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 the state fiscal year that ends in the federal fiscal year preceding each program year. 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 the prior federal fiscal year.

(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:

(Medicaid Payments + Cash subsidies from patient services received directly from state and local government)/Total hospital revenues (incl. cash subsidies from patient services received directly from state and local government)

+

Total charges for inpatient services for charity care/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

(1) 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)(3)(A) of Section 1923.

(a) The total amount of disproportionate share funds that will be expended for general hospitals in the disproportionate share and indigent care policy pools shall be equal to the state's disproportionate share allotment, as determined by CMS, less amounts reserved for psychiatric hospitals.

(2) The funds available in the indigent care pool shall be distributed through policy payment pools in paragraphs (D) through (H). Policy payment pools shall be allocated a percentage of Ohio's disproportionate share allotment defined in paragraph (C)(1)(a) as described in paragraphs (D)(2)(a) through (D)(2)(f) of this rule.

(a) High federal disproportionate share hospital pool: ~~7.92~~ 7.85%

(b) Medicaid indigent care pool: ~~20.59~~ 20.40%

(c) Disability assistance medical and uncompensated care pool: ~~61.70~~ 61.12%

(d) Uncompensated care for persons above 100% of poverty: ~~5.29~~ 5.24%

(e) Critical access and rural hospitals: ~~3.16~~ 4.06%

(f) Children's hospitals: ~~1.34~~ 1.33%

(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 which meets the high federal disproportionate share definition, multiply the ratio calculated in paragraph (D)(1)(a) by the amount allocated in paragraph (C)(2)(a) to determine each hospital's high federal disproportionate share hospital payment amount, subject to the following limitations:

(i) If the hospital's payment amount calculated in paragraph (D)(1)(b) is greater than or equal to its hospital specific disproportionate share limit, defined in paragraph (I), the hospital's high federal disproportionate share hospital payment is equal its hospital specific disproportionate share limit.

(ii) If the hospital's payment amount calculated in (D)(1)(b) is less than its hospital-specific disproportionate share limit, defined in paragraph (I), the hospital's high federal disproportionate share hospital payment is equal to the amount in paragraph (D)(1)(b).

(iii) If the hospital-specific disproportionate share limit, defined in paragraph (I), is equal to or less than zero, the hospital's high federal disproportionate share hospital payment is equal to zero.

(iv) If any hospital is limited by paragraph (D)(1)(b)(i), ~~reduce the total~~ calculate each hospital's limited ~~payment~~ amount by subtracting its hospital-specific disproportionate share limit from the amount determined in paragraph (D)(1)(b) and sum these amounts for all limited hospital(s). Subtract the sum of the limited ~~payments~~ amounts from the amount allocated in paragraph (C)(2)(a) and repeat the distribution described in paragraph (D)(1) until all funds for this pool are expended. Hospitals that have been limited, shall have their ratio set to zero for subsequent redistributions within the pool.

(iv) For all hospitals, sum the amounts calculated in paragraph (D)(1)(b). This amount is the hospital's high federal 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 is equal to zero.

(b) For each hospital, Medicaid MCP inpatient payments are as reported on the Medicaid Cost Report.

(c) For each hospital, Medicaid MCP outpatient payments are as reported on the Medicaid Cost Report.

(d) For each hospital, calculate Medicaid MCP inpatient shortfall by subtracting from the total Medicaid MCP inpatient costs, Medicaid MCP inpatient payments in paragraph (D)(2)(b).

(e) For each hospital, calculate Medicaid MCP outpatient shortfall by subtracting from the total Medicaid MCP outpatient costs, Medicaid MCP outpatient payments in paragraph (D)(2)(c).

(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).

(j) For each hospital, multiply the ratio calculated in paragraph (D)(2)(i) by the amount allocated in paragraph (C)(2)(b) to determine each hospital's Medicaid indigent care payment amount.

(k) Each hospital's indigent care payment amount is equal to the amount calculated in paragraph (D)(2)(j), subject to the following limitations:

(i) If the sum of a hospital's payment amounts calculated in paragraph (D)(1)(b) is greater than or equal to its hospital-specific disproportionate share limit, the hospital's Medicaid indigent care payment pool amount is equal to zero.

(ii) If the sum of a hospital's payment amounts calculated in paragraph (D)(1)(b) and the amount calculated in paragraph (D)(2)(j) is less than its hospital-specific disproportionate share limit defined in paragraph (I); the hospital's indigent care payment amount is equal to the amount calculated in paragraph (D)(2)(j).

(iii) If the sum of a hospital's indigent care and the payment amounts calculated in paragraph (D)(1)(b) is greater than the hospital's disproportionate share limit defined in paragraph (I), then the hospital's indigent care payment amount is equal to the difference between the hospital's disproportionate share limit and the sum of the payment amounts in paragraphs (D)(1)(b) and (D)(2)(j).

(iv) If any hospital is limited by paragraph (D)(2)(k)(i), calculate each hospital's limited ~~payment~~ amount by subtracting its hospital-specific disproportionate share limit from the amount determined in paragraph (D)(2)(j) and sum these amounts for all limited hospital(s). Subtract the sum of the limited ~~payments~~ amounts from the amount allocated in paragraph (C)(2)(b) and repeat the distribution described in paragraph (D)(2) until all funds for this pool are expended. Hospitals that have been limited, shall have their ratio set to zero for subsequent redistributions within the pool.

(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. For hospitals with total negative disability assistance and uncompensated care costs, the resulting sum is zero.

(b) For all hospitals, sum the amounts calculated in paragraph (D)(3)(a).

(c) For each hospital, calculate the ratio of the amount in paragraph (D)(3)(a) to the amount in paragraph (D)(3)(b).

