Common Sense Initiative

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Business Impact Analysis

Agency, Board, or Commission Name: Ohio Department of Medicaid

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Regulation/Package Title (a general description of the rules' substantive content):

Data and Payment Policies for Disproportionate Share and Indigent Care Adjustments for Hospital Services

Rule Number(s):
Subject to Business Impact Analysis: 5160-2-08.1 rescind/new and 5160-2-09 rescind/new
Not Subject to Business Impact Analysis, For Information Only: 5160-2-08 rescind/new

Date of Submission for CSI Review: 4/19/2024

Public Comment Period End Date: 4/26/2024

Rule Type/Number of Rules:

New/ 2 **rules**
Amended/____ **rules (FYR?** ___**)**
No Change/____ **rules (FYR?** ___**)**
Rescinded/ 2 **rules (FYR?** yes**)**

The Common Sense Initiative is established in R.C. 107.61 to eliminate excessive and duplicative rules and regulations that stand in the way of job creation. Under the Common Sense Initiative, agencies must balance the critical objectives of regulations that have an adverse impact on business with the costs of compliance by the regulated parties. Agencies should promote transparency, responsiveness, predictability, and flexibility while developing regulations that are fair and easy to follow. Agencies should prioritize compliance over punishment, and to that end, should utilize plain language in the development of regulations.

Reason for Submission

1. **R.C. 106.03 and 106.031 require agencies, when reviewing a rule, to determine whether the rule has an adverse impact on businesses as defined by R.C. 107.52. If the agency determines that it does, it must complete a business impact analysis and submit the rule for CSI review.**

   Which adverse impact(s) to businesses has the agency determined the rule(s) create?

   The rule(s):

   a. ☐ **Requires a license, permit, or any other prior authorization to engage in or operate a line of business.**
   b. ☒ **Imposes a criminal penalty, a civil penalty, or another sanction, or creates a cause of action for failure to comply with its terms.**
   c. ☒ **Requires specific expenditures or the report of information as a condition of compliance.**
   d. ☐ **Is likely to directly reduce the revenue or increase the expenses of the lines of business to which it will apply or applies.**

Regulatory Intent

2. **Please briefly describe the draft regulation in plain language.**
   Please include the key provisions of the regulation as well as any proposed amendments.

   Federal regulations in Section 1923 of the Social Security Act require that each state have a Disproportionate Share Hospital (DSH) program to recognize and make payments to qualifying hospitals that offset the cost of Medicaid Shortfall and the cost of care to the uninsured. While Section 1923 requires a DSH program and provides guidance, it does not specify a complete operational methodology. In partnership with the stakeholders, the Ohio Hospital Association (OHA), the Ohio Department of Medicaid (ODM) has developed a DSH program and distribution methodology. ODM has chosen to call our DSH program for acute care hospitals the Hospital Care Assurance Program (HCAP). Throughout this document, when responding to questions that refer to the federal regulations, ODM has used the term "Disproportionate Share Hospital" or "DSH", and when responding to questions about the OAC rules in this BIA, ODM has used the term "Hospital Care Assurance Program" or "HCAP."

   OAC rule 5160-2-08.1, entitled **Assessment rates**, is being proposed for rescission as part of the five-year rule review process. This rule sets forth the assessment rate for HCAP. The provisions of this rule are being incorporated in the new OAC rule 5160-2-08.1.

   OAC rule 5160-2-08.1, entitled **Assessment rates**, is being proposed for adoption to replace the rescinded rule of the same number. Amendments in the new rule include alphabetizing the definitions in paragraph (B), removing the certified mail requirement and replacing it

with language related to electronic mail (e-mail), as well as removing regulatory restrictions and updating language and citations as part of the five-year agency rule review process.

OAC rule 5160-2-09 entitled, **Payment policies for disproportionate share and indigent care adjustments for hospital services**, is being proposed for rescission due to extensive revision and reorganization of the rule body and as part of the five-year rule review process. This rule sets forth the conditions, requirements, and operation of HCAP as well as the distribution formula. The provisions of this rule are being incorporated in the new OAC rule 5160-2-09.

OAC rule 5160-2-09 entitled, **Payment policies for disproportionate share and indigent care adjustments for hospital services**, is being proposed for adoption to replace the rescinded rule of the same number. Amendments in the new rule include alphabetizing the definitions in paragraph (A), removing the certified mail requirement and replacing it with language related to electronic mail (e-mail), removing language related to inpatient and outpatient upper limit payments, rewording language in paragraph (K) to be clearer and more concise, as well as removing regulatory restrictions and updating language and citations as part of the five-year agency rule review process.

