

patient services received directly from state and local governments, plus

(b) Total charges for inpatient services for charity care (less cash subsidies above, and not including contractual allowances and discounts other than for indigent patients ineligible for Medicaid) divided by the total charges for inpatient services.

(3) A Medicaid inpatient utilization rate greater than or equal to one percent.

C. Determination of hospital disproportionate share groups for payment distribution

Hospitals determined to be disproportionate share as described above will be classified into one of four tiers for payment distribution based on the data described in paragraph a above. The tiers are described below:

(1) Tier one includes all hospitals deemed to be disproportionate share hospitals based on a low-income utilization rate greater than 25% but less than 40%, or deemed a disproportionate share hospital based on a Medicaid inpatient utilization rate that is one standard deviation above the mean Medicaid inpatient utilization rate for all hospitals receiving Medicaid payments in the state.

(2) Tier two includes all hospitals deemed to be disproportionate share hospitals based on a low-income utilization rate greater than or equal to 40% but less than 50%.

(3) Tier three includes all hospitals deemed to be disproportionate share hospitals based on a low-income utilization rate greater than or equal to 50% but less than 60%.

(4) Tier four includes all hospitals deemed to be disproportionate share hospitals based on a low-income utilization rate greater than or equal to 60% .

D. Distribution of funds within each hospital tier

The funds available in a tier are distributed among hospitals in that tier according to the payment formulas described below. Hospitals will be distributed a payment amount based on the lesser of their uncompensated care costs or their disproportionate share payment. Uncompensated care costs are defined as total inpatient allowable costs less insurance revenues, self-pay revenues, total Medicaid revenues and uncompensated care costs rendered to patients with insurance for the service provided. Each hospital's disproportionate share payment is calculated on a tier-specific basis as follows:

Hospital specific
uncompensated care
Costs x
sum of uncompensated
care costs for all

Disproportionate share
funds available for
distribution in the tier

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hospitals in the tier

(1) Funds available for distribution by tier.

- (a) Tier 1. A maximum of 5% of the disproportionate share funds will be distributed to the hospitals in tier one.

If no hospitals fall into tier one, or all funds are not distributed, then undistributed funds from tier one will be added to the funds available for distribution in tier four.

- (b) Tier 2. A maximum of 25% of the disproportionate share funds will be distributed to hospitals in tier two.

If no hospitals fall into tier two, or all funds are not distributed, then undistributed funds will be added to the funds available for distribution in tier four.

- (c) Tier 3. A maximum of 45% of the disproportionate share funds will be distributed to hospitals in tier three.

If no hospitals fall into tier one, or all funds are not distributed, then undistributed funds will be added to the funds available for distribution in tier four.

- (d) Tier 4. A minimum of 40% of the disproportionate share funds will be distributed to hospitals in tier four.

(2) Payment distribution

Each hospital will be distributed a payment amount based on the lesser of their:

- (a) Uncompensated care costs; or
- (b) Disproportionate share payment amount

E. Disproportionate share funds

The maximum amount of disproportionate share funds available for distribution to psychiatric hospitals will be determined by subtracting the funds distributed in accordance with rule 5101:3-2-09 of the administrative code from the state's disproportionate share limit as described in subparagraph (f) of section 1923 of the Social Security Act, 49 Stat. 620 (1935), 42 USC 1396-r-4 (f), as amended.

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5101:3-2-09 PAYMENT POLICIES FOR DISPROPORTIONATE SHARE AND INDIGENT CARE ADJUSTMENTS FOR HOSPITAL SERVICES.

THIS RULE IS APPLICABLE FOR THE PROGRAM YEAR THAT ENDS IN CALENDAR YEAR 2000, FOR ALL MEDICAID-PARTICIPATING PROVIDERS OF HOSPITAL SERVICES INCLUDED IN THE DEFINITION OF "HOSPITAL" AS DESCRIBED IN PARAGRAPH (A)(3) OF RULE 5101:3-2-08 OF THE ADMINISTRATIVE CODE.

(A) DEFINITIONS.