(d) For each hospital, multiply the ratio calculated in paragraph (D)(3)(c) by the amount calculated in paragraph (C)(2)(c) to determine each hospital's disability assistance medical and uncompensated care under one hundred per cent payment, subject to the following limitations:

(i) If the sum of a hospital's payment amounts calculated in paragraphs (D)(1) and (D)(2) 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 amount calculated in paragraphs (D)(1) and (D)(2) and the amount calculated in paragraph (D)(3)(d) 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 is equal to the amount calculated in paragraph (I).

(iii) If a hospital does not meet the condition described in paragraph (D)(3)(d)(i), and the sum of its payment amounts calculated in paragraph (D)(1) and (D)(2) and the amount calculated in paragraph (D)(3)(d) 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).

(iv) If any hospital is limited by paragraph (D)(3)(d)(i), calculate each hospital's limited ~~payment~~ amount by subtracting its hospital-specific disproportionate share limit from the amount determined in paragraph (D)(3)(d) and sum these amounts for all limited hospital(s). Subtract the sum of the limited ~~payments~~ amounts from the amount allocated in paragraph (C)(2)(c) and repeat the distribution described in paragraph (D)(3) until all funds for this pool are expended or all unlimited hospitals have received one hundred per cent of the amount described in paragraph (D)(3)(a). Hospitals that have been limited, shall have their ratio set to zero for subsequent redistributions within the pool.

(e) For all hospitals, sum the amounts calculated in paragraph (D)(3)(d).

(f) For each hospital, except those meeting either condition described in paragraph (D)(3)(d)(i) or (D)(3)-(d)(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)(d)(i) or (D)(3)(d)(iii), multiply the hospital's total uncompensated care costs above one hundred percent by zero.

(g) For all hospitals, sum the amounts calculated in paragraph (D)(3)(f).

(h) For each hospital, calculate the ratio of the amount in paragraph (D)(3)(f) to the amount in paragraph (D)(3)(g).

(i) Subtract the amount calculated in paragraph (D)(3)(e) from the amount allocated in paragraph (C)(2)(c) and add the amount calculated in paragraph (C)(2)(d).

(j) For each hospital, multiply the ratio calculated in paragraph (D)(3)(h)by the amount calculated in paragraph (D)(3)(i), 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 payment amounts calculated in paragraphs (D)(1), (D)(2) and (D)(3)(d) is greater than or equal to its hospital-specific disproportionate share limit defined in paragraph (I), the hospital's uncompensated care above one hundred per cent without insurance amount is equal to zero.

(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)(d) 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)(h) by the amount calculated in paragraph (D)(3)(i).

(iii) 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)(d) 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)(d).

(iv) If any hospital is limited by paragraph (D)(3)(j)(iii), calculate each hospital's limited ~~payment~~ amount by subtracting its hospital-specific disproportionate share limit from the amount determined in paragraph (D)(3)(d) and sum these amounts for all limited hospital(s). Subtract the sum of the limited ~~payments~~ amounts from the amount allocated in paragraph (D)(3)(i) and repeat - the distribution described in paragraph (D)(3)(g) through (D)(3)(j) until all funds for this pool are expended. Hospitals that have been limited, shall have their ratio set to zero for subsequent redistributions within the pool.

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

(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. Hospitals shall notify the Ohio Department of Job and Family Services of any change in their critical access hospital status, immediately following notification from CMS.

(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, calculate the ratio of each CAH hospital's Medicaid shortfall to total Medicaid shortfall for all CAH hospitals.

(c) For each CAH hospital, multiply the ratio calculated in paragraph (E)(1)(b) by ~~26.67~~ 32.01% of the amount allocated in paragraph (C)(2)(e) to determine each hospital's CAH payment amount.

(d) For all hospitals with CAH certification, sum the amounts calculated in paragraph (E)(1)(c).

(e) 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 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)(j).

(b) For each hospital with RAH classification, as qualified by paragraph (E)(2) and (E)(1)(e) subtract the amount calculated in paragraph (E)(2)(a), from the hospital's disproportionate share limit defined in paragraph (I). 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)(e), 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)(e), 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 the amount allocated in paragraph (C)(2)(e).

(f) For each hospital with RAH classification, as qualified by paragraph (E)(2) and (E)(1)(e), 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.

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

(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), 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) does not result in a net gain, nothing shall be redistributed under paragraphs (F)(3) and (F)(4).

(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)(f).

(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)(3)(a) and (F)(3)(b).

(d) For each hospital within a county with a closed hospital, multiply the ratio calculated in paragraph (F)(3)(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.

(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)(f).

(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.

(G) DISTRIBUTION OF FUNDS THROUGH THE CHILDREN'S HOSPITAL POOL.

(1) For each hospital meeting the children's hospital definition, sum the payment amounts as calculated in paragraphs (D), (E), and (F). This is the hospital's calculated payment amount.

(2) For each hospital meeting the children's hospital definition, with a calculated payment amount that is not greater than the disproportionate share limit, as described in paragraph (I), subtract the amount in paragraph (G)(1) from the amount described in paragraph (I).

(3) For hospitals meeting the children's hospital definition, with calculated payment amounts that are not greater than the disproportionate share limit, sum the amounts calculated in paragraph (G)(2).

(4) For each hospital meeting the children's hospital definition, with a calculated payment amount that is not greater than the disproportionate share limit, determine the ratio of the amounts in paragraphs (G)(2) and (G)(3).

(5) For each hospital meeting the children's hospital definition, with a calculated payment that is not greater than the disproportionate share limit, multiply the ratio calculated in paragraph (G)(4) by the amount allocated in paragraph (C)(2)(f). This amount is the children's hospital payment pool payment amount.

If the sum of the hospital's payment amounts calculated in paragraphs (D), (E), (F), and (G) is less than the hospital's disproportionate share limit defined in paragraph (I), then the hospital's children's hospital pool payment amount is equal to the amount calculated in paragraph (G)(5), not to exceed the amount defined in paragraph (I).