3. **Please list the Ohio statute(s) that authorize the agency, board or commission to adopt the rule(s) and the statute(s) that amplify that authority.**

   Authorizing: 5168.02, 5168.06
   Amplifying: 5168.01, 5168.02, 5168.03, 5168.04, 5168.05, 5168.06, 5168.07, 5168.08, 5168.09, 5168.10, 5168.11, 5168.13, 5168.99, 5168.991

4. **Does the regulation implement a federal requirement? Is the proposed regulation being adopted or amended to enable the state to obtain or maintain approval to administer and enforce a federal law or to participate in a federal program?**
   If yes, please briefly explain the source and substance of the federal requirement.

   Yes, this regulation implements a federal requirement and allows the state to participate in a federal program. As the state Medicaid agency, ODM is required by Section 1923 of the Social Security Act to implement DSH payments to help offset the cost of Medicaid shortfall and the cost of care to the uninsured population that is incurred by hospitals.

5. **If the regulation implements a federal requirement, but 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 HCAP program without exceeding the federal requirement.

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

   The public purpose of these regulations is to provide hospitals with additional funds to offset the cost of Medicaid shortfall and the cost of care to the uninsured. Due to a program size of approximately $750 million and requirements in Section 1923 of the Social Security Act, it is imperative that ODM have a structured and auditable program enshrined in OAC.

7. **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 federally mandated distribution of $750 million to hospitals in SFY 2023. The distributed amount is used to offset the Medicaid shortfall and the cost of care to the uninsured.

8. **Are any of the proposed rules contained in this rule package being submitted pursuant to R.C. 101.352, 101.353, 106.032, 121.93, or 121.931?**
   If yes, please specify the rule number(s), the specific R.C. section requiring this submission, and a detailed explanation.

   No

Development of the Regulation

9. **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.

   OHA took part in the development of these regulations. OHA submitted to ODM its recommendations for updates for the 2023 program year. This rule package, as drafted, implements OHA's recommendations.

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

    On August 2, 2023, OHA submitted a proposal to ODM to codify OHA's participation in OAC 5160-2-08 paragraph (D) and waive the administrative fee, as necessary, in OAC 5160-2-08 paragraph (D)(2). In addition, OHA advised that they are agreeable to revising language from OAC 5160-2-08.1 paragraph (G)(1) to remove the certified mail requirement when sending notification assessments to hospitals due to the advantages and ubiquity of electronic mail (email).

    On August 3, 2023, ODM accepted the proposal to remove the certified mail requirement. ODM decided not to codify OHA's participation in the OAC, because OHA's participation is being incorporated in a separate policy outside of the rulemaking process. ODM also decided to retain the previously existing language related to waiving administrative fees. The administrative fee is needed to encourage prompt compliance with program timelines in order to prevent compliant hospitals from waiting for these critically needed program funds.

11. 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 ODM on the Hospital Cost Report (ODM 02930) is used to develop the assessment rates and to measure hospitals' reported cost levels for their uncompensated care cost burden in relation to all other hospitals' uncompensated care costs.

12. 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? ***Alternative regulations may include performance-based regulations, which define the required outcome, but do not dictate the process the regulated stakeholders must use to comply.***

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. Alternative regulations were not considered due to requirements in Section 1923 of the Social Security Act that warrant a structured and auditable program to be enshrined in OAC.

13. 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 HCAP program and were reviewed by the Bureau of Health Plan Policy, ODM and ODM Legal Services to ensure that duplication does not exist and that none of the regulations in these rules are already codified elsewhere.

14. 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.

As described in OAC rule 5160-2-08.1, ODM assesses all acute care hospitals in Ohio. The assessment is designed to be two tiered, assessing a fixed rate on hospital costs up to a set threshold and then a separate rate for those costs above the threshold, thereby making the implementation of the assessment consistent and predictable for all hospitals. In addition, the financial model used to determine the assessment rates is examined in 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.

OAC rule 5160-2-09 distributes the HCAP funds to hospitals. The distribution is comprised of several policy pools that are each designed to distribute a portion of the total available HCAP funds using a specific measure, such as Medicaid shortfall, to calculate the distribution of that policy pool. The amount distributed from each policy pool to a specific hospital is based on a hospital's proportion of the specific measure for that policy pool compared to the statewide total for the policy pool. Due to the proportional relationship in each policy pool, a single hospital cannot fully predict the outcome because it does not have all the statewide data available to complete the calculations. Recognizing this fact, ODM and OHA jointly publish preliminary distribution models several times during the program year,

thus allowing hospitals to get a sense of total HCAP distribution that will be awarded to each hospital.

Adverse Impact to Business

15. Provide a summary of the estimated cost of compliance with the rule(s). Specifically, please do the following:

a. Identify the scope of the impacted business community, and

OAC rule 5160-2-08.1 imposes an HCAP assessment on all Ohio hospitals.