- (1) "TOTAL MEDICAID COSTS" FOR EACH HOSPITAL MEANS THE SUM OF THE AMOUNTS REPORTED IN ODHS 2930, SCHEDULE H, SECTION I, COLUMNS 1 AND 3, LINE 1 AND SECTION II, COLUMNS 1 AND 3, LINE 13.
- (2) "TOTAL TITLE V COSTS" FOR EACH HOSPITAL MEANS THE AMOUNT ON ODHS 2930, SCHEDULE H, SECTION I, COLUMN 2, LINE 1 AND SECTION II, COLUMN 2, LINE 13.
- (3) "TOTAL INPATIENT DISABILITY ASSISTANCE MEDICAL COSTS" FOR EACH HOSPITAL MEANS THE AMOUNT ON THE ODHS 2930, SCHEDULE F, COLUMNS 4 AND 5, LINE 8.
- (4) "TOTAL INPATIENT UNCOMPENSATED CARE COSTS UNDER ONE HUNDRED PERCENT" FOR EACH HOSPITAL MEANS THE AMOUNT ON THE ODHS 2930, SCHEDULE F, COLUMNS 4 AND 5, LINE 9.
- (5) "TOTAL INPATIENT UNCOMPENSATED CARE COSTS ABOVE ONE HUNDRED PERCENT" FOR EACH HOSPITAL MEANS THE AMOUNT ON THE ODHS 2930, SCHEDULE F, COLUMNS 4 AND 5, LINE 10.
- (6) "TOTAL OUTPATIENT DISABILITY ASSISTANCE MEDICAL COSTS" FOR EACH HOSPITAL MEANS THE AMOUNT ON THE ODHS 2930, SCHEDULE F, COLUMNS 4 AND 5, LINE 12.
- (7) "TOTAL OUTPATIENT UNCOMPENSATED CARE COSTS UNDER ONE HUNDRED PER CENT" FOR EACH HOSPITAL MEANS THE AMOUNT ON THE ODHS 2930, SCHEDULE F, COLUMNS 4 AND 5, LINE 13.
- (8) "TOTAL OUTPATIENT UNCOMPENSATED CARE COSTS ABOVE ONE HUNDRED PER CENT" FOR EACH HOSPITAL MEANS THE AMOUNT ON THE ODHS 2930, SCHEDULE F, COLUMNS 4 AND 5, LINE 14.
- (9) "TOTAL DISABILITY ASSISTANCE MEDICAL COSTS" MEANS THE SUM OF TOTAL INPATIENT DISABILITY ASSISTANCE COSTS AS DESCRIBED IN PARAGRAPH (A)(3) OF THIS RULE, AND TOTAL OUTPATIENT DISABILITY ASSISTANCE COSTS AS DESCRIBED IN PARAGRAPH (A)(6) OF THIS RULE.
- (10) "TOTAL UNCOMPENSATED CARE COSTS UNDER ONE HUNDRED PER CENT" MEANS THE SUM OF TOTAL INPATIENT UNCOMPENSATED CARE COSTS UNDER ONE HUNDRED PER CENT AS DESCRIBED IN PARAGRAPH (A)(4) OF THIS RULE, AND TOTAL OUTPATIENT UNCOMPENSATED CARE COSTS

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UNDER ONE HUNDRED PER CENT AS DESCRIBED IN PARAGRAPH (A)(7) OF THIS RULE.