If any hospital is limited as described in paragraph (G)(5), calculate each hospital's limitation limited amount by subtracting the amount defined in paragraph (I) from the amount determined in paragraph (G)(5) and sum these amounts for all limited hospital(s). Subtract the sum of the limited amounts from the amount calculated in paragraph (C)(2)(f) and repeat the distribution described in paragraph (G) until all funds for this pool are expended. Hospitals that have been limited, shall have their ratio set to zero for subsequent redistributions within the pool.

(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 (H)(2), to determine if a hospital's calculated payment amount is greater than its disproportionate share limit.

(2) For each hospital, sum the hospital's total payments allocated in paragraphs (D)(1)(b), (D)(2)(k), AND (D)(3)(j), (E)(2)(g), (F)(3)(d), (F)(4)(d) and (G)(5).

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 (I)(3).

(3) RE-DISTRIBUTION 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), subtract the payment amount described in paragraph (H)(1) from the amount of the disproportionate share limit.

(b) For each hospital with calculated payment amounts that are not greater than the disproportionate share limit, sum the amounts calculated in paragraph (H)(3)(a).

(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 (H)(3)(a) and (H)(3)(b).

(d) For each hospital with a calculated payment amount that is not greater than the disproportionate share limit, multiply the ratio calculated in paragraph (H)(3)(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. For each hospital, add Medicaid MCP shortfall as calculated in paragraph (D)(2)(f).

(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 of federal poverty level, and inpatient uncompensated care above one hundred per cent of federal poverty level.

(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 of federal poverty level, and outpatient uncompensated care above one hundred per cent of federal poverty level.

(4) For each hospital, calculate the hospital disproportionate share limit by adding the Medicaid shortfall and Medicaid MCP shortfall as described in paragraph (I)(1), inpatient uncompensated care as described in paragraph (I)(2), and outpatient uncompensated care as described in paragraph (I)(3).

(5) The hospital will receive the lesser of the disproportionate share limit as described in paragraph (I)(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 the state fiscal year that ends in the federal fiscal year preceding each program year. 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.

5101:3-2-07.5 **Disproportionate share adjustment.**

This rule describes the disproportionate share definition and limitations on payment methods described in rule 5101:3-2-09 of the Administrative Code ~~and assessment determinations described in rule 5101:3-2-08.1 of the Administrative Code~~ for the program year specified in paragraph (A)(9) of rule 5101:3-2-08 of the Administrative Code.

(A) For the program year specified in paragraph (A)(9) of rule 5101:3-2-08 of the Administrative Code, paragraphs (B) to (D) of this rule set forth the definition of disproportionate share as well as other procedures and data used for the disproportionate share calculations ~~and assessment determinations as described in rule 5101:3-2-08.1 of the Administrative Code and payment determinations~~ as described in rule 5101:3-2-09 of the Administrative Code.

(B) Source data for calculations.

The source data used for the calculations made in paragraphs (C) and (D) of this rule will be the hospital's cost-reporting period ending in the state fiscal year as specified in paragraph (B) of rule 5101:3-2-08 of the Administrative Code.

(C) Determination of disproportionate share qualification.

(1) For each hospital calculate the medicaid utilization rate by dividing the sum of total medicaid days and managed care plan (MCP) days as defined in paragraph (A) of rule 5101:3-2-09 of the Administrative Code by total facility days as defined in paragraph (A) of rule 5101:3-2-09 of the Administrative Code.

(2) Each hospital with a medicaid utilization rate greater than or equal to one per cent qualifies as a disproportionate share hospital for the purposes of rule 5101:3-2-09 of the Administrative Code.

(3) Each hospital with a medicaid utilization rate less than one per cent qualifies as a nondisproportionate share hospital for the purposes of rule 5101:3-2-09 of the Administrative Code.

(D) Limitations on disproportionate share and indigent care payments made to hospitals.

(1) For purposes of this rule, for each hospital, calculate medicaid fee for service (FFS) shortfall by subtracting from total medicaid costs, as defined in paragraph (A) of rule 5101:3-2-09 of the Administrative Code, total medicaid payments, as described in paragraph (A) of rule 5101:3-2-09 of the Administrative Code. For those hospitals exempt from the prospective payment system as described in rule 5101:3-2-07.1 of the Administrative Code, the medicaid shortfall equals zero.

(2) For each hospital, calculate the total medicaid shortfall by adding the medicaid FFS shortfall as defined in paragraph (D)(1) of this rule to the medicaid MCP shortfall as defined in paragraph (E)(2)(d) of rule 5101:3-2-09 of the Administrative Code.

(3) For each hospital, determine the total cost of uncompensated care for people without insurance as described in paragraphs (D)(3)(a) to (D)(3)(c) of this rule.

(a) For each hospital, "total inpatient uncompensated care costs for people without insurance" means the sum of the inpatient disability assistance medical costs, uncompensated care costs below the poverty level, and uncompensated care costs above the poverty level amounts from the JFS 02930, schedule F, column 5, line 11.

(b) For each hospital, "total outpatient uncompensated care costs for people without insurance" means the sum of the outpatient disability assistance medical costs, uncompensated care costs below the poverty level, and uncompensated care costs above the poverty level amounts from the JFS 02930, schedule F, column 5, line 15.

(c) For each hospital, total uncompensated care costs for patients without insurance is equal to the sum of paragraphs (D)(3)(a) and (D)(3)(b) of this rule.

(4) For each hospital, determine the amount received under section 1011 - federal reimbursement of emergency health services furnished to undocumented aliens from the JFS 02930, schedule E, line 7b.

~~(4)~~(5) For each hospital, calculate the hospital disproportionate share limit by adding the total medicaid shortfall as described in paragraph (D)(2) of this rule and total uncompensated care costs for people without insurance as described in paragraph (D)(3)(c) of this rule and subtracting section 1011 payments as described in paragraph (D)(4) of this rule.

~~(5)~~(6) The hospital will receive the lesser of the disproportionate share limit as described in paragraph ~~(D)(4)~~ (D)(5) of this rule or the disproportionate share and indigent care payment as calculated in rule 5101:3-2-09 of the Administrative Code.