OAC rule 5160-2-09 imposes a penalty of $1,000 a day on all hospitals that do not report to ODM 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 ODM every October 1st of the program year their certification as a CAH, or any change in their CAH status, in order to be considered a CAH for disproportionate share payment purposes.

b. Quantify and identify the nature of all adverse impact (e.g., fees, fines, employer time for compliance, etc.).
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.

OAC rule 5160-2-08.1 requires acute care hospitals to pay an assessment of 0.62410782% of their adjusted total facility costs up to $216,372,500 and 0.460150% for any amount in excess of $216,372,500. Collectively, hospitals will be required to pay approximately $229 million in assessments for state fiscal year of 2024. These funds will be used to make DSH payments to acute care hospitals totaling $749.5 million through OAC rule 5160-2-09 and will outweigh the total assessments paid by the hospitals.

All hospitals are expected to pay the assessment on or before the specified dates. The OAC rule 5160-2-09 rule imposes a penalty of $1,000 per day upon hospitals that do not pay their assessment by the due date and/or submit information as required by the assigned due date.

With regards to the penalty, ODM anticipates that hospitals will comply with the due dates of the assessment and thus will not be subject to any penalties.

16. Are there any proposed changes to the rules that will <u>reduce</u> a regulatory burden imposed on the business community? Please identify. *(Reductions in regulatory burden may include streamlining reporting processes, simplifying rules to improve readability, eliminating requirements, reducing compliance time or fees, or other related factors).*

No.

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

These regulations will provide approximately $523 million in federal funds to Ohio, which will be distributed to Ohio acute care hospitals to help mitigate some of their uncompensated care costs.

Regulatory Flexibility

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

No. Compliance is required by the Revised Code section 5168.01 to 5168.09.

19. 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.

20. 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.

5160-2-08 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 5168.01 of the Revised Code.

(A) Definitions.

(1) "Adjusted total facility costs" means the result of subtracting the sum of the amounts defined in paragraphs (A)(11), (A)(12), (A)(13), (A)(15), (A)(16), and (A)(17) of this rule from the amount defined in paragraph (A)(14) of this rule.

(2) "Disproportionate share hospital" means a hospital that meets the provisions for disproportionate share status as defined in rule 5160-2-09 of the Administrative Code.

(3) "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.

(4) "Health care services administration fund" means the fund described under section 5162.52 of the Revised Code.

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

(6) "Hospital care assurance program fund" means the fund described under division (A) of section 5168.11 of the Revised Code.

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

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

(9) "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 Ohio department of medicaid (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.

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

(11) "Total ambulance costs" for each hospital means the amount on ODM 02930,

schedule B, column 3, line 95. For non-medicaid participating hospitals, total ambulance costs will be determined from the medicare cost report.

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

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

(14) "Total facility costs" for each hospital means the amount from the ODM 02930, "Ohio Medicaid Hospital Cost Report," for the applicable state fiscal year, schedule B, column 3, line 202. For non-medicaid participating hospitals, total facility costs will be determined from the medicare cost report.

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

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

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

(B) Source data for calculations.

(1) The calculations described in this rule for each program year will be based on cost report data described in rule 5160-2-23 of the Administrative Code that reflects the completed interim settled medicaid cost report (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 5160-2-23 of the Administrative Code will be used until a cost report that meets the obligations 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 will 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 report data filed by the previous owner that reflects that hospital's most recent completed interim settled medicaid cost report will 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 report data filed by the previous owner that reflects that hospital's most recent completed interim settled medicaid cost report and the cost report 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 will 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 is subject to any adjustments made upon departmental review that is completed each year and subject to the provisions of paragraph (D) 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 will be adjusted to reflect the portion of the year that the hospital was open during the current program year. That partial year data will 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 will 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 health care services administration fund.

From the first installment of assessments paid under rule 5160-2-08.1 of the Administrative Code and intergovernmental transfers made under rule 5160-2-08.1 of the Administrative Code during each program year, the department will 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 5168.06 of the Revised Code and intergovernmental transfers made under section 5168.07 of the Revised Code during each program year.

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

During each program year, the department may provide any data the department chooses to use for disproportionate share and indigent care adjustments, described in rule 5160-2-09 of the Administrative Code, to each hospital. The department may forward an electronic copy of the data or may make the data available on the medicaid provider portal. The department will notify each hospital of the availability of the data via electronic copy. Not later than thirty calendar days after the department forwards an electronic copy of the notification, 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 needs to 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, thirty business days after the expiration of all hospitals' thirty-day data correction periods, the department will 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 (D)(1) of this rule, will be subject to an administrative fee. The administrative late fee will be 0.03 per cent of the hospital's adjusted total facility cost as calculated in paragraph (A)(1) of this rule. The hospital will include payment of the administrative late fee with the written request to correct data.

(3) All amounts received by the department under this paragraph will be deposited into the state treasury to the credit of the health care services administration fund, described under paragraph (A)(4) of this rule.

