CSI - Ohio

The Common Sense Initiative

Business Impact Analysis

Agency Name: Department of Medicaid

Regulation/Package Title: BHPP Hospital Disproportionate Share Hospital

Rule Number(s): 5160-2-09

Date: 6/19/18

Rule Type:

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- ☐ Rescinded

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

Regulatory Intent

1. **Please briefly describe the draft regulation in plain language.**

   Rule 5160-2-09 of the Ohio Administrative Code sets forth the conditions, requirements, and operation of the Hospital Care Assurance Program (HCAP) as well as the distribution formula and payment policies for disproportionate share hospitals (DSH). The proposed amendment updates the Ohio Administrative Code (OAC), removes the term Rural Access Hospital and replaces it with the term Rural Hospital and updates the references to "RAH" within the rule to "RH" Additional proposed amendments include: (1)

references to the Disability Assistance (DA) program throughout the rule have been removed since the DA program is no longer in existence, (2) the definition of Total Inpatient Disability Assistance Medical Costs in paragraph (A)(5) have been removed, (3) the definition of Total Outpatient Disability Assistance Medical Costs in paragraph (A)(9) have been removed, (4) updating the reference to line number 202 from 201 on Schedule I of the cost report, and (5) the definition of Total Disability Assistance Medical Costs in paragraph (A)(12) have been removed. Additional proposed amendments include references to the percentage of HCAP funds that were distributed from the Medicaid indigent care pool for the 2016 program year were removed from paragraph (D)(2)(b), references to the percentage of HCAP funds that were distributed from the uncompensated care pool for the program year 2016 were removed from paragraph (D)(2)(c), and references to transplant in paragraph (A)(18) were removed since transplant services are no longer reimbursed by costs and therefore the payment does not need to be calculated separately. Furthermore, the proposed amendments update paragraph references to the rule and establishes a definition of a Rural Hospital as being a hospital that is geographically located in an Ohio county, that is not classified into a Core Based Statistical Area (CBSA) as designated in the inpatient prospective payment system (IPPS) case-mix and wage index table as published by the Centers for Medicare and Medicaid Services (CMS).

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

   5168.02, 5168.06 and 5168.09

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 but do not go beyond the federal requirements.

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 the distribution of approximately $654 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.**
If applicable, please include the date and medium by which the stakeholders were initially contacted.

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 March 8, 2018, the Department met with OHA during our monthly policy meeting to discuss the Department's proposal to amend the definition of a rural hospital as it pertains to HCAP. The Department proposes to establish a definition that a hospital is considered rural if the hospital is geographically located in an Ohio county which is not classified into a Core Based Statistical Area (CBSA).

On March 9, 2018 OHA sent an email informing the Department that they are in agreement that the definition of a rural hospital should be amended in order to maintain the distribution of the rural pool to those hospitals it was originally designed to benefit, which are smaller, rural hospitals that serve underserved populations, as compared to their similarly sized peers.

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 Ohio Medicaid Hospital Cost Report (ODM 02930) is 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?**

Section 5168.02 of the Revised Code requires the Department to adopt administrative rules to administer the DSH program. Additionally, section 5168.09 of the Revised Code requires the

Department to establish a methodology to pay hospitals that is sufficient to distribute all money allocated for the current DSH program.

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, the Department did not specifically consider a performance-based regulation. These rules were developed to comply with the requirements of Section 5168.02, 5168.06 and 5168.09 of the Revised Code. This is a federally mandated program.

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 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 financial model used to determine the distribution amounts to Ohio hospitals is examined in great detail for accuracy by the Department and OHA. In accordance with Sections 5168.02 and 5168.06 of the Revised Code, the Department may consult with hospitals in order to minimize cash flow difficulties hospitals may encounter with regards to paying their HCAP assessments on time, thereby providing consistency and predictably to hospitals in regards to their cash flow needs.

OHA, with assistance from ODM, presents a preliminary model at their annual conference in June of each year. This presentation provides hospitals the opportunity to find out, in advance of the operation of the program, the amount of funds from each payment pool that will be distributed for the current program year.

Adverse Impact to Business

14. Provide a summary of the estimated cost of compliance with the rule. Specifically, please do the following:

a. Identify the scope of the impacted business community;
All Ohio hospitals that are Medicaid providers.

b. Identify the nature of the adverse impact (e.g., license fees, fines, employer time for compliance); and
A penalty of $1,000 a day is imposed on all hospitals that do not report to the Department the charges and payments for services rendered during their hospital

fiscal year by the specified due date. A penalty of $1,000 a day is also imposed on all hospitals that do not pay the HCAP assessment on or before the specified dates. This rule also requires a Critical Access Hospital (CAH) to report to the Department every October 1st of the program year their certification as a CAH in order to be considered a CAH for disproportionate share payment purposes, or any change in their CAH status.

c. Quantify the expected adverse impact from the regulation.
The adverse impact can be quantified in terms of dollars, hours to comply, or other factors; and may be estimated for the entire regulated population or for a "representative business." Please include the source for your information/estimated impact.