5101:3-2-09 **Payment policies for disproportionate share and indigent care adjustments for hospital services.**

This rule is applicable for each program year for all medicaid-participating providers of hospital services included in the definition of "hospital" as described under section 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, for the applicable state fiscal year, schedule H, section I, columns 1 and 3, line 1 and section II, column 1, line 10.

(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 10.

(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 per cent" 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.

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(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~~2, 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 the sum of total medicaid days plus MCP 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 7, 15, 26, and column 3, lines 7 and 26.

(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 7, less the amount described in paragraph (A)(30) of this rule, 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 amount reported on the JFS 02930, schedule H, column 1, line 15, divided by the amount reported on the JFS 02930, schedule H, section II, column 1, line 10.

(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 on JFS 02930 schedule I, column 2, line 107.

(23) "Medicaid managed care plan (MCP) outpatient payments" for each hospital means the amount on JFS 02930 schedule I, column 4, line 107.

(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 (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 centers for medicare and medicaid services (CMS).

(27) "Critical Access Hospital (CAH)" means a hospital that is certified as a critical access hospital by CMS and that has notified the Ohio department of health and the Ohio department of 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. Hospitals shall notify the Ohio department of job and family services of any change in their critical access hospital status, including continued CAH designations, immediately following notification from CMS.

(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. .

(29) "Children's hospitals" are those hospitals that meet the definition in paragraph (A)(2) of rule 5101:3-2-07.2 of the Administrative Code

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(30) "Other medicaid payments" for each hospital means the amount reported in JFS 02930, schedule H, section I, column 1, line 5.

(31) "Total program amount" means the sum of the amounts in paragraphs ~~(J)(2)~~ (I)(3) and (I)(4)of this rule.

(B) Source data for calculations.

(1) The calculations described in this rule will be based on cost-reporting data described in paragraph (B)(1) of rule 5101:3-2-08 of the Administrative Code.

(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 that meets the requirements of this paragraph is available. If, for a new hospital, there is no available or valid cost report filed with the department, the hospital will be excluded until valid data is available. ~~For hospitals that have changed ownership, the cost reporting data filed by the previous owner that reflects that hospital's completed interim settled medicaid cost report and the cost reporting data filed by the new owner that reflects that hospital's completed interim settled medicaid cost report, will be combined and annualized by the department to reflect one full year of operation. If there is no available or valid cost report from the previous owner, the department shall annualize the cost report from the new owner to reflect one full year of operation. 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.~~

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 current program year. That partial year data shall be used to determine the distribution to that closed hospital. The difference between the closed hospital's distribution based on the full year cost report and the partial year cost report shall be redistributed to the remaining hospitals in accordance with paragraph (G) of this rule.

For a hospital facility identifiable to a unique medicaid provider number that closed during the immediate prior program year, the cost report data shall be used to determine the distribution that would have been made to that closed

hospital. This amount shall be redistributed to the remaining hospitals in accordance with paragraph (G) of this rule.

(4) Replacement hospital facilities.

If a new hospital facility is opened for the purpose of replacing an existing (original) hospital facility identifiable to a unique medicaid provider number and the original facility closes during the program year defined in paragraph (A) of rule 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) Hospitals that have changed ownership.

For a change of ownership that occurs during the program year, the cost reporting data filed by the previous owner that reflects that hospital's most recent completed interim settled medicaid cost report shall be annualized to reflect one full year of operation. The data will be allocated to each owner based on the number of days in the program year the hospital was owned.

For a change of ownership that occurred in a previous program year, the cost reporting data filed by the previous owner that reflects that hospital's most recent completed interim settled medicaid cost report and the cost reporting data filed by the new owner that reflects that hospital's most recent completed interim settled medicaid cost report, will be combined and annualized by the department to reflect one full year of operation. If there is no available or valid cost report from the previous owner, the department shall annualize the cost report from the new owner to reflect one full year of operation.

~~(5)~~(6) Cost report data used in the calculations described in this rule will be the cost report data described in this paragraph subject to any adjustments made upon departmental review prior to final determination that is completed each year and subject to the provisions of rule 5101:3-2-08 of the Administrative Code.

(C) Creation of the disproportionate share and indigent care pool.

The disproportionate share and indigent care pool are created in compliance with Section 1923 of the Social Security Act. Furthermore, it is an assurance of this rule that the amount of payments made to disproportionate share hospitals will not exceed, in the aggregate, the limits prescribed under subparagraph (f)(3)(A) of Section 1923.

(D) Allocation of funds for distribution.

(1) The total "indigent care payment funds" available and expended for general hospitals shall be equal to the state's disproportionate share allotment, determined by the United States center for medicare and medicaid services (CMS) for that program year less amounts reserved for psychiatric hospitals.

(a) The indigent care pool funds available are allocated to payment policy pools as described in paragraph (D)(2) of this rule.

(b) The total indigent care payment policy pools are distributed as described in paragraphs (E) through (I) of this rule.

(2) The funds available in the indigent care pool shall be distributed through policy payment pools in paragraphs (E) through (I) of this rule. Policy payment pools shall be allocated a percentage of the indigent care pool as described in paragraphs (D)(2)(a) through (D)(2)(f) of this rule.

(a) High federal disproportionate share hospital pool: ~~7.92~~ 7.85%

(b) Medicaid indigent care pool: ~~20.59~~ 20.40%

(c) Disability assistance medical and uncompensated care pool below 100% of poverty: ~~61.70~~ 61.12%

(d) Uncompensated care for persons above 100% of poverty: ~~5.29~~ 5.24%

(e) Critical access and rural hospitals: ~~3.16~~ 4.06%

(f) Children's hospitals: ~~1.34~~ 1.33%

(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)(15) of this rule shall receive funds from the high federal disproportionate share indigent care payment pool.