(4) The department will 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.

(E) Confidentiality.

Except as specifically directed by the provisions of this rule and rule 5160-2-24 of the Administrative Code, information filed will 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 will be released publicly by the department of medicaid or by any person under contract with the department who has access to such information.

5160-2-08.1 **Assessment rates.**

(A) Applicability.

The provisions of this rule apply as long as the United States centers for medicare and medicaid services (CMS) determines that the assessment imposed under section 5168.06 of the Revised Code is a permissible health care related tax. Whenever the Ohio department of medicaid (department) is informed that the assessment is an impermissible health care-related tax, the department will 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) Definitions

(1) "Current program year" - The program year beginning the first day of October of the most recent calendar year and ending on the thirtieth day of September the following calendar year.

(2) "Past program year" - Any program year beginning the first day of October in a calendar year preceding the current program year and ending the thirtieth day of September the following calendar year.

(3) "Program year" - The period beginning the first day of October of a calendar year and ending on the thirtieth day of September of the following calendar year.

(C) The program years to which this rule applies are identified in paragraphs (C)(1) to (C)(3) of this rule. When the department is notified by CMS that an additional disproportionate share allotment is available for a past program year, the department may amend the assessment rates for the past program year.

(1) The assessment rates applicable to the current program year are specified in paragraph (D) of this rule.

(2) The assessment rates applicable to the past program year when federal allotment is increased are specified in paragraph (E)(1) of this rule.

(3) The revised assessment rates applicable to the past program year when federal allotment is decreased are specified in paragraph (E)(2) of this rule.

(D) Calculation of assessment amounts.

The calculations described in this rule will be based on the cost report data described in rule 5160-2-23 of the Administrative Code that reflects the most recently completed interim settled medicaid cost report for all hospitals. For non-medicaid participating hospitals, the calculations will 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)(1) of rule 5160-2-08 of the Administrative Code.

(2) For hospitals with adjusted total facility costs, as described in paragraph (D)(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 (D)(1) of this rule by one and one half per cent. The product will be each hospital's assessment amount. For hospitals with adjusted total facility costs, as described in paragraph (D)(1) of this rule, that are greater than $216,372,500, multiply a factor of one and one half per cent times the hospital's adjusted total facility costs as described in paragraph (D)(1) of this rule, up to $216,372,500. Multiply a factor of one per cent times the hospital's adjusted total facility costs as described in paragraph (D)(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 (D)(2) of this rule are subject to adjustment under the provisions of paragraph (G) of this rule.

(4) The department may establish a rate lower than the rates described in paragraph (D)(2) of this rule based on the assessment necessary to maximize the disproportionate share allotment for the current program year.

(E) Federal allotment adjustment.

(1) For past program years in which the federal disproportionate share allotment has increased, the department will recalculate the assessment rate for that program year and notify each hospital via rate letter of the additional amount to be paid by the hospital to collect the state share necessary to expend the additional allotment. The adjusted assessment rate described in this paragraph will be calculated in accordance with paragraph (D) of this rule. The assessment collected will then be matched with federal funds and distributed to hospitals based upon the distribution model for the applicable past program year. Notwithstanding paragraph (D)(3) of this rule, the provisions outlined in paragraph (G)(2) of this rule are not applicable to any past program year.

(2) When the department is notified by CMS of a decrease in the federal disproportionate share allotment for a past program year, the department will recalculate the distribution for that program year and notify each hospital via recoupment letter of the amount to be recouped. Of the total amount recouped, the portion that was funded with federal funding will be returned to CMS. The portion of the recoupment that is state funds will be applied toward the prescribed assessment for a future program year. Notwithstanding paragraph (D)(3) of this rule, the provisions outlined in paragraph (G)(2) of

this rule are not applicable to any past program year.

(F) Determination of intergovernmental transfer amounts.

The department may mandate governmental hospitals, as described in paragraph (A)(3) of rule 5160-2-08 of the Administrative Code, to make intergovernmental transfers each program year.

The department will notify each governmental hospital of the amount of the intergovernmental transfer it is mandated to make during the program year.

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

(G) Notification and reconsideration procedures.

(1) The department will forward an electronic copy of the results of the determinations made under paragraphs (D) and (E) of this rule to each hospital. If no hospital submits a request for reconsideration as described in paragraph (G)(2) of this rule, the preliminary determinations constitute the final reconciliation of the amounts that each hospital is to pay under this rule.

(2) Not later than fourteen calendar days after the department sends an electronic copy of the preliminary determinations as described in paragraphs (D) and (E) of this rule, any hospital may submit to the department a written request for reconsideration of the preliminary determination made under paragraphs (D) and (E) of this rule. The request is to be accompanied by written materials setting forth the basis for the reconsideration.