- (11) "TOTAL UNCOMPENSATED CARE COSTS ABOVE ONE HUNDRED PER CENT" MEANS THE SUM OF TOTAL INPATIENT UNCOMPENSATED CARE COSTS ABOVE ONE HUNDRED PER CENT AS DESCRIBED IN PARAGRAPH (A)(5) OF THIS RULE, AND TOTAL OUTPATIENT UNCOMPENSATED CARE COSTS ABOVE ONE HUNDRED PER CENT AS DESCRIBED IN PARAGRAPH (A)(8) OF THIS RULE.
- (12) "MANAGED CARE PLAN DAYS" (MCP DAYS) MEANS FOR EACH HOSPITAL THE AMOUNT ON THE ODHS 2930, SCHEDULE I, COLUMN 1, LINE 103.
- (13) "HIGH FEDERAL DISPROPORTIONATE SHARE HOSPITAL" MEANS A HOSPITAL WITH A RATIO OF TOTAL MEDICAID DAYS PLUS MCP DAYS TO TOTAL FACILITY DAYS GREATER THAN THE STATEWIDE MEAN RATIO OF TOTAL MEDICAID DAYS TO TOTAL FACILITY DAYS PLUS ONE STANDARD DEVIATION.
- (14) "TOTAL MEDICAID PAYMENTS" FOR EACH HOSPITAL MEANS THE SUM OF THE AMOUNTS REPORTED ON THE ODHS 2930, SCHEDULE H, COLUMN 1, LINES 8, 19, 24, AND 25, AND COLUMN 3, LINES 8, 19, 24 AND 25, MINUS THE AMOUNTS ON SCHEDULE H, COLUMN 1, LINES 6 AND 18.
- (15) "TOTAL MEDICAID DAYS" MEANS FOR EACH HOSPITAL THE AMOUNT ON THE ODHS 2930, SCHEDULE C, COLUMN 6, LINE 35 AND COLUMN 10, LINE 35.
- (16) "TOTAL FACILITY DAYS" MEANS FOR EACH HOSPITAL THE AMOUNT REPORTED ON THE ODHS 2930, SCHEDULE C, COLUMN 4, LINE 35.
- (17) "MEDICAID OUTPATIENT COST-TO-CHARGE RATIO" MEANS THE AMOUNT ON THE ODHS 2930, SCHEDULE F, COLUMN 3, LINE 12.
- (18) "TOTAL MEDICAID MANAGED CARE PLAN (MCP) COSTS" MEANS THE ACTUAL COST TO THE HOSPITAL OF CARE RENDERED TO MEDICAL ASSISTANCE RECIPIENTS ENROLLED IN A MANAGED CARE PLAN THAT HAS ENTERED INTO A CONTRACT WITH THE DEPARTMENT OF JOB AND FAMILY SERVICES AND IS THE AMOUNT ON ODHS 2930, SCHEDULE I, COLUMN 3, LINE 101 AND COLUMN 5, LINE 101.

IN THE EVENT THE HOSPITAL CANNOT IDENTIFY THE COSTS ASSOCIATED WITH RECIPIENTS ENROLLED IN A HEALTH MAINTENANCE ORGANIZATION, THE DEPARTMENT SHALL ADD THE PAYMENTS MADE OR CHARGES INCURRED FOR THE RECIPIENT, AS REPORTED BY THE HEALTH MAINTENANCE ORGANIZATION AND VERIFIED BY THE DEPARTMENT, TO TOTAL MEDICAID MANAGED CARE COSTS.

- (19) "ADJUSTED TOTAL FACILITY COSTS" MEANS THE AMOUNT DESCRIBED IN PARAGRAPH (D)(1) OF RULE 5101:3-2-08 OF THE ADMINISTRATIVE CODE.

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- (20) "TOTAL UNCOMPENSATED CARE COSTS ABOVE ONE HUNDRED PERCENT WITH INSURANCE" MEANS FOR EACH HOSPITAL THE SUM OF THE AMOUNTS ON THE ODHS 2930, SCHEDULE F, COLUMN 5, LINE 10 AND LINE 14.

(B) APPLICABILITY.

THE REQUIREMENTS OF THIS RULE APPLY AS LONG AS THE UNITED STATES HEALTH CARE FINANCING ADMINISTRATION DETERMINES THAT THE ASSESSMENT IMPOSED UNDER SECTION 5112.06 OF THE REVISED CODE IS A PERMISSIBLE HEALTH CARE RELATED TAX PURSUANT TO SECTION 1903(W) OF THE SOCIAL SECURITY ACT, 49 STAT 620 (1935), 42 U.S.C.A. 1396b(W), AS AMENDED. WHENEVER THE DEPARTMENT OF JOB AND FAMILY SERVICES IS INFORMED THAT THE ASSESSMENT IS AN IMPERMISSIBLE HEALTH CARE-RELATED TAX, THE DEPARTMENT SHALL PROMPTLY REFUND TO EACH HOSPITAL THE AMOUNT OF MONEY CURRENTLY IN THE HOSPITAL CARE ASSURANCE PROGRAM FUND THAT HAS BEEN PAID BY THE HOSPITAL, PLUS ANY INVESTMENT EARNINGS ON THAT AMOUNT.

