rule. This amount is the hospital's statewide residual payment pool payment amount subject to the following limitation:

If the ~~amount~~ sum of the hospital's payment amounts calculated in paragraphs (E), (F), (G), and (H) of this rule is less than the amount of the hospital's disproportionate share limit defined in paragraph (A)~~(28)~~(31) of this rule, then hospital's residual pool payment amount is equal to the amount defined in paragraph (I)(5)(d) of this rule, not to exceed the amount defined in paragraph (A)~~(28)~~(31) of this rule.

(J) Disproportionate share adjustment.

(1) Determination of disproportionate share qualification.

(a) For each hospital, calculate the medicaid utilization rate as defined in paragraph (A)(23) of this rule.

(b) Each hospital with a medicaid utilization rate greater than or equal to one per cent and meets the obstetric services requirements as defined in paragraph (A)(36) of this rule qualifies as a disproportionate share hospital for the purposes of this rule.

(c) Each hospital with a medicaid utilization rate less than one per cent or does not meet the obstetric services requirements as defined in paragraph (A)(36) of this rule qualifies as a nondisproportionate share hospital for the purposes of this rule.

(2) Limitations on disproportionate share and indigent care payments made to hospitals.

(a) For each hospital, calculate medicaid fee for service (FFS) shortfall by subtracting from total medicaid FFS costs, as defined in paragraph (A)(1) of this rule, total medicaid FFS payments, as described in paragraph (A)(21) of this rule.

(b) For each hospital, calculate medicaid managed care plan (MCP) shortfall by subtracting from total medicaid MCP costs, as defined in paragraph (A)(24) of this rule, the total medicaid MCP payments, as described in paragraph (A)(27) of this rule.

(c) For each hospital, calculate the total medicaid shortfall by adding the medicaid FFS shortfall as defined in paragraph (J)(2)(a) of this rule to the medicaid MCP shortfall as defined in paragraph (J)(2)(b) of this rule.

(d) For each hospital, determine the total cost of uncompensated care for people without insurance by taking the sum of the amounts described in paragraphs (A)(6) and (A)(15) of this rule.

(e) For each hospital, determine the amount received under section 1011 - federal reimbursement of emergency health services furnished to undocumented aliens from the ODM 02930, schedule E, line 7b.

(f) For each hospital, calculate the hospital disproportionate share limit by adding the total medicaid shortfall as described in paragraph (J)(2)(c) of this rule and total uncompensated care costs for people without insurance as described in paragraph (J)(2)(d) of this rule and subtracting section 1011 payments as described in paragraph (J)(2)(e) of this rule.

(g) The hospital will receive the lesser of the disproportionate share limit as described in paragraph (J)(2)(f) of this rule or the sum of disproportionate share and indigent care payments as calculated in paragraphs (E) to (I) of this rule.

~~(J)~~(K) Payments and adjustments.

(1) Every hospital that must make payments of assessments and/or intergovernmental transfers to the department of ~~job and family services~~ medicaid under the provisions of rule ~~5101:3-2-08.1~~5160-2-08.1 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 (E) and (F) of rule ~~5101:3-2-08.1~~5160-2-08.1 of the Administrative Code, all payments of assessments and intergovernmental transfers, when applicable, from hospitals under rule ~~5101:3-2-08~~5160-2-08 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)~~(K)(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 of hospital as described under section ~~5112.01~~ 5168.01 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)~~(K)(2) of this rule and the hospital care assurance match fund described in paragraph ~~(J)~~(K)(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 rule ~~5101:3-2-08.1~~5160-2-08.1 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~~5160-2-07.17 of the Administrative Code; and

(d) The payment made to hospitals does not exceed the hospital's disproportionate share limit as calculated in paragraph ~~(D)~~(J)(2) of this 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; and

(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)~~(K)(6)(a) of this rule shall be made from the hospital care assurance program fund. Amounts recovered under paragraph ~~(J)~~(K)(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)~~(K)(6)(a) of this rule or the amount to be recovered from the hospital under paragraph ~~(J)~~(K)(6)(b) of this rule to the court of common pleas of Franklin county.

