

- (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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- (10) "Total outpatient uncompensated care costs above one hundred per cent without insurance" for each hospital means the amount on the ~~ODHS 2930~~JFS 02930, schedule F, column 5, line 14.
- (11) "Total disability assistance medical costs" means the sum of total inpatient disability assistance costs as described in paragraph (A)(5) of this rule, and total outpatient disability assistance costs as described in paragraph (A)(8) of this rule.
- (12) "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)(6) of this rule, and total outpatient uncompensated care costs under one hundred per cent as described in paragraph (A)(9) of this rule.
- (13) "Total uncompensated care costs above one hundred per cent without insurance" 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)(10) of this rule.
- (14) "Managed care plan days" (MCP days) means for each hospital the amount on the ~~ODHS 2930~~JFS 02930, schedule I, column 1, line 103.
- (15) "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.
- (16) "Total medicaid payments" for each hospital means the sum of the amounts reported on the ~~ODHS 2930~~JFS 02930, 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.
- (17) "Total medicaid days" means for each hospital the amount on the ~~ODHS 2930~~JFS 02930, schedule C, column 6, line 35 and column 10, line 35.
- (18) "Total facility days" means for each hospital the amount reported on the ~~ODHS 2930~~JFS 02930, schedule C, column 4, line 35.
- (19) "Medicaid inpatient payment-to-cost ratio" for each hospital means the sum of

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the amounts reported on the ~~ODHS 2930~~JFS 02930, schedule H, columns 1 and 3, line 8, divided by the sum of the amounts reported on the ~~ODHS 2930~~JFS 02930, schedule H, section I, columns 1 and 3, line 1.

- (20) "Medicaid outpatient payment-to-cost ratio" for each hospital means the sum of the amounts reported on the ~~ODHS 2930~~JFS 02930, schedule H, columns 1 and 3, line 19, divided by the sum of the amounts reported on the ~~ODHS 2930~~JFS 02930, schedule H, section II, columns 1 and 3, line 13.
- (21) "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~~JFS 02930, 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.
- (22) "Medicaid managed care plan (MCP) inpatient payments" for each hospital means the amount defined in paragraph (A)(2) of this rule multiplied by the ratio calculated in paragraph (A)(19) of this rule.
- (23) "Medicaid managed care plan (MCP) outpatient payments" for each hospital means the amount defined in paragraph (A)(3) of this rule multiplied by the ratio calculated in paragraph (A)(20) of this rule.
- (24) "Total medicaid managed care plan (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" means the amount described in paragraph (D)(1) of rule 5101:3-2-08 of the Administrative Code.
- (26) "Rural hospital" means a hospital that is classified as a rural hospital by the health care financing administration, or that is classified as a rural hospital in accordance with paragraphs (A)(3) and (A)(5) of rule 5101:3-2-07.2 of the Administrative Code, and reconciled with the Ohio department of health's, annual hospital registration report.
- (27) "Critical Access Hospital (CAH)" means a hospital that is certified as a critical

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access hospital by the health care financing administration, and that has notified the Ohio department of health and the Ohio department of job and family services of such certification.

(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.

- (1) 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 ~~2000~~2001.
- (2) 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 ~~2000~~2001 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.
- (3) Closed hospitals with unique medicaid provider numbers.

For a hospital facility, identifiable to a unique medicaid provider number, that closes during the program year defined in paragraph (A) of rule 5101:3-2-08 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 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 (H) of this rule.

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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 (H) of this rule.

(4) Replacement hospital facilities.

If a new hospital facility is opened for the purpose of replacing an existing (original) hospital facility identifiable to a unique medicaid provider number and the original facility closes during the program year defined in paragraph (A) of rule 5101:3-2-08 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) 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) and (H) of rule 5101:3-2-08 of the Administrative Code.

(D) Determination of indigent care pool.

(1) The "indigent care pool" means the sum of the following:

- (a) The total assessments paid by all hospitals less the assessments deposited into the legislative budget services fund and the health care services administration fund described in paragraph (F) and (G) 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 and the health care services

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administration fund described in paragraph (F) and (G) 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 (J)(4) of this rule.

(F) Distribution of funds through the indigent care payment pools

The funds are distributed among the hospitals according to indigent care payment pools described in paragraphs (E)(1) to (E)(3) of this rule.

(1) Hospitals meeting the high federal disproportionate share hospital definition described in paragraph (A)(15) 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 five million dollars~~ \$41,441,812. 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)(16) of this rule. For hospitals with a negative medicaid shortfall, the medicaid shortfall amount is equal to zero.