(C) SOURCE DATA FOR CALCULATIONS.

THE CALCULATIONS DESCRIBED IN THIS RULE WILL BE BASED ON COST-REPORTING DATA DESCRIBED IN RULE 5101:3-2-23 OF THE ADMINISTRATIVE CODE WHICH REFLECT THE HOSPITAL'S COST REPORTING PERIOD ENDING IN STATE FISCAL YEAR 1999.

FOR NEW HOSPITALS, THE FIRST AVAILABLE COST REPORT FILED WITH THE DEPARTMENT IN ACCORDANCE WITH RULE 5101:3-2-23 OF THE ADMINISTRATIVE CODE WILL BE USED UNTIL A COST REPORT WHICH MEETS THE REQUIREMENTS OF THIS PARAGRAPH IS AVAILABLE. IF, FOR A NEW HOSPITAL, THERE IS NO AVAILABLE OR VALID COST REPORT FILED WITH THE DEPARTMENT, THE HOSPITAL WILL BE EXCLUDED UNTIL VALID DATA IS AVAILABLE. FOR HOSPITALS WHICH HAVE CHANGED OWNERSHIP, THE COST REPORTING DATA FILED BY THE PREVIOUS OWNER WHICH REFLECTS THAT HOSPITAL'S COST REPORTING PERIOD ENDING IN STATE FISCAL YEAR 1999 WILL BE USED. 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. FOR HOSPITALS THAT CLOSE DURING THE PROGRAM YEAR, NO COST REPORT DATA WILL BE USED.

COST REPORT DATA USED IN THE CALCULATIONS DESCRIBED IN THIS RULE WILL BE THE COST REPORT DATA DESCRIBED IN THIS PARAGRAPH SUBJECT TO ANY ADJUSTMENTS MADE UPON DEPARTMENTAL REVIEW PRIOR TO FINAL DETERMINATION WHICH IS COMPLETED EACH YEAR AND SUBJECT TO THE PROVISIONS OF PARAGRAPHS (G) TO (G)(5) OF RULE 5101:3-2-08 OF THE ADMINISTRATIVE CODE.

(D) DETERMINATION OF INDIGENT CARE POOL.

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- (1) THE "INDIGENT CARE POOL" MEANS THE SUM OF THE FOLLOWING:
- (a) THE TOTAL ASSESSMENTS PAID BY ALL HOSPITALS LESS THE ASSESSMENTS DEPOSITED INTO THE LEGISLATIVE BUDGET SERVICES FUND DESCRIBED IN PARAGRAPH (F) OF RULE 5101:3-2-08 OF THE ADMINISTRATIVE CODE.
 - (b) THE TOTAL AMOUNT OF INTERGOVERNMENTAL TRANSFERS REQUIRED TO BE MADE BY GOVERNMENTAL HOSPITALS LESS THE AMOUNT OF TRANSFERS DEPOSITED INTO THE LEGISLATIVE BUDGET SERVICES FUND DESCRIBED IN PARAGRAPH (F) OF RULE 5101:3-2-08 OF THE ADMINISTRATIVE CODE.
 - (c) THE TOTAL AMOUNT OF FEDERAL MATCHING FUNDS THAT WILL BE MADE AVAILABLE IN THE SAME PROGRAM YEAR AS A RESULT OF PAYMENTS MADE UNDER PARAGRAPH (H)(4) OF THIS RULE.

(E) DISTRIBUTION OF FUNDS THROUGH THE INDIGENT CARE PAYMENT POOLS

THE FUNDS ARE DISTRIBUTED AMONG THE HOSPITALS ACCORDING TO INDIGENT CARE PAYMENT POOLS DESCRIBED IN PARAGRAPHS (E)(1) TO (E)(3) OF THIS RULE.