If one or more hospitals submit such a request, the department will hold a public hearing in Columbus, Ohio not later than thirty calendar days after the preliminary determinations have been sent by the department for the purpose of reconsidering its preliminary determinations. The department will send an electronic copy of the written notice with the date, time, and place of the hearing to every hospital at least ten calendar 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 will reconsider and may adjust the preliminary determinations. The result of the reconsideration is the final reconciliation of the amounts that each hospital is to pay under the provisions of this rule.

(3) The department will forward to each hospital an electronic copy of the written notice of the amount the hospital is to pay under the final reconciliation. Any hospital may appeal the amount it is to 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 paragraphs (D) and (E) of this rule or adjust the amount of the intergovernmental transfers needed under paragraph (F) of this rule, and, as a result of the adjustment, adjust each hospital's assessment and intergovernmental transfer, to reflect refinements made by CMS during that program year.

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

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

(3) "Critical Access Hospital (CAH)" means a hospital that is certified as a critical access hospital by the centers for medicare and medicaid services (CMS), and that has notified the Ohio department of health and the Ohio department of medicaid of such certification, and that meets the definition in paragraph (A)(3) of rule 5160-2-05 of the Administrative Code. The Ohio department of medicaid is to 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 will notify the Ohio department of medicaid of any change in their critical access hospital status, including continued CAH designations, immediately following notification from CMS.

(4) "High federal disproportionate share hospital" means a hospital with a ratio of total medicaid days, as defined in paragraph (A)(18) of this rule, to total facility days, as defined in paragraph (A)(12) 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.

(5) "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.

(6) "Managed care plan (MCP) days" for each hospital means the amount on the ODM 02930, "Ohio Medicaid Hospital Cost Report".

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

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

(9) "Medicaid utilization rate" for each hospital means the rate calculated by dividing the sum of total medicaid days, as defined in paragraph (A)(18) of

this rule, by the total facility days, as defined in paragraph (A)(12) of this rule.

(10) "Obstetric services requirements (OSR)" for each hospital means 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)(11) of this rule, this provision includes any physician with staff privileges at the hospital to perform non-emergency obstetric procedures. This provision will 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.

(11) "Rural Hospital (RH)" means a hospital 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 October first of each program year by CMS, and that meets the definition in paragraph (A)(7) of rule 5160-2-05 of the Administrative Code.

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

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

(14) "Total FFS medicaid days" for each hospital means the amount on the ODM 02930.

(15) "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.

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

(17) "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.

(18) "Total medicaid days" for each hospital means the sum of total medicaid FFS days, as defined in paragraph (A)(14) of this rule, and MCP days, as defined in paragraph (A)(6) of this rule.

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

(20) "Total medicaid managed care plan (MCP) inpatient costs" for each hospital means the amount on ODM 02930, schedule I, column 3, line 202.

(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 Ohio department of medicaid and is the amount on the ODM 02930, schedule I, column 3, line 202 and column 5, line 202.

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

(23) "Total medicaid MCP payments" for each hospital is the sum of the amount calculated in paragraph (A)(7) of this rule and the amount calculated in paragraph (A)(8) of this rule.

(24) "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.

(25) "Total outpatient uncompensated care costs for people without insurance" for each hospital means the sum of the 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.

(26) "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 reported on the ODM 02930, schedule F, columns 4 and 5.

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

(28) "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.

(29) "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)(15) of this rule, and total outpatient uncompensated care costs above one hundred per cent without insurance, as described in paragraph (A)(24) of this rule.

(30) "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, as described in paragraph (A)(16) of this rule and the total outpatient uncompensated care costs for people without insurance, as described in paragraph (A)(25) of this rule.

(31) "Total uncompensated care costs under one hundred per cent" for each hospital means the sum of the total inpatient uncompensated care costs under one hundred per cent, as described in paragraph (A)(17) of this rule, and the total outpatient uncompensated care costs under one hundred per cent, as described in paragraph (A)(26) of this rule.

(B) Applicability.

The provisions 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 Ohio department of medicaid (department) is informed that the assessment is an impermissible health care-related tax, the department will 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 provisions 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, as defined in paragraph (A) of rule 5160-2-08 of the Administrative Code, the cost report data used will be adjusted to reflect the portion of the year the hospital was open during the current program year. That partial year data will 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 will 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 will be used to determine the distribution that would have been made to that closed hospital. This amount will 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, as defined in paragraph (A) of rule 5160-2-08 of the Administrative Code, the cost report data from the original facility will 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 report data filed by the previous owner that reflects that hospital's most

recently completed interim settled medicaid cost report will 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 report data filed by the previous owner that reflects that hospital's most recently completed interim settled medicaid cost report and the cost report data filed by the new owner that reflects that hospital's most recently 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 will 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 necessary 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 CMS for that program year.

