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do not meet the definition described in paragraph (A)(27) of this rule, shall receive funds from the rural access hospital RAH payment pool.

- (a) For each hospital with RAH classification, as qualified by paragraphs (G)(2) and (G)(1)(d) of this rule, sum the hospital's total payments allocated in paragraphs (E)(1)(b), (E)(2)(h), and (E)(3)(i), and (F)(5)(c) of this rule.
- (b) For each hospital with RAH classification, as qualified by paragraphs (G)(2) and (G)(1)(d) of this rule subtract the amount calculated in paragraph (G)(2)(a) of this rule, from the amount calculated in paragraph (F)(1) of this rule. If this difference for the hospital is negative, then for the purpose of this calculation set the difference equal to zero.
- (c) For all hospitals with RAH classification, as qualified by paragraphs (G)(2) and (G)(1)(d) of this rule, sum the amounts calculated in paragraph (G)(2)(b) of this rule.
- (d) For each hospital with RAH classification, as qualified by paragraphs (G)(2) and (G)(1)(d) of this rule, determine the ratio of the amounts in paragraphs (G)(2)(b) and (G)(2)(c) of this rule.
- (e) Subtract the amount calculated in paragraph (G)(1)(c) of this rule from ~~\$8,098,914~~ \$14,540,726.
- (f) For each hospital with RAH classification, as qualified by paragraphs (G)(2) and (G)(1)(d) of this rule, multiply the ratio calculated in paragraph (G)(2)(d) of this rule, by the amount calculated in paragraph (G)(2)(e) of this rule, to determine each hospital's rural access hospital payment pool amount.
- (g) For each hospital, sum the amount calculated in paragraph (G)(1)(b) of this rule, and the amount calculated in paragraph (G)(2)(f) of this rule. This amount is the hospital's rural and critical access payment amount.
- (H) 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 (H)(1) to (H)(3) of this rule.

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- (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), (G), 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 rule 5101:3-2-08 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), (G), and (I) of this rule, less any amounts that would have been paid by the closed hospital under provisions of rule 5101:3-2-08 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), (G), and (I) of this rule does not result in a net gain, nothing shall be redistributed under paragraphs (H)(2) and (H)(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 (H)(1) of this rule, sum the amount calculated in paragraph (E)(3)(a) of this rule, and the amount calculated in paragraph (E)(3)(d) of this rule.
- (b) For all hospitals within a county with a closed hospital, sum the amounts calculated in paragraph (H)(2)(a) of this rule.
- (c) For each hospital within a county with a closed hospital, determine the ratio of the amounts in paragraphs (H)(2)(a) and (H)(2)(b) of this rule.
- (d) For each hospital within a county with a closed hospital, multiply the ratio calculated in paragraph (H)(2)(c) of this rule, by the amount calculated in paragraph (H)(1) of this rule, to determine each hospital's county redistribution of closed hospitals payment amount.

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

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- (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 (H)(1) of this rule, sum the amount calculated in paragraph (E)(3)(a) of this rule, and the amount calculated in paragraph (E)(3)(d) 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 (H)(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 (H)(3)(a) and (H)(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 (H)(3)(c) of this rule, by the amount calculated in paragraph (H)(1) of this rule, to determine each hospital's county redistribution of closed hospitals payment amount.
- (I) Distribution model adjustments and limitations through the statewide residual pool.
- (1) For each hospital, sum the payment amounts as calculated in paragraphs (F)(2), (F)(5), (G)(2)(g), (H)(2)(d) and (H)(3)(d) of this rule. This is the hospital's calculated payment amount.
- (2) For each hospital, subtract the hospital's disproportionate share limit as calculated in paragraph (F)(1) 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 (F)(1) of this rule, then the difference is the hospital's residual payment funds.
- (3) 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 (F)(1) 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)(2) of this rule is subtracted from the hospital's calculated payment amount as

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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)(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 (J)(4) minus the sum of the lesser of each hospital's calculated payment amount calculated in (I)(1) of this rule or the hospital's disproportionate share limit calculated in paragraph (F)(1) of this rule.

(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 (I)(3) of this rule, subtract the amount in paragraph (I)(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 (I)(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 (I)(4)(a) and (I)(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 (I)(4)(c) of this rule by the total amount distributed through the statewide residual pool described in paragraph (I)(3)(b) of this rule. This amount is the hospital's statewide residual payment pool payment amount.

(J) Payments and adjustments.