- (1) HOSPITALS MEETING THE HIGH FEDERAL DISPROPORTIONATE SHARE HOSPITAL DEFINITION DESCRIBED IN PARAGRAPH (A)(13) OF THIS RULE SHALL RECEIVE FUNDS FROM THE HIGH FEDERAL DISPROPORTIONATE SHARE INDIGENT CARE PAYMENT POOL.
- (a) FOR EACH HOSPITAL WHICH MEETS THE HIGH FEDERAL DISPROPORTIONATE SHARE DEFINITION, CALCULATE THE RATIO OF THE HOSPITAL'S TOTAL MEDICAID COSTS AND TOTAL MEDICAID MCP COSTS TO THE SUM OF TOTAL MEDICAID COSTS AND TOTAL MEDICAID MCP COSTS FOR ALL HOSPITALS WHICH MEET THE HIGH FEDERAL DISPROPORTIONATE SHARE DEFINITION.
 - (b) FOR EACH HOSPITAL WHICH MEETS THE HIGH FEDERAL DISPROPORTIONATE SHARE DEFINITION, MULTIPLY THE RATIO CALCULATED IN PARAGRAPH (E)(1)(a) OF THIS RULE BY THIRTY MILLION DOLLARS. THIS AMOUNT IS THE HOSPITAL'S FEDERAL HIGH DISPROPORTIONATE SHARE HOSPITAL PAYMENT AMOUNT.
- (2) HOSPITALS SHALL RECEIVE FUNDS FROM THE MEDICAID INDIGENT CARE PAYMENT POOL.
- (a) FOR EACH HOSPITAL, CALCULATE MEDICAID SHORTFALL BY SUBTRACTING FROM TOTAL MEDICAID COSTS, AS DEFINED IN PARAGRAPH (A)(1) OF THIS RULE, THE TOTAL MEDICAID PAYMENTS, AS DEFINED IN PARAGRAPH (A)(14) OF THIS RULE. FOR HOSPITALS WITH A NEGATIVE MEDICAID SHORTFALL, THE MEDICAID SHORTFALL AMOUNT IS EQUAL TO ZERO.

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- (b) FOR EACH HOSPITAL, SUM THE HOSPITAL'S MEDICAID SHORTFALL AS CALCULATED IN PARAGRAPH (E)(2)(a) OF THIS RULE, TOTAL MEDICAID COSTS, TOTAL MEDICAID MCP COSTS, AND TOTAL TITLE V COSTS.
- (c) FOR ALL HOSPITALS, SUM ALL HOSPITALS MEDICAID SHORTFALL AS CALCULATED IN PARAGRAPH (E)(2)(a) OF THIS RULE, TOTAL MEDICAID COSTS, TOTAL MEDICAID MCP COSTS, AND TOTAL TITLE V COSTS.
- (d) FOR EACH HOSPITAL, CALCULATE THE RATIO OF THE AMOUNT IN PARAGRAPH (E)(2)(b) OF THIS RULE TO THE AMOUNT IN PARAGRAPH (E)(2)(c) OF THIS RULE.
- (e) FOR EACH HOSPITAL, MULTIPLY THE RATIO CALCULATED IN PARAGRAPH (E)(2)(d) OF THIS RULE BY \$90,810,067 TO DETERMINE EACH HOSPITAL'S MEDICAID INDIGENT CARE PAYMENT AMOUNT.

(3) HOSPITALS SHALL RECEIVE FUNDS FROM THE DISABILITY ASSISTANCE MEDICAL AND UNCOMPENSATED CARE INDIGENT CARE PAYMENT POOL.

- (a) FOR EACH HOSPITAL, MULTIPLY A FACTOR OF 0.30 BY THE HOSPITAL'S TOTAL UNCOMPENSATED CARE COSTS ABOVE ONE HUNDRED PERCENT WITHOUT INSURANCE, AS DESCRIBED IN PARAGRAPH (A)(20) OF THIS RULE.
- (b) FOR EACH HOSPITAL, SUM TOTAL DISABILITY ASSISTANCE MEDICAL COSTS, TOTAL UNCOMPENSATED CARE COSTS UNDER ONE HUNDRED PER CENT, AND THE AMOUNT CALCULATED IN PARAGRAPH (E)(3)(a) OF THIS RULE.
- (c) FOR ALL HOSPITALS, SUM TOTAL DISABILITY ASSISTANCE MEDICAL COSTS, TOTAL UNCOMPENSATED CARE COSTS UNDER ONE HUNDRED PER CENT, AND THE AMOUNTS CALCULATED IN PARAGRAPH (E)(3)(a) OF THIS RULE.
- (d) FOR EACH HOSPITAL, CALCULATE THE RATIO OF THE AMOUNT IN PARAGRAPH (E)(3)(b) OF THIS RULE TO THE AMOUNT IN PARAGRAPH (E)(3)(c) OF THIS RULE.
- (e) FOR EACH HOSPITAL, MULTIPLY THE RATIO CALCULATED IN PARAGRAPH (E)(3)(d) OF THIS RULE BY THREE HUNDRED TEN MILLION DOLLARS TO DETERMINE EACH HOSPITAL'S DISABILITY ASSISTANCE MEDICAL AND UNCOMPENSATED CARE INDIGENT CARE PAYMENT AMOUNT.