(2) The funds available in the indigent care pool will be distributed through policy payment pools in accordance with paragraphs (E) to (I) of this rule. Policy payment pools will 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: 77.26 per cent.

(c) Uncompensated care pool below one hundred per cent of poverty: zero per cent.

(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)(4) of this rule, will 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)(5) of this rule, the hospital's high federal disproportionate share hospital payment is the amount defined in paragraph (A)(5).

(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)(5) 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)(5) 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)(5) of this rule, calculate each hospital's limited payment by subtracting the amount defined in paragraph (A)(5) 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 will 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)(5) 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)(5) 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)(5) 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)(5) of this rule, then the payment is equal to the difference between the hospital-specific disproportionate share limit, defined in

paragraph (A)(5) 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)(5) 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 will receive funds from the uncompensated care indigent care payment pool.

(a) For each hospital, sum the total inpatient uncompensated care costs under one hundred per cent, as defined in paragraph (A)(17) of this rule, and the total outpatient uncompensated care costs under one hundred per cent, as defined in paragraph (A)(26) of this rule. For hospitals with total negative 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 uncompensated care under one hundred per cent payment, subject to the following limitations:

(i) If the sum of a hospital's payment amounts, as 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)(5) of this rule, the hospital's uncompensated care under one hundred per cent payment amount is equal to zero.

(ii) If the sum of a hospital's payment amounts, as 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)(5) of this rule, the hospital's 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, as 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)(5) of this rule, the hospital's 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)(5) 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 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, as described in paragraphs (F)(1) to (F)(2) of this rule.

(1) Hospitals meeting the definition described in paragraph (A)(3) of this rule will receive funds from the 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)(5) 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 will be included in the RH payment pool described in paragraph (F)(2)(a) of this rule.

(2) Hospitals that meet the definition described in paragraph (A)(11) of this rule but do not meet the definition described in paragraph (A)(3) of this rule, will receive funds from the RH payment pool.

(a) For each hospital with 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 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)(5) 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 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 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 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 RH 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, as 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, will 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 will 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, will 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 will 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 will 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 located 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, as 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)(5) of this rule.

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

(c) For each hospital located 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 located 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, as 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)(5) 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)(5) of this rule.

(3) Redistribution of closed hospital funds to hospitals in a bordering county.

(a) For each hospital located 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, as 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)(5) of this rule.

(b) For all hospitals located 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 located 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 located 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, as 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)(5) 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)(5) 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)(2) 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)(2) of this rule, with a calculated payment amount that is not greater than the disproportionate share limit, as described in paragraph (A)(5) of this rule, subtract the amount in paragraph (H)(1) of this rule from the disproportionate share limit, as described in paragraph (A)(5) of this rule.

(3) For hospitals meeting the children's hospital definition, described in paragraph (A)(2) of this rule, with calculated payment amounts that are not greater than the disproportionate share limit, as described in paragraph (A)(5) 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)(2) of this rule, with a calculated payment amount that is not greater than the disproportionate share limit, as described in paragraph (A)(5) 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)(2) of this rule, with a calculated payment that is not greater than the disproportionate share limit, as described in paragraph (A)(5) 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, as 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)(5) of this rule, then the hospital's children's hospital payment 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)(5) 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)(5) 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)(5) 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 paragraph (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, as 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)(5) of this rule, then the hospital's residual payment 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)(5) 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)(9) of this rule.

(b) Each hospital with a medicaid utilization rate greater than or equal to one per cent and that meets the obstetric services requirements, as defined in paragraph (A)(10) 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 that does not meet the obstetric services requirements, as defined in paragraph (A)(10) of this rule, qualifies as a non-disproportionate 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)(13) of this rule, total medicaid FFS payments, as described in

paragraph (A)(19) of this rule.

(b) For each hospital, calculate medicaid MCP shortfall by subtracting from total medicaid MCP costs, as defined in paragraph (A)(21) of this rule, the total medicaid MCP payments, as described in paragraph (A)(23) 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 finding the sum of the amounts described in paragraphs (A)(16) and (A)(25) 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 has to make payments of assessments and/or intergovernmental transfers to the Ohio department of medicaid under the provisions of rule 5160-2-08.1 of the Administrative Code will make the payments in accordance with the payment schedule as described in this rule. If the department determines that the hospital is to make payments, the hospitals will meet the payment schedule developed by the department after consultation with the hospitals or a designated representative thereof.

If the Franklin county court of common pleas determines that the hospital is obligated to make payments, the hospital will 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 will 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 will be deposited to the credit of the hospital care assurance program fund. All investment earnings of the fund will be credited to the fund. The department will 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 money credited to the hospital care assurance program fund will 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 that the department makes to hospitals under paragraph (K)(4) of this rule will be credited to the hospital care assurance match fund. All investment earnings of the fund will be credited to the fund. All money credited to the hospital care assurance match fund will be used solely to make payments to hospitals under the provisions of this rule.