(a) For each hospital that meets the high federal disproportionate share definition, calculate the ratio of the hospital's total medicaid costs and total medicaid MCP costs to the sum of total medicaid costs and total medicaid MCP costs for all hospitals that meet the high federal disproportionate share definition.

(b) For each hospital that meets the high federal disproportionate share definition, multiply the ratio calculated in paragraph (E)(1)(a) of this rule by the amount allocated in paragraph (D)(2)(a) of this rule to determine each hospital's high federal disproportionate share hospital payment amount, subject to the following limitations:

(i) If the hospital's payment amount calculated in paragraph (E)(1)(b) of this rule is greater than or equal to its hospital-specific disproportionate share limit defined in paragraph (A)(28) of this rule, the hospital's high federal disproportionate share hospital payment is the amount defined in paragraph (A)(28).

(ii) If the hospital's payment amount calculated in (E)(1)(b) of this rule is less than its hospital-specific disproportionate share limit defined in paragraph (A)(28) of this rule, the hospital's high federal disproportionate share hospital payment is equal to the amount in paragraph (E)(1)(b) of this rule and any additional amount provided by paragraph (E)(1)(b)(iv) of this rule.

(iii) If the hospital-specific disproportionate share limit defined in paragraph (A)(28) of this rule is equal to or less than zero, the hospital's high federal disproportionate share hospital payment is equal to zero.

(iv) If any hospital is limited as described in paragraph (E)(1)(b)(i) of this rule, calculate each hospital's ~~limitation~~ limited ~~payment~~ amount by subtracting the amount defined in paragraph (A)(28) of this rule from the amount determined in paragraph (E)(1)(b) and sum these amounts for all limited hospital(s). ~~Make the sum of the limitation amounts available to the remaining hospitals in the pool by repeating~~ Subtract the sum of the limited ~~payments~~ amounts from the amount allocated in paragraph (D)(2)(a) of this rule and repeat the distribution described in paragraph (E)(1) of this rule until all funds for this pool are expended.

Hospitals that have been limited, shall have their ratio set to zero for subsequent redistribution within the pool.

(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.

(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.

(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)(e) 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 the amount allocated in paragraph (D)(2)(b) of this rule to determine each hospital's medicaid indigent care payment amount subject to the following limitations:

(i) If the sum of a hospital's payment amounts calculated in paragraph (E)(1) of this rule is greater than or equal to its hospital-specific disproportionate share limit defined in paragraph (A)(28) of this rule,

the hospital's medicaid indigent care payment pool amount is equal to zero.

(ii) If the sum of a hospital's payment amounts calculated in paragraphs (E)(1) and (E)(2)(h) of this rule is less than its hospital-specific disproportionate share limit defined in paragraph (A)(28) of this rule, then the payment is equal to the amount in paragraph (E)(2)(h) of this rule and any amount provided by paragraph (E)(2)(h)(iv) of this rule.

(iii) If the sum of a hospital's payment amounts calculated in paragraphs (E)(1) and (E)(2)(h) of this rule is greater than its hospital-specific disproportionate share limit defined in paragraph (A)(28) of this rule, then the payment is equal to the difference between the amount calculated in paragraph (A)(28) of this rule and the amount calculated in paragraph (E)(1) of this rule.

(iv) If any hospital is limited as described in paragraph (E)(2)(h)(iii) of this rule, calculate each hospital's ~~limitation~~ limited ~~payment~~ amount by subtracting the amount defined in paragraph (A)(28) of this rule from the amount determined in paragraph (E)(2)(h) and sum these amounts for all limited hospital(s). ~~Make the sum of the limitation amounts available to the remaining hospitals in the pool by repeating~~ Subtract the sum of the limited ~~payments~~ amounts from the amount allocated in paragraph (D)(2)(b) of this rule and repeat the distribution described in paragraph (E)(2) of this rule until all funds for this pool are expended. Hospitals that have been limited, shall have their ratio set to zero for subsequent redistributions within the pool.

(v) For all hospitals, sum the amounts calculated in paragraph (E)(2)(h) of this rule. This amount is the hospital's medicaid indigent 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. For hospitals with total negative disability assistance and uncompensated care costs, the resulting sum is equal to zero.

(b) For all hospitals, sum the amounts calculated in paragraph (E)(3)(a) of this rule.

(c) For each hospital, calculate the ratio of the amount in paragraph (E)(3)(a) of the rule to the amount in paragraph (E)(3)(b) of this rule.

(d) For each hospital, multiply the ratio calculated in paragraph (E)(3)(c) of this rule by the amount allocated in paragraph (D)(2)(c) of this rule to determine each hospital's disability assistance medical and uncompensated care under one hundred per cent payment, subject to the following limitations:

(i) If the sum of a hospital's payment amounts calculated in paragraphs (E)(1) and (E)(2) of this rule is greater than or equal to its hospital-specific disproportionate share limit defined in paragraph (A)(28) of this rule, the hospital's 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 amount calculated in paragraphs (E)(1) and (E)(2) of this rule and the amount calculated in paragraph (E)(3)(d) of this rule is less than its hospital-specific disproportionate share limit defined in paragraph (A)(28) of this rule, the hospital's disability medical and uncompensated care under one hundred per cent payment amount is equal to the amount calculated in paragraph (E)(3)(d) of this rule and any amount provided by paragraph (E)(3)(d)(iv) of this rule.

(iii) If a hospital does not meet the condition described in paragraph (E)(3)(d)(i) of this rule, and the sum of its payment amounts calculated in paragraph (E)(1) and (E)(2) of this rule and the amount calculated in paragraph (E)(3)(d) of this rule is greater than its hospital-specific disproportionate share limit defined in paragraph (A)(28) of this rule, the hospital's 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 (E)(1) and (E)(2) of this rule.