(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

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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) and (G) 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 (J)(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 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 (J)(2) of this rule and the hospital care assurance match fund described in paragraph (J)(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)}

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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 5101:3-2-07.17 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 5101:3-2-07.5 of the Administrative Code.
- (6) If an audit conducted by the department of the amounts of payments made and received by hospitals under the provisions of this rule identifies amounts that, due to errors by the department, a hospital should not have been required to pay but did pay, should have been required to pay but did not pay, should not have received but did receive, or should have received but did not receive, the department shall:
- (a) Make payments to any hospital that the audit reveals paid amounts it should not have been required to pay but did pay or did not receive amounts it should have received;
 - (b) Take action to recover from a hospital any amounts that the audit reveals it should have been required to pay but did not pay or that it should not have received but did receive.
- (7) Payments made under paragraph (J)(6)(a) of this rule shall be made from the

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hospital care assurance program fund. Amounts recovered under paragraph (J)(6)(b) of this rule shall be deposited to the credit of the hospital care assurance program fund. Any hospital may appeal the amount the hospital is to be paid under paragraph (J)(6)(a) of this rule or the amount to be recovered from the hospital under paragraph (J)(6)(b) of this rule to the court of common pleas of Franklin county.

(K) Confidentiality.

Except as specifically required by the provisions of this rule and rule 5101:3-2-24 of the Administrative Code, information filed shall not include any patient-identifying material. Information including patient-identifying information is not a public record under section 149.43 of the Revised Code and no patient-identifying material shall be released publicly by the department of job and family services or by any person under contract with the department who has access to such information.

(L) Penalties for failure to report or make payment.

- (1) Any hospital that fails to report the information required under this rule and under paragraph (A) of rule 5101:3-2-23 of the Administrative Code on or before the dates specified in this rule and in rule 5101:3-2-23 of the Administrative Code shall be fined one hundred dollars for each day after the due date that the information is not reported.
- (2) In addition to any other remedy available to the department under law to collect unpaid assessments and transfers, any hospital that fails to make payments of the assessments and intergovernmental transfers to the department of job and family services on or before the dates specified in this rule or under any schedule for delayed payments established under paragraph (J)(1) of this rule shall be fined one hundred dollars for each day after the due date, not to exceed more than twenty thousand dollars.
- (3) The director of job and family services shall waive the penalties provided for in paragraphs (L)(1) and (L)(2) of this rule for good cause shown by the hospital.

(M) 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

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determination as described in paragraph (G)(3) of rule 5101:3-2-08 of the Administrative Code, the hospital must submit its first assessment to the department.

All subsequent assessments and intergovernmental transfers, when applicable, must be made on or before the fifth day after the date on the warrant or electronic funds transfer (EFT) issued as payment by the department as described in paragraph (M)(2) of this rule.

- (2) On or before the tenth day after the departments 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 paragraph (G)(2) of rule 5101:3-2-08 of the Administrative Code, and before the last payment is made, as described in this paragraph, the payments to the remaining hospitals will be adjusted in accordance with paragraphs (E) to (J)(7) of this rule.

Effective: 7/22/2002

R.C. 119.032 review dates: 5/7/2002 and 07/22/2007

CERTIFIED ELECTRONICALLY

Certification

07/12/2002 08:40 AM

Date

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Payment policies for disproportionate share and indigent care adjustments for psychiatric hospitals.

This rule is applicable for the program year that ends in calendar year ~~2001~~2002, for all medicaid-participating psychiatric hospitals as described in paragraphs (B), (C) and (D) of rule 5101:3-2-01 of the Administrative Code.

(A) Definitions.

- (1) "Inpatient days" means for each psychiatric hospital the number of inpatient hospital days as reported ~~in the medicare cost report, HCFA 2552-96, worksheet S-3, part I, column 6 and in JFS 02930, schedule C, column 4~~ plus the number of inpatient hospital days that would have been covered by medicaid if medicaid coverage were available to the population served age twenty-two to sixty-four as reported on JFS 02930, schedule F, column 6, line 24.
- (2) "Insurance revenues" ~~means are reported on JFS 0290, schedule F, column 1, line 24 and mean~~ for each psychiatric hospital the revenues received in the same twelve ~~month~~months of the hospital's cost-reporting period for inpatient services provided to, billed to, and received from all sources other than medicaid or self-pay revenues as described in paragraph (A)(4) of this rule.
- (3) "Medicaid inpatient utilization rate" means for each psychiatric hospital the ratio of the hospital's number of inpatient days attributable to patients who were eligible for medical assistance as described in paragraph (A)(6) of this rule divided by the hospital's total inpatient days as described in paragraph (A)(1) of this rule.
- (4) "Self-pay revenues" means for each psychiatric hospital the revenues received in the same twelve ~~month~~months of the hospital's cost-reporting period for inpatient services provided to, billed to, and received from either the person that received inpatient services or the family of the person that received inpatient services as reported on JFS 02930, schedule F, column 2, line 24.
- (5) "Total inpatient allowable costs" for each psychiatric hospital means the sum of the general service and capital related costs for inpatient hospital services reported ~~in the medicare cost report, HCFA 2552-96, multiplied by the approved method to apportion the medicare total costs as approved by the medicare intermediary in JFS 02930 schedule B, column 7.~~
- (6) "Total medicaid days" for each psychiatric hospital means the amount on the ~~ODHS 2930~~JFS 02930, schedule C, column 6, line 35 ~~and plus~~ the number of days that would have been covered by medicaid if medicaid coverage were