(4) The department will make payments to each medicaid participating hospital meeting the definition of hospital, as described under section 5168.01 of the Revised Code. The payments will 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 will 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 will 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 will 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 will 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 5160-2-17 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 paid but did pay, should have paid but did not pay, should have received but did not receive, or should not have received but did receive, the department will:

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

(b) Take action to recover from a hospital any amounts that the audit reveals it should have paid 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 will be made from the hospital care assurance program fund. Amounts recovered under paragraph (K)(6)(b) of this rule will 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 prescribed by the provisions of this rule and rule 5160-2-24 of the Administrative Code, information filed will not include any patient-identifying material. Information that includes patient-identifying information is not a public record under section 149.43 of the Revised Code, and no

patient-identifying material will be released publicly by the Ohio 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 as prescribed 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 will 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 on or before the dates specified in this rule or under any schedule for delayed payments established under paragraph (K)(1) of this rule will be fined one thousand dollars for each day after the due date.

(3) The director of the Ohio department of medicaid may 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 forwards an electronic copy of the final determination, as described in rule 5160-2-08.1 of the Administrative Code, the hospital is to submit its first assessment to the department.

All subsequent assessments and intergovernmental transfers, when applicable, will be made on or before the fifth working 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 will submit its assessment amount to the Ohio department of medicaid via EFT.

(2) On or before the tenth working day after the department's deadline for receiving assessments and intergovernmental transfers, the department will make a payment to each hospital. However, the department will 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.

DRAFT - NOT FOR FILING

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 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 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 5168.01 of the Revised Code.

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

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

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

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

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

(9) "Total facility costs" for each hospital means the amount from the ODM 02930, "Ohio Medicaid Hospital Cost Report," for the applicable state fiscal year, schedule B, column 3, line 202. For non-medicaid participating hospitals, total facility costs shall be determined from the medicare cost report.

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

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

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

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

(14) "Total Durable Medical Equipment (DME) rental costs" for each hospital means the amount on ODM

02930, schedule B, column 3, line 96. For non-medicaid participating hospitals, total DME rental costs shall be determined from the medicare cost report.

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

(16) "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.

(17) "Adjusted total facility costs" means the result of subtracting the sum of the amounts defined in paragraphs (A)(10), (A)(11), (A)(12), (A)(13), (A)(14) and (A)(15) of this rule from the amount defined in paragraph (A)(9) 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 5160-2-23 of the Administrative Code that reflects the completed interim settled medicaid cost report (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 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 (D) 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 health care services administration fund.

From the first installment of assessments paid under rule 5160-2-08.1 of the Administrative Code and intergovernmental transfers made under rule 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 5168.06 of the Revised Code and intergovernmental transfers made under section 5168.07 of the Revised Code during each program year.

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

During each program year, the department may provide any data the department may choose to use for disproportionate share and indigent care adjustments, described in rule 5160-2-09 of the Administrative Code, to each hospital. The department may mail the data or may make the data available on the medicaid provider portal. The department will notify each hospital of the availability of the data via regular or electronic mail (e-mail). Not later than thirty days after the department mails or e-mails the notification, 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, thirty-days after 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 (D)(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)(17) 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)(7) 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.

(E) 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.

DRAFT - NOT FOR FILING

5160-2-08.1 Assessment rates.

(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 5168.06 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 match fund that has been paid by the hospital, plus any investment earnings on that amount.

(B) Definitions

(1) "Program year" - The period beginning the first day of October of a calendar year and ending on the thirtieth day of September of the following calendar year.

(2) "Current program year" - The program year beginning the first day of October of the most recent calendar year and ending on the thirtieth day of September the following calendar year.

(3) "Past program year" - Any program year beginning the first day of October in a calendar year preceding the current program year and ending the thirtieth day of September the following calendar year.

(C) The program years to which this rule applies are identified in paragraphs (C)(1) to (C)(3) of this rule. When the department is notified by the CMS that an additional disproportionate share allotment is available for a past program year, the department may amend the assessment rates for the past program year.

(1) The assessment rates applicable to the current program year are specified in paragraph (D) of this rule.

(2) The assessment rates applicable to the past program year when federal allotment is increased are specified in paragraph (E)(1) of this rule.

(3) The revised assessment rates applicable to the past program year when federal allotment is decreased are specified in paragraph (E)(2) of this rule.

(D) Calculation of assessment amounts.

The calculations described in this rule will be based on the 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)(17) of rule 5160-2-08 of the Administrative Code.