(iv) If any hospital is limited as described in paragraph (E)(3)(d)(iii) of this rule, calculate each hospital's ~~limitation~~ limited ~~payment~~ amount by subtracting the amount defined in paragraph (A)(28) of this rule from the amount determined in paragraph (E)(3)(d) and sum these amounts for all limited hospital(s). ~~Make the sum of the limitation amounts available to the remaining hospitals in the pool by repeating~~ Subtract the sum of the limited ~~payments~~ amounts from the amount allocated in paragraph (D)(2)(c) of this rule and repeat the distribution described in paragraph (E)(3) of this rule until all funds for this pool are expended or all unlimited hospitals have received one hundred percent of the amount described in paragraph (E)(3)(a) of this rule. Hospitals that have been limited, shall have their ratio set to zero for subsequent redistributions within the pool.

(e) For all hospitals, sum the amounts calculated in paragraph (E)(3)(d) of this rule.

(f) For each hospital except those meeting either condition described in paragraph (E)(3)(d)(i) or (E)(3)(d)(iii) of this rule, multiply a factor of 0.30 by the hospital's total uncompensated care costs above one hundred per cent without insurance, as described in paragraph (A)(13) of this rule. For hospitals meeting the conditions described in paragraph (E)(3)(d)(i) or (E)(3)(d)(iii) of this rule, multiply the hospital's total uncompensated care costs above one hundred per cent by zero.

(g) For all hospitals, sum the amounts calculated in paragraph (E)(3)(f) of this rule.

(h) For each hospital, calculate the ratio of the amount in paragraph (E)(3)(f) of this rule to the amount in paragraph (E)(3)(g) of this rule.

(i) Subtract the amount calculated in paragraph (E)(3)(e) of this rule from the amount allocated in paragraph (D)(2)(c) of this rule and add the amount allocated in paragraph (D)(2)(d) of this rule.

(j) For each hospital, multiply the ratio calculated in paragraph (E)(3)(h) of this rule by the amount calculated in paragraph (E)(3)(i) of this rule to determine each hospital's uncompensated care above one hundred per cent without insurance payment, subject to the following limitations:

(i) If the sum of a hospital's payment amounts calculated in paragraphs (E)(1), (E)(2) and (E)(3)(d) of this rule is greater than or equal to its hospital-specific disproportionate share limit defined in paragraph (A)(28) of this rule, the hospital's uncompensated care above one hundred per cent without insurance amount is equal to zero.

(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 (E)(1), (E)(2), and (E)(3)(d) of this rule is less than the hospital's disproportionate share limit defined in paragraph (A)(28) of this rule, 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 (E)(3)(h) of this rule by the amount calculated in paragraph (E)(3)(i) of this rule and any amount provided by paragraph (E)(3)(j)(iv) of this rule.

(iii) If the sum of a hospital's uncompensated care above one hundred per cent without insurance payment and the payment amounts calculated in paragraphs (E)(1), (E)(2), and (E)(3)(d) of this rule is greater than the hospital's disproportionate share limit defined in paragraph (A)(28) of

this rule, 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 (E)(1), (E)(2), and (E)(3)(d) of this rule.

(iv) If any hospital is limited as described in paragraph (E)(3)(j)(iii) of this rule, calculate each hospital's ~~limitation~~ limited ~~payment~~ amount by subtracting the amount defined in paragraph (A)(28) of this rule from the amount determined in paragraph (E)(3)(j) and sum these amounts for all limited hospital(s). ~~Make the sum of the limitation amounts available to the remaining hospitals in the pool by repeating~~ Subtract the sum of the limited ~~payments~~ amounts from the amount allocated in paragraph (E)(3)(i) of this rule and repeat the distribution described in paragraph the distribution described in paragraphs (E)(3)(g) through (E)(3)(j) of this rule until all funds for this pool are expended. Hospitals that have been limited, shall have their ratio set to zero for subsequent redistributions within the pool.

(k) -For each hospital, sum the amount calculated in paragraph (E)(3)(d) of this rule, and the amount calculated in paragraph (E)(3)(j) 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 rural and critical access payment pools.

The funds are distributed among the hospitals according to rural and critical access payment pools described in paragraphs (F)(1) to (F)(2) of this rule.

(1) Hospitals meeting the definition described in paragraph (A)(27) of this rule, shall receive funds from the critical access hospital (CAH) payment pool.

(a) For each hospital with CAH certification, calculate the medicaid shortfall as described in paragraph (E)(2)(a) of this rule.

(b) For each hospital with CAH certification:

(i) Calculate the ratio of each CAH hospital's medicaid shortfall to total medicaid shortfall for all CAH hospitals.

(ii) For each CAH hospital, multiply the ratio calculated in paragraph (F)(1)(b)(i) of this rule by ~~26.67~~ 32.01 percent of the amount allocated in paragraph (D)(2)(e) of this rule to determine each hospital's CAH payment amount.

(c) For all hospitals with CAH certification, sum the amounts calculated in paragraph (F)(1)(b) of this rule.

(d) For each hospital with CAH certification, if the amount described in paragraph (F)(1)(a) of this rule is equal to zero, the hospital shall be included in the RAH payment pool described in paragraph (F)(2)(a) of this rule.

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

(a) For each hospital with RAH classification, as qualified by paragraphs (F)(2) and (F)(1)(d) of this rule, sum the hospital's total payments allocated in paragraphs (E)(1)(b), (E)(2)(h), and (E)(3)(k) of this rule.

(b) For each hospital with RAH classification, as qualified by paragraphs (F)(2) and (F)(1)(d) of this rule subtract the amount calculated in paragraph (F)(2)(a) of this rule, from the amount calculated in paragraph (A)(28) of this rule. If this difference for the hospital is negative, then for the purpose of this calculation set the difference equal to zero.

(c) For all hospitals with RAH classification, as qualified by paragraphs (F)(2) and (F)(1)(d) of this rule, sum the amounts calculated in paragraph (F)(2)(b) of this rule.