(F) DISTRIBUTION OF FUNDS THROUGH THE DISPROPORTIONATE SHARE LIMIT POOL.

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- (1) FOR EACH HOSPITAL, CALCULATE THE HOSPITAL'S SPECIFIC DISPROPORTIONATE SHARE LIMIT AS DEFINED IN PARAGRAPH (D) OF RULE 5101:3-2-075 OF THE ADMINISTRATIVE CODE.
- (2) FOR EACH HOSPITAL, SUM THE HOSPITAL'S TOTAL PAYMENTS ALLOCATED IN PARAGRAPHS (E)(1)(b), (E)(2)(e), AND (E)(3)(e) OF THIS RULE.
- (3) FOR EACH HOSPITAL, MULTIPLY A FACTOR OF 0.50 BY THE AMOUNT CALCULATED IN PARAGRAPH (D)(2) OF RULE 5101:3-2-08 OF THE ADMINISTRATIVE CODE.
- (4) FOR EACH HOSPITAL, SUM THE AMOUNTS CALCULATED IN PARAGRAPHS (F)(2) AND (F)(3) OF THIS RULE.
- (5) FUNDS IN THE DISPROPORTIONATE SHARE LIMIT POOL WILL BE DISTRIBUTED AS DESCRIBED IN PARAGRAPHS (F)(5)(a) TO (F)(5)(c) OF THIS RULE.

- (a) FOR EACH HOSPITAL, IF THE AMOUNT CALCULATED IN PARAGRAPH (F)(2) OF THIS RULE IS GREATER THAN THE AMOUNT CALCULATED IN (F)(1) OF THIS RULE, THE HOSPITAL WILL RECEIVE NO PAYMENT FROM THE DISPROPORTIONATE SHARE LIMIT POOL.
- (b) FOR EACH HOSPITAL, IF THE AMOUNT CALCULATED IN PARAGRAPH (F)(4) OF THIS RULE IS LESS THAN THE AMOUNT CALCULATED IN PARAGRAPH (F)(1) OF THIS RULE, THE AMOUNT IN PARAGRAPH (F)(3) WILL BE THE HOSPITAL'S DISPROPORTIONATE SHARE LIMIT POOL PAYMENT AMOUNT.
- (c) FOR EACH HOSPITAL, IF THE AMOUNT CALCULATED IN PARAGRAPH (F)(4) OF THIS RULE IS GREATER THAN THE AMOUNT CALCULATED IN PARAGRAPH (F)(1) OF THIS RULE AND THE AMOUNT CALCULATED IN PARAGRAPH (F)(2) OF THIS RULE IS LESS THAN THE AMOUNT CALCULATED IN PARAGRAPH (F)(1) OF THIS RULE, THEN THE HOSPITAL'S DISPROPORTIONATE SHARE LIMIT POOL PAYMENT AMOUNT WILL BE THE DIFFERENCE BETWEEN THE AMOUNTS IN PARAGRAPHS (F)(1) AND (F)(2) OF THIS RULE.

(G) DISTRIBUTION MODEL ADJUSTMENTS AND LIMITATIONS THROUGH THE STATEWIDE RESIDUAL POOL.

