

**TRANSMITTAL AND NOTICE OF APPROVAL OF
STATE PLAN MATERIAL**

1. TRANSMITTAL NUMBER:
03-008A

2. STATE
OHIO

FOR: CENTERS FOR MEDICAID AND MEDICAID SERVICES

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE
SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
March 27, 2003

5. TYPE OF PLAN MATERIAL (Check One):

- NEW STATE PLAN
- AMENDMENT TO BE CONSIDERED AS NEW PLAN
- AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR part 441 - Subpart C; 42 CFR Part 441 - Subpart D; 42 CFR
part 447 - Subpart C

7. FEDERAL BUDGET IMPACT:
a. FFY 2003 \$(55,598,330)
b. FFY 2004 \$ 8,576,750

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Pages 13-22 of Attachment 4.19-A,
Rules 5101:3-2-09 and 5101:3-2-10.

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION
OR ATTACHMENT (If Applicable):
Pages 13-22 of Attachment 4.19-A,
Rules 5101:3-2-09 and 5101:3-2-10.

10. SUBJECT OF AMENDMENT:

Disproportionate share and indigent care adjustments for general hospitals and psychiatric hospitals.

11. GOVERNOR'S REVIEW (Check One):

- GOVERNOR'S OFFICE REPORTED NO COMMENT
- COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
- NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL

OTHER, AS SPECIFIED: Governor has
delegated review to ODJFS Director.

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME: Thomas J. Hayes

14. TITLE: Director

15. DATE SUBMITTED: May 12, 2003

16. RETURN TO:

Ohio Department of Job and Family Services
30 E. Broad Street, 27th Floor
Columbus, Ohio 43215

Attention: Becky Jackson
Bureau of Health Plan Policy

17. DATE RECEIVED:

MAY 23 2003

AUG 28 2003

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:

MAR 27 2003

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:

Charlene Brown

22. TITLE:

Deputy Director, CMSO

23. REMARKS:

Pen and ink change to block 8 PAGES 13-22

Disproportionate Share and Indigent Care for General Hospitals

This Section applies to all general hospitals eligible to participate in Medicaid who do not meet the criteria in paragraphs (B), (C) and (D) of Rule 5101:3-2-01.

(A) SOURCE DATA FOR CALCULATIONS

The calculations described for determining disproportionate share hospitals and in making disproportionate share and indigent care payments will be based on data provided in annual cost reports submitted to the department under the provisions of Rule 5101:3-2-23. The cost reports used will be for the hospital's cost reporting period ending in state fiscal year 2002. If specific program data is not available from these reports, the otherwise most recent, reviewed, cost report information will be used. The CMS data used will be as reported by CMS for federal fiscal year 2001.

(B) DETERMINATION OF DISPROPORTIONATE SHARE HOSPITALS

The department makes additional payments to hospitals that qualify for a disproportionate share adjustment. Hospitals that qualify (including Children's and DRG exempt hospitals) are those that meet at least one of the criteria described under (1) and (2) below, and that also meet the criteria described under (3) below:

- (1) Have a Medicaid utilization rate greater than or equal to one percent.
- (2) Have a low income utilization rate in excess of 25 percent, where low income utilization rate is:

$$\frac{\text{Medicaid payments} + \text{Cash subsidies for patient services received directly from state and local government}}{\text{Total hospital revenues}}$$

(including cash subsidies for patient services received directly from state and local governments)

+

$$\frac{\text{Total charges for inpatient services for charity care}}{\text{Total charges for inpatient services}}$$

- (3) Have at least two obstetricians who have staff privileges at the hospital and who have agreed to provide obstetric services to individuals who are entitled to Medicaid, except that:
 - (i) The provisions of (3) do not apply to hospitals the inpatients of which are predominantly individuals under 18 years of age; or
 - (ii) The provisions of (3) do not apply if the hospital does not offer non-emergency obstetric services to the general population as of December 22, 1987; or
 - (iii) In the case of hospitals located in a rural area (as defined for purposes of Section 1886 of the Social Security Act), the term "obstetrician" includes any physician with staff privileges at the hospital to perform non-emergency obstetric procedures.

Hospitals that do not qualify for a disproportionate share adjustment receive additional payments in the form of an indigent care adjustment.