(d) For each hospital with RAH classification, as qualified by paragraphs (F)(2) and (F)(1)(d) of this rule, determine the ratio of the amounts in paragraphs (F)(2)(b) and (F)(2)(c) of this rule.

(e) Subtract the amount calculated in paragraph (F)(1)(c) of this rule from the amount allocated in paragraph (D)(2)(e) of this rule.

(f) For each hospital with RAH classification, as qualified by paragraphs (F)(2) and (F)(1)(d) of this rule, multiply the ratio calculated in paragraph (F)(2)(d) of this rule, by the amount calculated in paragraph (F)(2)(e) of this rule, to determine each hospital's rural access hospital payment pool amount.

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

(G) Distribution of funds through the county redistribution of closed hospitals payment pools.

If funds are available in accordance with paragraph (B) of this rule, the funds are distributed among the hospitals according to the county redistribution of closed hospitals payment pools described in paragraphs (G)(1) to (G)(3) of this rule.

(1) If a hospital facility that is identifiable to a unique medicaid provider number closes during the current program year, the payments that would have been made to that hospital under paragraphs (E), (F), (H), and (I) of this rule for the portion of the year it was closed, less any amounts that would have been paid by the closed hospital under provisions of rules 5101:3-2-08 and 5101:3-2-08.1 of the Administrative Code for the portion of the year it was closed, shall be distributed to the remaining hospitals in the county where the closed hospital is located. If another hospital does not exist in such a county, the funds shall be distributed to hospitals in bordering counties within the state.

For each hospital identifiable to a unique medicaid provider number that closed during the immediate prior program year, the payments that would have been made to that hospital under paragraphs (E), (F), (H), and (I) of this rule, less any amounts that would have been paid by the closed hospital under provisions of rules 5101:3-2-08 and 5101:3-2-08.1 of the Administrative Code, shall be distributed to the remaining hospitals in the county where the closed hospital was located. If another hospital does not exist in such a county, the funds shall be distributed to hospitals in bordering counties within the state.

If the closed hospital's payments under paragraphs (E), (F), (H), and (I), of this rule does not result in a net gain, nothing shall be redistributed under paragraphs (G)(2) and (G)(3) of this rule.

(2) Redistribution of closed hospital funds within the county of closure.

(a) For each hospital within a county with a closed hospital as described in paragraph (G)(1) of this rule, sum the amount calculated in paragraph (E)(3)(a) of this rule, and the amount calculated in paragraph (E)(3)(f) of this rule if the sum of a hospital's total payments calculated in paragraphs (E)(1), (E)(2), (E)(3), (F)(1), and (F)(2) of this rule does not exceed the hospital's disproportionate share limit defined in paragraph (A)(28) of this rule.

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

(c) For each hospital within a county with a closed hospital, determine the ratio of the amounts in paragraphs (G)(2)(a) and (G)(2)(b) of this rule.

(d) For each hospital within a county with a closed hospital, multiply the ratio calculated in paragraph (G)(2)(c) of this rule, by the amount calculated in paragraph (G)(1) of this rule, to determine each hospital's county

redistribution of closed hospitals payment amount, subject to the following limitation:

If the sum of a hospital's payment amounts calculated in paragraphs (E)(1), (E)(2), (E)(3)(d), (F)(1), and (F)(2) of this rule is less than the hospital's disproportionate share limit defined in paragraph (A)(28) of this rule, then the hospital's redistribution of closed hospital funds amount is equal to the amount in paragraph (G)(2)(d) of this rule, not to exceed the amount defined in paragraph (A)(28) of this rule.

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

(a) For each hospital within a county that borders a county with a closed hospital where another hospital does not exist, as described in paragraph (G)(1) of this rule, sum the amount calculated in paragraph (E)(3)(a) of this rule, and the amount calculated in paragraph (E)(3)(f) of this rule if the sum of a hospital's total payments calculated in paragraphs (E)(1), (E)(2), (E)(3), (F)(1) and (F)(2) of this rule does not exceed the hospital's disproportionate share limit defined in paragraph (A)(28) of this rule.

(b) For all hospitals within counties that border a county with a closed hospital where another hospital does not exist, sum the amounts calculated in paragraph (G)(3)(a) of this rule.

(c) For each hospital within a county that borders a county with a closed hospital where another hospital does not exist, determine the ratio of the amounts in paragraphs (G)(3)(a) and (G)(3)(b) of this rule.

(d) For each hospital within a county that borders a county with a closed hospital where another hospital does not exist, multiply the ratio calculated in paragraph (G)(3)(c) of this rule, by the amount calculated in paragraph (G)(1) of this rule, to determine each hospital's county redistribution of closed hospitals payment amount subject to the following limitation:

If the sum of a hospital's payment amounts calculated in paragraphs (E)(1), (E)(2), (E)(3)(d), (F)(1), and (F)(2) of this rule is less than the hospital-specific disproportionate share limit defined in paragraph (A)(28) of this rule, the hospital's redistribution of closed hospital funds amount is the amount defined in paragraph (G)(3)(d) of this rule, not to exceed the amount defined in paragraph (A)(28) of this rule.

(H) Distribution of funds through the children's hospital pool.

(1) For each hospital meeting the children's hospital definition described in paragraph (A)(29) of this rule, sum the payment amounts as calculated in

paragraphs (E), (F), and (G) of this rule. This is the hospital's calculated payment amount.

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

(3) For hospitals meeting the children's hospital definition described in paragraph (A)(29) of this rule, with calculated payment amounts that are not greater than the disproportionate share limit, sum the amounts calculated in paragraph (H)(2) of this rule.

(4) For each hospital meeting the children's hospital definition described in paragraph (A)(29) of this rule, with a calculated payment amount that is not greater than the disproportionate share limit, determine the ratio of the amounts in paragraphs (H)(2) and (H)(3) of this rule.