(2) For hospitals with adjusted total facility costs, as described in paragraph (D)(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 (D)(1) of this rule by one and one half per cent. The product will be each hospital's assessment amount. For hospitals with adjusted total facility costs, as described in paragraph (D)(1) of this rule, that are greater than $216,372,500, multiply a factor of one and one half per cent times the hospital's adjusted total facility costs as described in paragraph (D)(1) of this rule, up to $216,372,500.

Multiply a factor of one per cent times the hospital's adjusted total facility costs as described in paragraph (D)(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 (D)(2) of this rule are subject to adjustment under the provisions of paragraph (G) of this rule.

(4) The department may establish a rate lower than the rates described in paragraph (D)(2) of this rule based on the assessment necessary to maximize the disproportionate share allotment for the current program year.

(E) Federal allotment adjustment.

(1) For past program years in which the federal disproportionate share allotment has increased, the department shall recalculate the assessment rate for that program year and notify each hospital via rate letter of the additional amount to be paid by the hospital to collect the state share necessary to expend the additional allotment. The adjusted assessment rate described in this paragraph will be calculated in accordance with paragraph (D) of this rule. The assessment collected will then be matched with federal funds and distributed to hospitals based upon the distribution model for the applicable past program year. Notwithstanding paragraph (D)(3) of this rule, the provisions outlined in paragraph (G)(2) of this rule are not applicable to any past program year.

(2) When the department is notified by the CMS of a decrease in the federal disproportionate share allotment for a past program year, the department shall recalculate the distribution for that program year and notify each hospital via recoupment letter of the amount to be recouped. Of the total amount recouped, the portion that was funded with federal funding shall be returned to the CMS. The portion of the recoupment that is state funds shall be applied toward the required assessment for a future program year. Notwithstanding paragraph (D)(3) of this rule, the provisions outlined in paragraph (G)(2) of this rule are not applicable to any past program year.

(F) 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.

(G) Notification and reconsideration procedures.

(1) The department shall mail by certified mail, return receipt requested, the results of the determinations made under paragraphs (D) and (E) of this rule to each hospital. If no hospital submits a request for reconsideration as described in paragraph (G)(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 paragraphs (D) and (E) of this rule, any hospital may submit to the department a written request for reconsideration of the preliminary determination made under paragraphs (D) and (E) 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 paragraphs (D) and (E) of this rule or adjust the amount of the intergovernmental transfers required under paragraph (F) 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.

DRAFT - NOT FOR FILING

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 202.

(3) "Total medicaid MCP outpatient costs" for each hospital means the amount on ODM 02930 schedule I, column 5, line 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 uncompensated care costs for people without insurance" for each hospital means the sum of the 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) "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.

(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.

(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.

(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.

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

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

(12) "Total outpatient uncompensated care costs for people without insurance" for each hospital means the sum of the 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.

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

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

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

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

(17) "High federal disproportionate share hospital" means a hospital with a ratio of total medicaid days as defined in paragraph (A)(16) of this rule to total facility days as defined in paragraph (A)(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.

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

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

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

(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.

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

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

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

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

(26) "Rural Hospital (RH)" means a hospital 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 October first of each program year by the centers for medicare and medicaid services (CMS).

(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. 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.

(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.

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

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

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

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

(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))(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: 77.26 per cent.

(c) Uncompensated care pool below one hundred per cent of poverty: zero per cent.

(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)(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)(28) of this rule, the hospital's high federal disproportionate share hospital payment is the amount defined in paragraph (A)(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)(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)(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)(28) 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)(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)(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)(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)(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)(28) of this rule, then the payment is equal to the difference between the hospital-specific disproportionate share limit defined in paragraph (A)(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)(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 uncompensated care indigent care payment pool.

(a) For each hospital, sum total inpatient uncompensated care costs under one hundred per cent defined in paragraph (A)(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 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 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) of this rule, the hospital's 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) of this rule, the hospital's 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) of this rule, the hospital's 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) 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 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) 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)(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 RH payment pool described in paragraph (F)(2)(a) of this rule.

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

(a) For each hospital with 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 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)(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 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 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 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 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)(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)(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)(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)(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)(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)(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)(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)(29) of this rule, with a calculated payment amount that is not greater than the disproportionate share limit, as described in paragraph (A)(28) of this rule, subtract the amount in paragraph (H)(1) of this rule from the

disproportionate share limit, as described in paragraph (A)(28) of this rule.

(3) For hospitals meeting the children's hospital definition described in paragraph (A)(29) of this rule, with calculated payment amounts that are not greater than the disproportionate share limit, as described in paragraph (A)(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)(29) of this rule, with a calculated payment amount that is not greater than the disproportionate share limit, as described in paragraph (A)(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)(29) of this rule, with a calculated payment that is not greater than the disproportionate share limit, as described in paragraph (A)(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)(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)(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)(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)(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 paragraph (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)(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)(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)(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)(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)(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)(18) of this rule.

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

(2) On or before the tenth working 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.