(C) DISPROPORTIONATE SHARE AND INDIGENT CARE POOL

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The disproportionate share and indigent care pool are created in compliance with the Medicaid Voluntary Contribution and Provider Specific Tax Amendments of 1991 and the regulations issued in the August 13, 1993 Federal Register. Furthermore, it is an assurance of this plan that the amount of payments made to disproportionate share hospitals will not exceed, in the aggregate, the limits prescribed under subparagraph (f)(2)(A) of Section 1923.

(D) DISTRIBUTION FORMULAS FOR INDIGENT CARE PAYMENT POOLS.

- (1) Hospitals meeting the high federal disproportionate share hospital definition, are eligible to receive funds from the high federal disproportionate share indigent care payment pool. A high federal disproportionate share hospital is defined as one whose ratio of total Medicaid days and Medicaid MCP days to total days is greater than the statewide mean ratio of total Medicaid days and Medicaid MCP days to total days plus one standard deviation. Funds are distributed to hospitals which meet this definition according to the following formula.
- (a) For each hospital that meets the definition of high disproportionate share, calculate the ratio of the hospital's total Medicaid costs and total Medicaid MCP costs to the sum of total Medicaid costs and Medicaid MCP costs for all hospitals which meet the definition of high federal disproportionate share described in paragraph (D)(1).
- (b) For each hospital, multiply the ratio calculated in paragraph (D)(1)(a) by \$41,441,812. This is the hospital's federal high disproportionate share hospital payment amount.
- (2) Hospitals are eligible to receive funds from the Medicaid indigent care payment pool according to the following formulas.
- (a) For each hospital, calculate Medicaid shortfall by subtracting from total Medicaid costs total Medicaid payments. For hospitals with a negative Medicaid shortfall, the Medicaid shortfall amount is equal to zero.
- (b) For each hospital, calculate Medicaid MCP inpatient payments by multiplying Medicaid fee-for-service (FFS) inpatient payment-to-cost ratio by Medicaid MCP inpatient costs.
- (c) For each hospital, calculate Medicaid MCP outpatient payments by multiplying Medicaid FFS outpatient payment-to-cost ratio by Medicaid MCP outpatient costs.
- (d) For each hospital, calculate Medicaid MCP inpatient shortfall by subtracting from the total Medicaid MCP inpatient costs, Medicaid MCP inpatient payments, as calculated in paragraph (D)(2)(b). For hospitals with a negative Medicaid MCP inpatient shortfall, the Medicaid MCP inpatient shortfall amount is equal to zero.
- (e) For each hospital, calculate Medicaid MCP outpatient shortfall by subtracting from the total Medicaid MCP outpatient costs, Medicaid MCP outpatient payments, as calculated in paragraph (D)(2)(c). For hospitals with a negative Medicaid MCP outpatient shortfall, the Medicaid MCP outpatient shortfall amount is equal to zero.
- (f) For each hospital, calculate Medicaid MCP shortfall as the sum of the amount calculated in paragraph (D)(2)(d), and the amount calculated in paragraph (D)(2)(e).
- (g) For each hospital, sum the hospital's Medicaid shortfall, Medicaid MCP shortfall, total Medicaid costs, total Medicaid MCP costs, and total Title V costs.
- (h) For all hospitals, sum all hospitals Medicaid shortfall, Medicaid MCP shortfall, total Medicaid costs, Total Medicaid MCP costs, and total Title V costs.
- (i) For each hospital, calculate the ratio of the amount in paragraph (D)(2)(g) to the amount in paragraph (D)(2)(h).