A penalty of $1,000 per day will be imposed upon hospitals that either do not report the required information on time or do not pay their assessments by the assigned due date. Additionally, if a CAH does not report to the Department each October 1st of the program year their certification or any change in their CAH status, they will lose their consideration as a CAH for disproportionate share payment purposes. We anticipate that hospitals will comply with the assessment due dates and thus will not be subject to any penalties. We also anticipate hospitals designated as a CAH will notify the Department by the required date in order to keep their CAH status for disproportionate share payment purposes.

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

These regulations will provide approximately $654 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.

Although compliance is required by sections 5168.01 to 5168.09 of the Revised Code, sections 5168.02 and 5168.06 of the Revised Code gives the Director the flexibility to establish an alternate schedule for hospitals to pay their HCAP assessment in order to reduce the hospitals' cash flow difficulties. This rule allows the Department to waive any penalties if good cause is shown by the hospital.

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.

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 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 reported on ODM 02930, schedule H, section I, columns 1 and 3, line 1 and outpatient medicaid program costs as reported on ODM 02930, "Ohio Medicaid Hospital Cost Report," 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 ODM 02930 schedule I, column 3, line ~~201~~202.

(3) "Total medicaid MCP outpatient costs" for each hospital means the amount on ODM 02930 schedule I, column 5, line ~~201~~202.

(4) "Total Title V costs" for each hospital means the sum of the inpatient and outpatient program costs as reported on 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 on the ODM 02930, schedule F, columns 4 and 5.~~

~~(6)~~(5) "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.

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

~~(8)~~(7) "Total inpatient uncompensated care costs above one hundred per cent without insurance" for each hospital means the sum of the inpatient uncompensated care

costs over one hundred per cent for patients without insurance as reported on the ODM 02930, schedule F, column 5.

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

~~(10)~~(8) "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 on the ODM 02930, schedule F, columns 4 and 5.

~~(11)~~(9) "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 on the ODM 02930, schedule F, column 5.

~~(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)(9) of this rule.~~

~~(13)~~(10) "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)~~(7)~~(6) of this rule, and total outpatient uncompensated care costs under one hundred per cent as described in paragraph (A)~~(10)~~(8) of this rule.

~~(14)~~(11) "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)~~(8)~~(7) of this rule, and total outpatient uncompensated care costs above one hundred per cent without insurance as described in paragraph (A)~~(11)~~(9) of this rule.

~~(15)~~(12) "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 poverty level as represented on the ODM 02930, schedule F.

~~(16)~~(13) "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)~~(5) of this rule and the total outpatient uncompensated care costs for people without insurance in paragraph (A)~~(15)~~(12) of this rule.

~~(17)~~(14) "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~~.

~~(18)~~(15) ~~"~~ "MCP days" mean for each hospital, the amount on the ODM 02930, schedule I, column 2, line 204.

~~(19)~~(16) "Total medicaid days" for each hospital means the sum of total medicaid FFS days as defined in paragraph (A)~~(17)~~(14) of this rule and MCP days as defined in (A)~~(18)~~(15) of this rule.

~~(20)~~(17) "High federal disproportionate share hospital" means a hospital with a ratio of total medicaid days as defined in paragraph (A)~~(19)~~(16) of this rule to total facility days as defined in paragraph (A)~~(22)~~(19) of this rule greater than the statewide mean ratio of the sum of total medicaid days to the sum of total facility days plus one standard deviation.

~~(21)~~(18) "Total medicaid 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 ODM 02930, schedule H, column 1, lines 7, 15, and 26~~, and column 3, lines 7 and 26~~.

~~(22)~~(19) "Total facility days" means for each hospital the amount reported on the ODM 02930, schedule C, column 4, line 49.

~~(23)~~(20) "Medicaid utilization rate" for each hospital means the rate calculated by dividing the sum of total medicaid days as defined in paragraph (A)~~(19)~~(16) of this rule by the total facility days as defined in paragraph (A)~~(22)~~(19) of this rule.

~~(24)~~(21) "Total medicaid MCP costs" for each hospital means the actual cost to the hospital of care rendered to medical assistance recipients enrolled in a MCP that has entered into a contract with the department of medicaid and is the amount on ODM 02930, schedule I, column 3, line 202 and column 5, line 202.