~~(K)~~(L) Confidentiality.

Except as specifically required by the provisions of this rule and rule ~~5101:3-2-24~~

5160-2-24 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~~ medicaid or by any person under contract with the department who has access to such information.

~~(L)~~(M) 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~~5160-2-23 of the Administrative Code on or before the dates specified in this rule and in rule ~~5101:3-2-23~~5160-2-23 of the Administrative Code shall be fined one 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~~medicaid on or before the dates specified in this rule or under any schedule for delayed payments established under paragraph ~~(J)~~(K)(1) of this rule shall be fined one thousand dollars for each day after the due date.

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

~~(M)~~(N) 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 rule ~~5101:3-2-08.1~~5160-2-08.1 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)~~(N)(2) of this rule.

(a) Beginning in the program year that ends in calendar year 2006, and each

year thereafter, each hospital shall submit its assessment amount to the Ohio department of ~~job and family services~~medicaid via electronic funds transfer.

(2) On or before the tenth day after the department's 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 rule ~~5101:3-2-08.1~~5160-2-08.1 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)~~(K)(7) of this rule.

Effective:

Five Year Review (FYR) Dates:

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Certification

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Date

Promulgated Under:	119.03
Statutory Authority:	5164.02, 5168.02
Rule Amplifies:	5162.03, 5164.02, 5164.70, 5168.01, 5168.02, 5168.03, 5168.04, 5168.05, 5168.06, 5168.07, 5168.08, 5168.09, 5168.10, 5168.11, 5168.12, 5168.13, 5168.14
Prior Effective Dates:	5/16/94 (Emer), 7/24/94, 3/10/95, 3/16/96, 8/7/96 (Emer), 10/21/96, 11/1/97, 8/6/98 (Emer), 9/18/98 (Emer), 8/5/99 (Emer), 9/15/99 (Emer), 8/16/00 (Emer), 9/28/00, 8/2/01, 7/22/02, 7/28/03, 7/1/04, 10/1/04, 7/22/05, 10/27/06 (Emer), 11/30/06, 8/3/08, 8/13/09, 12/25/10

5160-2-10 **Payment policies for disproportionate share and indigent care adjustments for psychiatric hospitals.**

This rule is applicable for each program year for all medicaid-participating psychiatric hospitals as described in paragraphs (B)~~, (C), (D), (E) and~~to (F) of rule ~~5101:3-2-01~~5160-2-01 of the Administrative Code.

(A) Definitions for each psychiatric hospital.

(1) "Inpatient days" ~~means for each psychiatric hospital~~ is the number of inpatient hospital days as reported ~~in JFS~~ on ODM 02930, for the applicable state fiscal year, schedule C, section I, column 4.

(2) "Insurance revenues" ~~are reported on JFS 02930, schedule F, section II, column 1, line 24 and mean for each psychiatric hospital~~ are the revenues received in the same twelve months of the hospital's cost-reporting period for inpatient services provided to, billed to, and received from all sources other than medicaid or self-pay revenues as described in paragraph (A)(4) of this rule. Each psychiatric hospital reports insurance revenues on ODM 02930, schedule F, section II, column 1.

(3) "Medicaid inpatient utilization rate" ~~means for each psychiatric hospital~~ is the ratio of the psychiatric hospital's number of inpatient days attributable to patients who were medicaid eligible ~~for medical assistance~~ as described in paragraph (A)(6) of this rule divided by the psychiatric hospital's total number of inpatient days as described in paragraph (A)(1) of this rule.

(4) "Self-pay revenues" ~~means for each psychiatric hospital~~ are the revenues received in the same twelve months of the hospital's cost-reporting period for inpatient services provided to, billed to, and received from either the person that received inpatient services or the family of the person that received inpatient services. ~~as reported~~ Each psychiatric hospital reports self-pay revenues on ~~JFS~~ ODM 02930, schedule F, section II, column 2~~, line 24~~.