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- (j) For each hospital, multiply the ratio calculated in paragraph (D)(2)(i) by ~~\$90,810,067~~ \$76,009,499 to determine each hospital's Medicaid indigent care payment amount.
- (3) Hospitals are eligible to receive funds from the disability assistance medical and uncompensated care indigent care payment pool.
- (a) For each hospital, sum total disability assistance medical costs and total uncompensated care costs under one hundred per cent.
- (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 (D)(3)(a), subject to the following limitations:
- (i) If the sum of a hospital's payment amounts calculated in paragraphs (D)(1) and (D)(2) of this rule is greater than or equal to its hospital-specific disproportionate share limit defined in paragraph (I), the hospital's disability assistance medical and uncompensated care under one hundred per cent payment amount is equal to zero.
- (ii) If the sum of a hospital's payment amounts calculated in paragraphs (D)(1) and (D)(2) and the amount calculated in paragraph (D)(3)(a) of this rule is less than its hospital-specific disproportionate share limit defined in paragraph (I); the hospital's disability medical and uncompensated care under one hundred per cent payment amount is equal to the amount calculated in paragraph (D)(3)(a) of this rule.
- (iii) If a hospital does not meet the condition described in paragraph (D)(3)(b)(i), and the sum of its payment amounts calculated in paragraphs (D)(1) and (D)(2) and the amount calculated in paragraph (D)(3)(a) is greater than its hospital-specific disproportionate share limit defined in paragraph (I); the hospital's disability medical and uncompensated care under one hundred per cent payment amount is equal to the difference between the hospital's disproportionate share limit and the sum of the payment amounts calculated in paragraphs (D)(1) and (D)(2).
- (c) For all hospitals, sum the amounts calculated in paragraph (D)(3)(b).
- (d) For each hospital, except those meeting either condition described in paragraph (D)(3)(b)(i) or (D)(3)(b)(iii) multiply a factor of 0.30 by the hospital's total uncompensated care costs above one hundred percent without insurance. For hospitals meeting the conditions described in paragraph (D)(3)(b)(i) or (D)(3)(b)(iii) of this rule, multiply the hospital's total uncompensated care costs above one hundred percent by zero.
- (e) For all hospitals, sum the amounts calculated in paragraph (D)(3)(d).
- (f) For each hospital, calculate the ratio of the amount in paragraph (D)(3)(d) to the amount in paragraph (E)(3)(e).
- (g) Subtract the amount calculated in paragraph (D)(3)(c) from ~~\$316,441,812~~ \$272,682,379.
- (h) For each hospital, multiply the ratio calculated in paragraph (D)(3)(f) by the amount calculated in paragraph (D)(3)(g), to determine each hospital's uncompensated care above one hundred percent without insurance payment amount, subject to the following limitations:
- (i) If the sum of a hospital's uncompensated care above one hundred per cent without insurance payment and the payment amounts calculated in paragraphs (D)(1), (D)(2), and (D)(3)(b) is less than the hospital's disproportionate share limit defined in paragraph (I), then the hospital's uncompensated care above one hundred per cent without insurance payment is equal to the product of multiplying the ratio calculated in paragraph (D)(3)(f) by the amount calculated in paragraph (D)(3)(g) of this rule.

(ii) If the sum of a hospital's uncompensated care above one hundred per cent without insurance payment and the payment amounts calculated in paragraphs (D)(1), (D)(2), and (D)(3)(b) is greater than the hospital's disproportionate share limit defined in paragraph (I), then the hospital's uncompensated care above one hundred per cent without insurance payment is equal to the difference between the hospital's disproportionate share limit and the sum of the payment amounts calculated in paragraphs (D)(1), (D)(2), and (D)(3)(b).

- (i) For each hospital, sum the amount calculated in paragraph (D)(3)(b), and the amount calculated in paragraph (D)(3)(h). This amount is the hospital's disability assistance medical and uncompensated care indigent care payment amount.

~~(F)~~(E) 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 (E)(1) to (E)(2).