~~(25)~~(22) "Medicaid MCP inpatient payments" for each hospital means the amount on ODM 02930 schedule I, column 2, line 208.

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

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

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

~~(29)~~(26) "Rural ~~Access~~ Hospital ~~(RAH)~~(RH)" means~~means~~ a hospital geographically located in an Ohio county that is not ~~that is~~ classified ~~as~~ into a core based statistical area (CBSA) as designated in the inpatient prospective payment system (IPPS) case-mix and wage index table as published October 1 of each program year ~~rural hospital~~ by the centers for medicare and medicaid services (CMS).

~~(30)~~(27) "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 medicaid of such certification. ~~Beginning in the program year that ends in calendar year 2004, the~~ The Ohio department of 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 medicaid of any change in their critical access hospital status, including continued CAH designations, immediately following notification from CMS.

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

~~(32)~~(29) "Children's hospitals" are those hospitals that meet the definition in paragraph (A)~~(2)~~(3) of rule ~~5160-2-07.2~~5160-2-05 of the Administrative Code.

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

~~(34)~~(31) "Outpatient upper limit payment" for each hospital means the amount reported on ODM 02930, schedule H, section II, column 1, line 14.

~~(35)~~(32) "Total program amount" means the sum of the amounts in paragraphs (K)(2) and (K)(3) of this rule.

~~(36)~~(33) "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 (B) of rule 5160-2-08 of the Administrative Code. For rural hospitals as defined in paragraph (A)~~(29)~~(26) of this rule, this requirement includes any physician with staff privileges at the hospital to perform non-emergency obstetric procedures. This requirement shall not apply to a hospital whose inpatients are predominantly individuals under eighteen years of age or a hospital which did not offer non-emergency obstetric 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 5168.06 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 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 5160-2-08 of the Administrative Code.

(2) For new hospitals, the first available cost report filed with the department in accordance with rule 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 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 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 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 assessment deposited into the health care services administration fund described in rule 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 the transfer deposited into the health care services administration fund described in rule 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 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)(e) of this rule.

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

(b) Medicaid indigent care pool: ~~72.01 per cent for program year 2016, and~~ 77.26 per cent ~~for program year 2017 and each year thereafter~~.

(c) ~~Disability assistance medical and uncompensated~~ Uncompensated care pool below one hundred per cent of poverty: ~~5.25 per cent for program year 2016, and~~ zero per cent ~~for program year 2017 and each year thereafter~~.

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

(e) Children's hospitals: 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)~~(20)~~(17) 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)~~(31)~~(28) of this rule, the hospital's high federal disproportionate share hospital payment is the amount defined in paragraph (A)~~(31)~~(28).

(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)~~(31)~~(28) 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)~~(31)~~(28) 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)~~(28) of this rule, calculate each hospital's limited payment by subtracting the amount defined in paragraph

(A)~~(31)~~(28) 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)~~(28) of this rule.

(b) For all hospitals, sum the amounts calculated in paragraph (E)(2)(a) of this rule.

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

(d) For each hospital, multiply the ratio calculated in paragraph (E)(2)(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)~~(31)~~(28) 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)(d) of this rule is less than its hospital-specific disproportionate share limit defined in paragraph (A)~~(31)~~(28) of this rule, then the payment is equal to the amount in paragraph (E)(2)(d) of this rule and any amount provided by paragraph (E)(2)(d)(iv) of this rule.

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

(A)~~(31)~~(28) 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)(d)(iii) of this rule, calculate each hospital's limited payment by subtracting the amount defined in paragraph (A)~~(31)~~(28) of this rule from the amount determined in paragraph (E)(2)(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)(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)(12) of this rule and~~ total inpatient uncompensated care costs under one hundred per cent defined in paragraph (A)~~(13)~~(6) of this rule and total outpatient uncompensated care costs under one hundred per cent defined in paragraph (A)(8) 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)~~(31)~~(28) of this rule, the hospital's ~~disability assistance medical~~

~~and~~ uncompensated care under one hundred per cent payment amount is equal to zero.

(ii) If the sum of a hospital's payment 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)~~(31)~~(28) of this rule, the hospital's ~~disability medical and~~ uncompensated care under one hundred per cent payment amount is equal to the amount calculated in paragraph (E)(3)(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)~~(31)~~(28) of this rule, the hospital's ~~disability medical and~~ uncompensated care under one hundred per cent payment amount is equal to the difference between the hospital's disproportionate share limit and the sum of the payment amounts calculated in paragraphs (E)(1) and (E)(2) of this rule.