- (1) FOR EACH HOSPITAL, SUM THE PAYMENT AMOUNTS AS CALCULATED IN PARAGRAPHS (F)(2) AND (F)(5) OF THIS RULE.
- (2) FOR EACH HOSPITAL, SUBTRACT THE AMOUNT CALCULATED IN PARAGRAPH (F)(1) OF THIS RULE FROM THE PAYMENT AMOUNT AS CALCULATED IN PARAGRAPH (G)(1) OF THIS RULE TO DETERMINE IF A

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HOSPITAL'S CALCULATED PAYMENT AMOUNT IS GREATER THAN ITS DISPROPORTIONATE SHARE LIMIT.

(3) IF A HOSPITAL'S CALCULATED PAYMENT AMOUNT, AS CALCULATED IN PARAGRAPH (G)(1) OF THIS RULE, IS GREATER THAN ITS DISPROPORTIONATE SHARE LIMIT, THEN THE HOSPITAL'S PAYMENT IS EQUAL TO THE HOSPITAL'S DISPROPORTIONATE SHARE LIMIT.

(a) THE PORTION OF THE CALCULATED AMOUNT ABOVE THE DISPROPORTIONATE SHARE LIMIT, REFERRED TO AS RESIDUAL PAYMENT FUNDS, IS SUBTRACTED FROM THE HOSPITAL'S CALCULATED PAYMENT AMOUNT AND IS APPLIED TO AND DISTRIBUTED AS THE STATEWIDE RESIDUAL PAYMENT POOL AS DESCRIBED IN PARAGRAPH (G)(4) OF THIS RULE.

(b) THE TOTAL AMOUNT DISTRIBUTED THROUGH THE STATEWIDE RESIDUAL POOL WILL BE THE SUM OF THE HOSPITAL CARE ASSURANCE FUND DESCRIBED IN PARAGRAPH (H)(4) MINUS THE SUM OF THE LESSOR OF EACH HOSPITAL'S PAYMENT AMOUNT CALCULATED IN (G)(1) OR THE HOSPITAL'S DISPROPORTIONATE SHARE LIMIT.

(4) 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 (G)(3) OF THIS RULE, SUBTRACT THE AMOUNT IN PARAGRAPH (G)(1) OF THIS RULE FROM THE AMOUNT IN PARAGRAPH (F)(1) OF THIS RULE.

(b) FOR ALL HOSPITALS WITH CALCULATED PAYMENT AMOUNTS THAT ARE NOT GREATER THAN THE DISPROPORTIONATE SHARE LIMIT, SUM THE AMOUNTS CALCULATED IN PARAGRAPH (G)(4)(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 PARAGRAPH (G)(4)(a) AND (G)(4)(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 (G)(4)(c) OF THIS RULE BY THE TOTAL AMOUNT DISTRIBUTED THROUGH THE STATEWIDE RESIDUAL POOL DESCRIBED IN PARAGRAPH (G)(3)(b) OF THIS RULE. THIS AMOUNT IS THE HOSPITAL'S STATEWIDE RESIDUAL PAYMENT POOL PAYMENT AMOUNT.

(H) PAYMENTS AND ADJUSTMENTS.

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- (1) EVERY HOSPITAL THAT MUST MAKE PAYMENTS OF ASSESSMENTS AND/OR INTERGOVERNMENTAL TRANSFERS TO THE DEPARTMENT OF JOB AND FAMILY SERVICES UNDER THE PROVISIONS OF RULE 5101:3-2-08 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 PARAGRAPH (F) OF RULE 5101:3-2-08 OF THE ADMINISTRATIVE CODE, ALL PAYMENTS OF ASSESSMENTS AND INTERGOVERNMENTAL TRANSFERS, WHEN APPLICABLE, FROM HOSPITALS UNDER RULE 5101:3-2-08 OF THE ADMINISTRATIVE CODE SHALL BE DEPOSITED TO THE CREDIT OF THE HOSPITAL CARE ASSURANCE PROGRAM FUND. ALL INVESTMENT EARNINGS OF THE FUND SHALL BE CREDITED TO THE FUND. THE DEPARTMENT SHALL MAINTAIN RECORDS THAT SHOW THE AMOUNT OF MONEY IN THE FUND AT ANY TIME THAT HAS BEEN PAID BY EACH HOSPITAL AND THE AMOUNT OF ANY INVESTMENT EARNINGS ON THAT AMOUNT. ALL MONEYS CREDITED TO THE HOSPITAL CARE ASSURANCE PROGRAM FUND SHALL BE USED SOLELY TO MAKE PAYMENTS TO HOSPITALS UNDER THE PROVISIONS OF THIS RULE.