(5) "Total inpatient allowable costs" ~~for each psychiatric hospital means~~ is the sum of the general service and capital related costs for inpatient hospital services. Each psychiatric hospital ~~reported~~ reports total inpatient allowable costs on ~~in JFS~~ ODM 02930 schedule B, column 7.

(6) "Total medicaid days" ~~for each psychiatric hospital means~~ is the sum of the amounts that each psychiatric hospital reports ~~reported on JFS~~ODM 02930,

schedule F, section II, columns 6 and 8~~, line 24~~. For hospitals meeting the conditions set forth in paragraphs (E) and (F) of rule ~~5101:3-2-01~~5160-2-01 of the Administrative Code, total medicaid days ~~means~~is the sum of the amounts reported on ~~JFS~~ ODM 02930, schedule F, section II, columns 6 to 8~~, line 24~~.

(7) "Total medicaid revenues" ~~for each psychiatric hospital means the amount reported on JFS 02930, schedule H, section I, column 1, line 7~~ are the revenues received in the same twelve months of the hospital's cost-reporting period for inpatient services provided to, billed to, and received from all sources other than insurance revenues as described in paragraph (A)(2) of this rule or self-pay revenues as described in paragraph (A)(4) of this rule. Each psychiatric hospital reports total medicaid revenues on ODM 02930, schedule H, section I, column 1.

(8) "Uncompensated care costs" ~~means for each psychiatric hospital~~ is the amount calculated by subtracting the sum of the total facility inpatient revenue as described in paragraph (A)(12) of this rule and the uncompensated care costs rendered to patients with insurance as described in paragraph (A)(9) of this rule from the total inpatient allowable costs as described in paragraph (A)(5) of this ~~rule less total facility revenue as described in paragraph (A)(12) of this rule less the uncompensated care costs rendered to patients with insurance for the services provided as described in paragraph (A)(9) of this~~ rule.

(9) "Uncompensated care costs rendered to patients with insurance" ~~means~~ is the costs for an individual that has insurance coverage for the service provided, but the full cost of the service was not reimbursed because of per diem caps or coverage limitations. ~~as reported on JFS~~Each psychiatric hospital reports uncompensated care costs rendered to patients with insurance on ODM 02930, schedule F, section II, column 5~~, line 24~~.

(10) "Charges for charity care" ~~means for each psychiatric hospital~~ is the total charges for inpatient services provided to indigent patients. ~~as reported on JFS 02930, schedule F, section II, column 3, line 24. It~~ which includes charges for services provided to individuals who do not possess health insurance for the service provided. ~~However, charity~~Charity care does not include bad debts, contractual allowances, or uncompensated care costs rendered to patients with insurance as described in paragraph (A)(9) of this rule. Each psychiatric hospital reports charges for charity care on ODM 02930, schedule F, section II, column 3.

(11) ~~Except for free-standing, state-owned psychiatric hospitals,~~ "Total charges for inpatient services" for each psychiatric hospital, except for free-standing, state-owned psychiatric hospitals, is ~~means for each psychiatric hospital~~ the

sum of the amounts reported for inpatient hospital services ~~in JFS~~ on ODM 02930, schedule B, column 6. For free-standing, state-owned psychiatric hospitals, "total charges for inpatient services" equals "total inpatient allowable costs" as defined in paragraph (A)(5) of this rule.

(12) "Total facility inpatient revenues" ~~means for each psychiatric hospital~~ is the sum of the hospital's insurance revenues as described in paragraph (A)(2) of this rule, self-pay revenues as described in paragraph (A)(4) of this rule, and total medicaid revenues as described in paragraph (A)(7) of this rule.

(13) "Cash subsidies for inpatient services received directly from state and local governments" ~~means for each psychiatric hospital~~ is the amount of cash subsidies each psychiatric hospital has received from state and local governments for inpatient services for the applicable state fiscal year. ~~as reported on JFS~~In accordance with paragraph (C) of this rule, each psychiatric hospital reports cash subsidies received from state and local government on ODM 02930, schedule F, section II, column 4.~~, line 24 and as reported by each hospital in accordance with paragraph (C) of this rule.~~

(B) Applicability.