- (1) Hospitals that are certified as critical access hospitals by the Centers for Medicare and Medicaid Services, and that have notified the Ohio Department of Health and the Ohio Department of Job and Family Services of such certification, shall receive funds from the critical access hospital (CAH) payment pool.
- (a) For each hospital with CAH certification, calculate the Medicaid shortfall by adding Medicaid FFS shortfall described paragraph (D)(2)(a), to the Medicaid MCP shortfall described in paragraph (D)(2)(f).
- (b) For each hospital with CAH certification, each hospital's CAH payment amount is equal to the amount calculated in paragraph (E)(1)(a).
- (c) For all hospitals with CAH certification, sum the amounts calculated in paragraph (E)(1)(b).
- (d) For each hospital with CAH certification, if the amount described in paragraph (E)(1)(a) of this rule is equal to zero, the hospital shall be included in the RAH payment pool described in paragraph (E)(2)(a).
- (2) Hospitals that are classified as a rural hospitals by the Centers for Medicare and Medicaid Services, but do not meet the definition described in paragraph (E)(1), shall receive funds from the rural access hospital (RAH) payment pool.
- (a) For each hospital with RAH classification, as qualified by paragraph (E)(2) And (E)(1)(d), sum the hospital's total payments allocated in paragraphs (D)(1)(b), (D)(2)(j), and (D)(3)(i).
- (b) For each hospital with RAH classification, as qualified by paragraph (E)(2) and (E)(1)(d) of this rule subtract the amount calculated in paragraph (E)(2)(a), from the hospital's disproportionate share limit defined in paragraph (I) from the amount calculated in paragraph (E)(1). 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 paragraph (E)(2) and (E)(1)(d), sum the amounts calculated in paragraph (E)(2)(b).
- (d) For each hospital with RAH classification, as qualified by paragraph (E)(2) and (E)(1)(d), determine the ratio of the amounts in paragraph (E)(2)(b) and (E)(2)(c).
- (e) Subtract the amount calculated in paragraph (E)(1)(c) from ~~\$14,540,726~~ \$12,170,824.
- (f) For each hospital with RAH classification, as qualified by paragraph (E)(2) and (E)(1)(d), multiply the ratio calculated in paragraph (E)(2)(d), by the amount calculated in paragraph (E)(2)(e), to determine each hospital's rah payment pool amount.

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- (g) For each hospital, sum the amount calculated in paragraph (E)(1)(b), and the amount calculated in paragraph (E)(2)(f). This amount is the hospital's rural and critical access payment amount.

~~(G)~~(F) DISTRIBUTION OF FUNDS THROUGH THE COUNTY REDISTRIBUTION OF CLOSED HOSPITALS PAYMENT POOLS.

- (1) Closed hospitals with unique Medicaid provider numbers.

For a hospital facility, identifiable to a unique Medicaid provider number, that closes during the program year, 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 (F)(2).

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 (F)(2).

If funds are available in accordance with paragraph (F)(1) of this rule, the funds are distributed among the hospitals according to the county redistribution of closed hospitals payment pools described in paragraphs (F)(2) to (F)(4).

- (2) 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 (D), (E), (G), and (H) for the portion of the year it was closed, less any assessment amounts that would have been paid by the closed hospital 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 (D), (E), (G), and (H), less any assessment amounts that would have been paid by the closed hospital, 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 (D), (E), (G), and (H) of this rule does not result in a net gain, nothing shall be redistributed under paragraphs (F)(3) and (F)(4) of this rule.

- (3) 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 (F)(2), sum the amount calculated in paragraph (D)(3)(a), and the amount calculated in paragraph (D)(3)(d).
- (b) For all hospitals within a county with a closed hospital, sum the amounts calculated in paragraph (F)(3)(a).
- (c) For each hospital within a county with a closed hospital, determine the ratio of the amounts in paragraph (F)(2)(a) and (F)(2)(b).
- (d) For each hospital within a county with a closed hospital, multiply the ratio calculated in paragraph (F)(2)(c), by the amount calculated in paragraph (F)(2) of this rule, to determine each hospital's county redistribution of closed hospitals payment amount.

- (4) 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 (F)(2), sum the amount calculated in paragraph (D)(3)(a), and the amount calculated in paragraph (D)(3)(d).
- (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 (F)(4)(a).
- (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 paragraph (F)(4)(a) and (F)(4)(b).
- (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 (F)(3)(c), by the amount calculated in paragraph (F)(2), to determine each hospital's county redistribution of closed hospitals payment amount.