- (3) ALL FEDERAL MATCHING FUNDS RECEIVED AS A RESULT OF HOSPITAL PAYMENTS OF ASSESSMENTS AND INTERGOVERNMENTAL TRANSFERS THE DEPARTMENT MAKES TO HOSPITALS UNDER PARAGRAPH (H)(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.

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- (4) THE DEPARTMENT SHALL MAKE PAYMENTS TO EACH HOSPITAL MEETING THE DEFINITION IN PARAGRAPH (A)(3) OF RULE 5101:3-2-08 OF THE ADMINISTRATIVE CODE. THE PAYMENTS SHALL BE BASED ON AMOUNTS THAT REFLECT THE SUM OF AMOUNTS IN THE HOSPITAL CARE ASSURANCE PROGRAM FUND DESCRIBED IN PARAGRAPH (H) (2) OF THIS RULE AND THE HOSPITAL CARE ASSURANCE MATCH FUND DESCRIBED IN PARAGRAPH (H)(3) OF THIS RULE. PAYMENTS TO EACH HOSPITAL SHALL BE CALCULATED AS DESCRIBED IN PARAGRAPHS (E), (F), AND (G) OF THIS RULE. FOR PURPOSES OF THIS PARAGRAPH, THE VALUE OF THE HOSPITAL CARE ASSURANCE MATCH FUND IS CALCULATED AS:

SUM OF HOSPITAL CARE ASSURANCE PROGRAM FUND

{1-(FEDERAL MEDICAL ASSISTANCE PERCENTAGE/100)}

THE PAYMENTS SHALL BE MADE SOLELY FROM THE HOSPITAL CARE ASSURANCE PROGRAM FUND AND THE HOSPITAL CARE ASSURANCE MATCH FUND. IF AMOUNTS IN THE FUNDS ARE INSUFFICIENT TO MAKE THE TOTAL AMOUNT OF PAYMENTS FOR WHICH HOSPITALS ARE ELIGIBLE, THE DEPARTMENT SHALL REDUCE THE AMOUNT OF EACH PAYMENT BY THE PERCENTAGE BY WHICH THE AMOUNTS ARE INSUFFICIENT. ANY AMOUNTS NOT PAID AT THE TIME THEY WERE DUE SHALL BE PAID TO HOSPITALS AS SOON AS MONEYS ARE AVAILABLE IN THE FUNDS.

- (5) ALL PAYMENTS TO HOSPITALS UNDER THE PROVISIONS OF THIS RULE ARE CONDITIONAL ON:
- (a) EXPIRATION OF THE TIME FOR APPEALS UNDER THE PROVISIONS OF PARAGRAPHS (G) TO (G)(4) OF RULE 5101:3-2-08 OF THE ADMINISTRATIVE CODE WITHOUT THE FILING OF AN APPEAL, OR ON COURT DETERMINATIONS, IN THE EVENT OF APPEALS, THAT THE HOSPITAL IS ENTITLED TO THE PAYMENTS;
 - (b) THE AVAILABILITY OF SUFFICIENT MONEYS IN THE HOSPITAL CARE ASSURANCE PROGRAM FUND AND THE HOSPITAL CARE ASSURANCE MATCH FUND TO MAKE PAYMENTS AFTER THE FINAL DETERMINATION OF ANY APPEALS;
 - (c) THE HOSPITAL'S COMPLIANCE WITH THE PROVISIONS OF RULE 5101:3-2-0717 OF THE ADMINISTRATIVE CODE.
 - (d) THE PAYMENT MADE TO HOSPITALS DOES NOT EXCEED THE HOSPITAL'S DISPROPORTIONATE SHARE LIMIT AS CALCULATED IN PARAGRAPH (D) OF RULE 5101:3-2-075 OF THE ADMINISTRATIVE CODE.

TN No. 00-012
Supersedes
TN No. 99-007

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