The requirements of this rule are limited pursuant to section 1923 of the Social Security Act, 42 USC 1396r-4.

(C) Source data for calculations.

The calculations described in this rule will be based on cost-reporting data described in paragraph (B)(1) of rule ~~5101:3-2-08~~5160-2-08 of the Administrative Code.

(D) Determination of disproportionate share qualifications for psychiatric hospitals.

Psychiatric hospitals will be determined to be disproportionate share if based on data described in paragraph (C) of this rule, they meet either qualification described in paragraph (D)(1) or (D)(2) of this rule and meet the qualification in paragraph (D)(3) of this rule.

(1) The hospital's medicaid inpatient utilization rate, as described in paragraph (A)(3) of this rule, is at least one standard deviation above the mean medicaid inpatient utilization rate for all hospitals receiving medicaid payments in the state; or

(2) ~~A~~The hospital's low-income utilization rate ~~in excess of~~ exceeds twenty-five per

cent.~~, where the~~ The low-income utilization rate, which is a ~~the~~ fraction expressed as a percentage, is the sum of:

(a) The sum of total medicaid revenues for inpatient services as described in paragraph (A)(7) of this rule~~, for inpatient services~~ and cash subsidies for inpatient services received directly from state and local governments as described in paragraph (A)(13) of this rule, divided by the sum of total facility inpatient revenues as described in paragraph (A)(12) of this rule~~,~~ and cash subsidies for inpatient services received directly from state and local governments as described in paragraph (A)(13) of this rule, plus

(b) Total charges for inpatient services for charity care as described in paragraph (A)(10) of this rule (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, as described in paragraph (A)(11) of this rule.

(3) A medicaid inpatient utilization rate as described in paragraph (A)(3) of this rule greater than or equal to one per cent.

(E) Determination of psychiatric hospital disproportionate share groupings for payment distribution.

Hospitals determined to qualify for~~be~~ disproportionate share as described in paragraph (D) of this rule will be classified into one of three tiers based on data described in paragraph (C) of this rule. The groupings for payment distribution are described in paragraphs (E)(1) to (E)(3) of this rule.

(1) Tier one includes hospitals that meet the criteria in either paragraph (E)(1)(a) or (E)(1)(b) of this rule.

(a) Hospitals deemed to be disproportionate share hospitals based on a low-income utilization rate as described in paragraph (D)(2) of this rule greater than twenty-five per cent but less than forty per cent.

(b) Hospitals with a low-income utilization rate as described in paragraph (D)(2) of this rule less than or equal to twenty-five per cent that are deemed a disproportionate share hospital based on a medicaid inpatient utilization rate as described in paragraph (D)(1) of this rule.

(2) Tier two includes all hospitals deemed to be disproportionate share hospitals based on a low-income utilization rate as described in paragraph (D)(2) of

this rule greater than or equal to forty per cent but less than fifty per cent.

(3) Tier three includes all hospitals deemed to be disproportionate share hospitals based on a low-income utilization rate as described in paragraph (D)(2) of this rule greater than or equal to fifty per cent.

(F) Distribution of funds within each hospital tier.

The funds available to each psychiatric hospital tier as described in paragraph (E) of this rule are distributed among the hospitals in each tier based on data described in paragraph (C) of this rule and according to the payment formulas described in paragraphs (F)(1) to (F)(3) of this rule.

(1) A maximum of ten per cent of the disproportionate share funds available to psychiatric hospitals as described in paragraph (H) of this rule will be distributed to the hospitals in tier one as described in paragraph (E)(1) of this rule according to the process described in paragraphs (F)(1)(a) to (F)(1)(f) of this rule.

(a) For each hospital in tier one, calculate the uncompensated care costs as described in paragraph (A)(8) of this rule.

(b) For all hospitals in tier one, sum all hospitals' uncompensated care costs as described in paragraph (A)(8) of this rule.

(c) For each hospital in tier one, calculate the ratio of the amount described in paragraph (F)(1)(a) of this rule to the amount described in paragraph (F)(1)(b) of this rule.