~~(E)~~(G) 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 (I).
- (2) For each hospital, sum the hospital's total payments allocated in paragraphs (D)(1)(b), (D)(2)(j), AND (D)(3)(i), ~~(E)(2)(g), (F)(3)(d) and (F)(4)(d)~~.
- (3) Multiply each hospital's adjusted total facility costs that are less than or equal to ~~\$214,904,130~~ \$231,039,300 by ~~0.0178~~ 0.0135. For hospitals with adjusted total facility costs that are greater than ~~\$214,904,130~~ \$231,039,300, multiply a factor of 0.01 times the hospital's adjusted total facility costs that are in excess of ~~\$214,904,130~~ \$231,039,300. For each hospital, multiply a factor of ~~0.50~~ 0.4185 by the amount calculated.
- (4) For each hospital, sum the amounts calculated in paragraphs (G)(2) and (G)(3).
- (5) Funds in the disproportionate share limit pool will be distributed as described in paragraphs (G)(5)(a) to (G)(5)(c).
 - (a) For each hospital, if the amount calculated in paragraph (G)(2) is greater than the amount calculated in (G)(1), the hospital will receive no payment from the disproportionate share limit pool.
 - (b) For each hospital, if the amount calculated in paragraph (G)(4) is less than the amount calculated in paragraph (G)(1), the amount in paragraph (G)(3) will be the hospital's disproportionate share limit pool payment amount.
 - (c) For each hospital, if the amount calculated in paragraph (G)(4) is greater than the amount calculated in paragraph (G)(1) and the amount calculated in paragraph (G)(2) is less than the amount calculated in paragraph (G)(1), then the hospital's disproportionate share limit pool payment amount will be the difference between the amounts in paragraphs (G)(1) and (G)(2).

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

- (1) For each hospital, subtract the hospital's specific disproportionate share limit as defined in paragraph (I) from the payment amount as calculated in paragraphs (G)(2), (G)(5), ~~(F)(2)(g) and (G)(3)(d) AND (G)(4)(d)~~ to determine if a hospital's calculated payment amount is greater than its disproportionate share limit.

If a hospital's calculated payment amount is greater than its disproportionate share limit, then the hospital's payment is equal to the hospital's disproportionate share limit. 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 the statewide residual payment pool as described in paragraph (H)(2).

- (2) RE-DISTRIBUTION OF RESIDUAL PAYMENT FUNDS IN THE STATEWIDE RESIDUAL PAYMENT POOL.

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STATE OF OHIO

ATTACHMENT 4.19-A

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(2) RE-DISTRIBUTION OF RESIDUAL PAYMENT FUNDS IN THE STATEWIDE RESIDUAL PAYMENT POOL.

- (a) For each hospital meeting the high federal disproportionate share hospital definition described in paragraph (D)(1), with a calculated payment amount that is not greater than the disproportionate share limit, as described in paragraph (I), subtract the payment amount described in paragraph (H)(1) from the amount of the disproportionate share limit.
- (b) For ~~all~~ hospitals meeting the high federal disproportionate share hospital definition described in paragraph (D)(1), with calculated payment amounts that are not greater than the disproportionate share limit, sum the amounts calculated in paragraph (H)(2)(a).
- (c) For each hospital meeting the high federal disproportionate share hospital definition described in paragraph (D)(1), with a calculated payment amount that is not greater than the disproportionate share limit, determine the ratio of the amounts in paragraph (H)(2)(a) and (H)(2)(b).
- (d) For each hospital meeting the high federal disproportionate share hospital definition described in paragraph (D)(1), with a calculated payment amount that is not greater than the disproportionate share limit, multiply the ratio calculated in paragraph (H)(2)(c) of this rule by the total amount distributed through the statewide residual pool described in paragraph (H)(1). This amount is the hospital's statewide residual payment pool payment amount.

(I) LIMITATIONS ON DISPROPORTIONATE SHARE AND INDIGENT CARE PAYMENTS MADE TO HOSPITALS

- (1) For each hospital calculate Medicaid shortfall by subtracting from total Medicaid costs, total Medicaid payments. (NOTE: FOR HOSPITALS WITH A NEGATIVE MEDICAID SHORTFALL, THE MEDICAID SHORTFALL AMOUNT IS NOT EQUAL TO ZERO). For hospitals exempt from the prospective payment system, Medicaid shortfall equals zero.
- (2) For each hospital, calculate total inpatient costs for patients without insurance by multiplying the hospitals' inpatient Medicaid cost-to-charge ratio, by the sum of hospital's reported charges for inpatient disability assistance medical, inpatient uncompensated care under one hundred per cent, and inpatient uncompensated care above one hundred per cent.
- (3) For each hospital, calculate total outpatient costs for patients without insurance by multiplying the hospitals' outpatient Medicaid cost-to-charge ratio, by the sum of hospital's reported charges for outpatient disability assistance medical, outpatient uncompensated care under one hundred per cent, and outpatient uncompensated care above one hundred per cent.
- (4) For each hospital, calculate the hospital disproportionate share limit by adding the Medicaid shortfall as described in paragraph (1)(1), inpatient uncompensated care as described in paragraph (1)(2), and outpatient uncompensated care as described in paragraph (1)(3).
- (5) The hospital will receive the lesser of the disproportionate share limit as described in paragraph (1)(4) or the disproportionate share and indigent care payment as calculated in paragraphs (D), (E), (F), (G) and (H).