(b) For each hospital, calculate medicaid MCP inpatient shortfall by subtracting from the total medicaid managed care plan inpatient costs, as defined in paragraph (A)(2) of this rule, medicaid MCP inpatient payments, as defined in paragraph (A)(22) of this rule. For hospitals with a negative medicaid MCP inpatient shortfall, the medicaid MCP inpatient shortfall amount is equal to zero.

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- (c) For each hospital, calculate medicaid MCP outpatient shortfall by subtracting from the total medicaid managed care plan outpatient costs, as defined in paragraph (A)(3) of this rule, medicaid MCP outpatient payments, as defined in paragraph (A)(23) of this rule. For hospitals with a negative medicaid MCP outpatient shortfall, the medicaid MCP outpatient shortfall amount is equal to zero.
- (d) For each hospital, calculate medicaid MCP shortfall as the sum of the amount calculated in paragraph (E)(2)(b) of this rule, and the amount calculated in paragraph (E)(2)(c) of this rule.
- (e) For each hospital, sum the hospital's medicaid shortfall as calculated in paragraph (E)(2)(a) of this rule, medicaid MCP shortfall as calculated in paragraph (E)(2)(d) of this rule, total medicaid costs, total medicaid MCP costs, and total Title V costs.
- (f) For all hospitals, sum all hospitals medicaid shortfall as calculated in paragraph (E)(2)(a) of this rule, medicaid MCP shortfall as calculated in paragraph (E)(2)(d) of this rule, total medicaid costs, total medicaid MCP costs, and total Title V costs.
- (g) For each hospital, calculate the ratio of the amount in paragraph (E)(2)(c) of this rule to the amount in paragraph (E)(2)(f) of this rule.
- (h) For each hospital, multiply the ratio calculated in paragraph (E)(2)(g) 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, sum total disability assistance medical costs defined in paragraph (A)(11) of this rule and total uncompensated care costs under one hundred per cent defined in paragraph (A)(12) of this rule.
- (b) Each hospital's disability assistance medical and uncompensated care under one hundred per cent payment amount is equal to the amount calculated in paragraph (E)(3)(a) of this rule.
- (c) For all hospitals, sum the amounts calculated in paragraph (E)(3)(b) of this rule.

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- (d) 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)(13) of this rule.
- (e) For all hospitals, sum the amounts calculated in paragraph (E)(3)(d) of this rule.
- (f) For each hospital, calculate the ratio of the amount in paragraph (E)(3)(d) of this rule to the amount in paragraph (E)(3)(e) of this rule.
- (g) Subtract the amount calculated in paragraph (E)(3)(c) from ~~three hundred ten million dollars~~ \$316,441,812.
- (h) For each hospital, multiply the ratio calculated in paragraph (E)(3)(f) of this rule, by the amount calculated in paragraph (E)(3)(g) of this rule, to determine each hospital's uncompensated care above one hundred percent without insurance payment amount.
- (i) For each hospital, sum the amount calculated in paragraph (E)(3)(b) of this rule, and the amount calculated in paragraph (E)(3)(h) of this rule. This amount is the hospital's disability assistance medical and uncompensated care indigent care payment amount.
- (F) Distribution of funds through the disproportionate share limit pool.
- (1) For each hospital, calculate the hospital's specific disproportionate share limit as defined in paragraph (D) of rule 5101:3-2-07.5 of the Administrative Code.
- (2) For each hospital, sum the hospital's total payments allocated in paragraphs (E)(1)(b), (E)(2)(h), and (E)(3)(i) 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.

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- (a) For each hospital, if the amount calculated in paragraph (F)(2) of this rule is greater than the amount calculated in paragraph (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) of this rule 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 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 (G)(1) to (G)(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 medicaid shortfall as described in paragraph (E)(2)(a) of this rule.
 - (b) For each hospital with CAH certification, each hospital's CAH payment amount is equal to the amount calculated in paragraph (G)(1)(a) of this rule.
 - (c) For all hospitals with CAH certification, sum the amounts calculated in paragraph (G)(1)(b) of this rule.
 - (d) For each hospital with CAH certification, if the amount described in paragraph (G)(1)(a) of this rule is equal to zero, the hospital shall be included in the RAH payment pool described in paragraph (G)(2)(a) of this rule.
- (2) Hospitals meeting the definition described in paragraph (A)(26) of this rule but

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