(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)~~(31)~~(28) 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.

(e) For each hospital, sum the amount calculated in paragraph (E)(3)(d) 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)~~(30)~~(27) of this rule, shall receive funds from the critical access hospital (CAH) payment pool.

(a) For each hospital with CAH certification, calculate the remaining hospital-specific disproportionate share limit by subtracting the amounts calculated in paragraphs (E)(1), (E)(2) and (E)(3) of this rule from the amount described in paragraph (A)~~(31)~~(28) of this rule.

(b) For each hospital with CAH certification:

(i) Calculate the ratio of each CAH hospital's remaining hospital-specific disproportionate share limit as described in paragraph (F)(1)(a) of this rule to the total 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 38.81 per cent of the amount allocated in paragraph (D)(2)(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~~ RH payment pool described in paragraph (F)(2)(a) of this rule.

(2) Hospitals meeting the definition described in paragraph (A)~~(29)~~(26) of this rule but do not meet the definition described in paragraph (A)~~(30)~~(27) of this rule, shall receive funds from the rural ~~access~~ hospital ~~RAH~~ RH payment pool.

(a) For each hospital with ~~RAH~~ RH 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)(d), and (E)(3)(e) of this rule.

(b) For each hospital with ~~RAH~~ RH 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)~~(31)~~(28) of this rule. If this difference for the hospital is negative, then for the purpose of this calculation set the difference equal to zero.

(c) For all hospitals with ~~RAH~~ RH 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~~ RH 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)(d) of this rule.

(f) For each hospital with ~~RAH~~ RH 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 5160-2-08 and 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 5160-2-08 and 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, 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)~~(31)~~(28) 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), (F)(1), and (F)(2) of this rule is less than the hospital's disproportionate share limit defined in paragraph (A)~~(31)~~(28) 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)~~(31)~~(28) 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, 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)~~(31)~~(28) 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), (F)(1), and (F)(2) of this rule is less than the hospital-specific disproportionate share limit defined in paragraph (A)~~(31)~~(28) 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)~~(31)~~(28) 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)~~(32)~~(29) 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)~~(32)~~(29) of this rule, with a calculated payment amount that is not greater than the disproportionate share limit, as described in paragraph (A)~~(31)~~(28) of this rule, subtract the amount in paragraph (H)(1) of this rule from the disproportionate share limit, as described in paragraph (A)~~(31)~~(28) of this rule.

(3) For hospitals meeting the children's hospital definition described in paragraph (A)~~(32)~~(29) of this rule, with calculated payment amounts that are not greater than the disproportionate share limit, as described in paragraph (A)~~(31)~~(28) 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)~~(32)~~(29) of this rule, with a calculated payment amount that is not greater than the disproportionate share limit, as described in paragraph (A)~~(31)~~(28) 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)~~(32)~~(29) of this rule, with a calculated payment that is not greater than the disproportionate share limit, as described in paragraph (A)~~(31)~~(28) of this rule,

multiply the ratio calculated in paragraph (H)(4) of this rule by the amount allocated in paragraph (D)(2)(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), (F)(1), (F)(2), and (G) of this rule is less than the hospital's disproportionate share limit defined in paragraph (A)~~(31)~~(28) 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)~~(31)~~(28) 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)~~(31)~~(28) 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)(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)~~(31)~~(28) 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 (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 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)~~(31)~~(28) 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)~~(31)~~(28) 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)~~(20) 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)~~(33) 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)~~(33) 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)~~(18) of this rule.

(b) For each hospital, calculate medicaid MCP shortfall by subtracting from total medicaid MCP costs, as defined in paragraph (A)~~(24)~~(21) of this rule, the total medicaid MCP payments, as described in paragraph (A)~~(27)~~(24) 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)~~(5) and (A)~~(15)~~(12) 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.

(K) Payments and adjustments.

(1) Every hospital that must make payments of assessments and/or intergovernmental transfers to the department of medicaid under the provisions of rule 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 5160-2-08.1 of the Administrative Code, all payments of assessments and intergovernmental transfers, when applicable, from hospitals under rule 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 (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 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 (K)(2) of this rule and the hospital care assurance match fund described in paragraph (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 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 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 (J)(2) of this rule.

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

(L) Confidentiality.

Except as specifically required by the provisions of this rule and rule 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 medicaid or by any person under contract with the department who has access to such information.

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

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

(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 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 (N)(2) of this rule.

Each hospital shall submit its assessment amount to the Ohio department of medicaid via EFT.

~~(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 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 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 (K)(7) of this rule.

Effective:

Five Year Review (FYR) Dates: 1/1/2022

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Certification

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Date

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