Payments are made to each hospital in installments based on the amount calculated for the annual period. The annual period used in performing disproportionate share/indigent care adjustments is the hospital's fiscal year ending in state fiscal year 2002. Payments are subject to reconciliation if errors have been made in calculating the amount of disproportionate share indigent care adjustments or if adjustments must be made in order to comply with the federal regulations issued under H.R. 3595.

Expenses associated with payment of hospital assessments are allowable as a Medicaid cost for cost reporting purposes.

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***** DRAFT - NOT YET FILED *****

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 ~~2002~~2003, 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~~ under section 5112.01 of the Revised Code.

(A) Definitions.

- (1) "Total medicaid costs" for each hospital means the sum of the amounts reported in JFS 02930, schedule H, section I, columns 1 and 3, line 1 and section II, ~~columns~~column 1 and 3, line 13.
- (2) "Total medicaid managed care plan inpatient costs" for each hospital means the amount on JFS 02930 schedule I, column 3, line 101.
- (3) "Total medicaid managed care plan outpatient costs" for each hospital means the amount on JFS 02930 schedule I, column 5, line 101.
- (4) "Total Title V costs" for each hospital means the amount on JFS 02930, schedule H, section I, column 2, line 1 and section II, column 2, line 13.
- (5) "Total inpatient disability assistance medical costs" for each hospital means the amount on the JFS 02930, schedule F, columns 4 and 5, line 8.
- (6) "Total inpatient uncompensated care costs under one hundred percent" for each hospital means the amount on the JFS 02930, schedule F, columns 4 and 5, line 9.
- (7) "Total inpatient uncompensated care costs above one hundred per cent without insurance" for each hospital means the amount on the JFS 02930, schedule F, column 5, line 10.
- (8) "Total outpatient disability assistance medical costs" for each hospital means the amount on the JFS 02930, schedule F, columns 4 and 5, line 12.
- (9) "Total outpatient uncompensated care costs under one hundred per cent" for each hospital means the amount on the JFS 02930, schedule F, columns 4 and 5, line 13.

- (10) "Total outpatient uncompensated care costs above one hundred per cent without insurance" for each hospital means the amount on the 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 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 JFS 02930, schedule H, column 1, lines 8, 19, 24, and 25, and column 3, lines 8, ~~19, and~~ 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 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 JFS 02930, schedule C, column 4, line 35.
- (19) "Medicaid inpatient payment-to-cost ratio" for each hospital means the sum of

the amounts reported on the JFS 02930, schedule H, columns 1 and 3, line 8, divided by the sum of the amounts reported on the 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~~ amount reported on the JFS 02930, schedule H, ~~columns~~ column 1 and 3, line 19, divided by ~~the sum of the amounts~~ amount reported on the JFS 02930, schedule H, section II, ~~columns~~ column 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 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)~~(A) 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~~ centers for medicare and medicaid services.

- (27) "Critical Access Hospital (CAH)" means a hospital that is certified as a critical access hospital by the ~~health care financing administration~~ centers for medicare and medicaid services, and that has notified the Ohio department of health and the Ohio department of job and family services of such certification. Beginning in the program year that ends in calendar year 2004, the Ohio department of job and family services 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.
- (28) "Hospital-specific disproportionate share limit" means the limit on disproportionate share and indigent care payments made to hospitals as defined in paragraph (D) of rule 5101:3-2-07.5 of the Administrative Code.

(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 ~~2001~~2002.
- (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 most recent completed interim settled medicaid cost report and the cost reporting period ending in state fiscal year 2001 will be used. data filed by the new owner which reflects that hospital's most recent completed interim settled medicaid cost report, will