(d) Multiply the ratio for each hospital calculated in paragraph (F)(1)(c) of this rule in tier one by the amount in paragraph (F)(1) of this rule to determine each hospital's disproportionate share payment amount.

(e) Each hospital will be distributed a payment amount based on the lesser of:

(i) Uncompensated care costs as determined in paragraph (A)(8) of this rule; or

(ii) The hospital's disproportionate share payment as determined in paragraph (F)(1)(d) of this rule.

(f) 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 three and be distributed in accordance with the process described in paragraphs (F)(3)(a) to (F)(3)(e) of this rule.

(2) A maximum of thirty per cent of the disproportionate share funds available to psychiatric hospitals as described in paragraph (H) of this rule will be distributed to the hospitals in tier two as described in paragraph (E)(2) of this rule according to the process described in paragraphs (F)(2)(a) to (F)(2)(f) of this rule.

(a) For each hospital in tier two, calculate the uncompensated care costs as described in paragraph (A)(8) of this rule.

(b) For all hospitals in tier two, sum all hospitals' uncompensated care costs as described in paragraph (A)(8) of this rule.

(c) For each hospital in tier two, calculate the ratio of the amount described in paragraph (F)(2)(a) of this rule to the amount described in paragraph (F)(2)(b) of this rule.

(d) Multiply the ratio for each hospital calculated in paragraph (F)(2)(c) of this rule in tier two by the amount in paragraph (F)(2) of this rule to determine each hospital's disproportionate share payment amount.

(e) Each hospital will be distributed a payment amount based on the lesser of:

(i) Uncompensated care costs as determined in paragraph (A)(8) of this rule; or

(ii) The hospital's disproportionate share payment as determined in paragraph (F)(2)(d) of this rule.

(f) 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 three and be distributed in accordance with the process described in paragraphs (F)(3)(a) to (F)(3)(e) of this rule.

(3) A minimum of sixty per cent of the disproportionate share funds available to psychiatric hospitals as described in paragraph (H) of this rule will be distributed to the hospitals in tier three as described in paragraph (E)(3) of

this rule according to the process described in paragraphs (F)(3)(a) to (F)(3)(e) of this rule.

(a) For each hospital in tier three, calculate the uncompensated care costs as described in paragraph (A)(8) of this rule.

(b) For all hospitals in tier three, sum all hospitals uncompensated care costs as described in paragraph (A)(8) of this rule.

(c) For each hospital in tier three, calculate the ratio of the amount described in paragraph (F)(3)(a) of this rule to the amount described in paragraph (F)(3)(b) of this rule.

(d) Multiply the ratio for each hospital calculated in paragraph (F)(3)(c) of this rule in tier three by the amount in paragraph (F)(3) of this rule to determine each hospital's disproportionate share payment amount.

(e) Each hospital will be distributed a payment amount based on the lesser of:

(i) Uncompensated care costs as determined in paragraph (A)(8) of this rule; or

(ii) The hospital's disproportionate share payment as determined in paragraph (F)(3)(d) of this rule.

(G) Payments.

The department shall make payment in accordance with paragraphs (E) and (F) of this rule~~, for~~ to hospitals that are eligible to participate in the medicaid program only for the provision of inpatient psychiatric services as described in rule ~~5101:3-2-01~~5160-2-01 of the Administrative Code and that also meet the ~~criteria~~disproportionate share criteria described in paragraph (D) of this rule.

(H) 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~~5160-2-09 of the Administrative Code from the state's disproportionate share limit payment allotment determined by the United States centers for medicare and medicaid services (CMS) for that program year.

Effective:

Five Year Review (FYR) Dates:

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Certification

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Date

Promulgated Under:	119.03
Statutory Authority:	5164.02, 5168.02
Rule Amplifies:	5162.03, 5164.02, 5164.70, 5168.01, 5168.02, 5168.13
Prior Effective Dates:	8/12/95, 6/1/96 (Emer), 9/25/96 (Emer), 12/5/96, 12/6/97, 9/10/98, 9/26/99, 9/28/00, 9/27/01, 7/22/02, 7/28/03, 7/1/04, 7/22/05 , 9/15/06