(5) For each hospital meeting the children's hospital definition described in paragraph (A)(29) of this rule, with a calculated payment that is not greater than the disproportionate share limit, multiply the ratio calculated in paragraph (H)(4) of this rule by the amount allocated in paragraph (D)(2)(f) of this rule. This amount is the children's hospital payment pool payment amount, subject to the following limitation.

If the sum of the hospital's payment amounts calculated in paragraphs (E)(1), (E)(2), (E)(3)(d), (F)(1), (F)(2), and (G) of this rule is less than the hospital's disproportionate share limit defined in paragraph (A)(28) of this rule, then the hospital's children's hospital pool payment amount is equal to the amount calculated in paragraph (H)(5) of this rule, not to exceed the amount defined in paragraph (A)(28) of this rule.

If any hospital is limited as described in paragraph (H)(5) of this rule, calculate each hospital's ~~limitation~~ limited ~~payment~~ amount by subtracting the amount defined in paragraph (A)(28) of this rule from the amount determined in paragraph (H)(5) and sum these amounts for all limited hospital(s). ~~Make the sum of the limitation amounts available to the remaining hospitals in the pool by repeating~~ Subtract the sum of the limited ~~payments~~ amounts from the amount calculated in paragraph (D)(2)(f) of this rule and repeat the distribution described in paragraph (H) of this rule until all funds for this pool are expended. Hospitals that have been limited, shall have their ratio set to zero for subsequent redistributions within the pool.

(I) Distribution model adjustments and limitations through the statewide residual pool.

(1) For each hospital, sum the payment amounts as calculated in paragraphs (E), (F), (G), and (H), of this rule. This is the hospital's calculated payment amount.

(2) For each hospital, calculate the hospital's specific disproportionate share limit as defined in paragraph (A)(28) of this rule.

(3) For each hospital, subtract the hospital's disproportionate share limit as calculated in paragraph (I)(2) of this rule from the payment amount as calculated in paragraph (I)(1) of this rule to determine if a hospital's calculated payment amount is greater than its disproportionate share limit. If the hospital's calculated payment amount as calculated in paragraph (I)(1) of this rule is greater than the hospital's disproportionate share limit calculated in paragraph (I)(2)of this rule, then the difference is the hospital's residual payment funds.

(4) If a hospital's calculated payment amount, as calculated in paragraph (I)(1) of this rule, is greater than its disproportionate share limit defined in paragraph (I)(2) of this rule, then the hospital's payment is equal to the hospital's disproportionate share limit.

(a) The hospital's residual payment funds as calculated in paragraph (I)(3) of this rule is subtracted from the hospital's calculated payment amount as calculated in paragraph (I)(1) of this rule and is applied to and distributed as the statewide residual payment pool as described in paragraph (I)(5)of this rule.

(b) The total amount distributed through the statewide residual pool will be the aggregate indigent care payment funds described in paragraph (D)(1) minus the sum of the lessor of each hospital's calculated payment amount calculated in (I)(1) of this rule or the hospital's disproportionate share limit calculated in paragraph (I)(2) of this rule.

(5) Redistribution of residual payment funds in the statewide residual payment pool.

(a) For each hospital with a calculated payment amount that is not greater than the disproportionate share limit, as described in paragraph (I)(4) of this rule, subtract the amount in paragraph (I)(1) of this rule from the amount in paragraph (I)(2) of this rule.

(b) For hospitals with calculated payment amounts that are not greater than the disproportionate share limit, sum the amounts calculated in paragraph (I)(5)(a) of this rule.

(c) For each hospital with a calculated payment amount that is not greater than the disproportionate share limit, determine the ratio of the amounts in paragraphs (I)(5)(a) and (I)(5)(b)of this rule.

(d) For each hospital with a calculated payment amount that is not greater than the disproportionate share limit, multiply the ratio calculated in paragraph (I)(5)(c) of this rule by the total amount distributed through the statewide residual pool described in paragraph (I)(5)(b) of this rule. This amount is the hospital's statewide residual payment pool payment amount subject to the following limitation:

If the amount sum of the hospital's payment amounts calculated in paragraphs (E), (F), (G), and (H) of this rule is less than the amount hospital's disproportionate share limit defined in paragraph (A)(28) of this rule, then hospital's residual pool payment amount is equal to the amount defined in paragraph (I)(5)(d) of this rule, not to exceed the amount defined in paragraph (A)(28) of this rule.

(J) Payments and adjustments.

(1) All payments to hospitals under the provisions of this rule are conditional on:

(a) The hospital's compliance with the provisions of rule 5101:3-2-07.17 of the Administrative Code; and

(b) 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.

(2) If an audit conducted by the department of the amounts of payments made and received by hospitals under the provisions of this rule identifies amounts that, due to errors by the department, a hospital should not have been required to pay but did pay, should have been required to pay but did not pay, should not have received but did receive, or should have received but did not receive, the department shall:

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

(b) Take action to recover from a hospital any amounts that the audit reveals it should have been required to pay but did not pay or that it should not have received but did receive.

(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.

OS Notification

State/Title/Plan Number: **Ohio 10-007**

Type of Action: **SPA Approval**

Required Date for State Notification: **December 27, 2010**

Fiscal Impact: **FY 2010 $ 10,236,978**
FY 2011 $ 0

Number of Services Provided by Enhanced Coverage, Benefits or Retained Enrollment: 0

Number of Potential Newly Eligible People: 0

Eligibility Simplification: No

Provider Payment Increase: Yes

Delivery System Innovation: No

Number of People Losing Medicaid Eligibility: No

Reduces Benefits: No

Detail: **Effective for services on or after September 23, 2010, this amendment revises methodology for making disproportionate share hospital (DSH) payments to general acute care hospitals. Ohio makes DSH payments to eligible hospitals through the use of multiple payment pools. Specifically, this amendment revises the methodology for several of the pools to ensure that, despite some of the hospitals reaching their hospital-specific limit, the entire amount of the pool is paid out to each remaining eligible hospital that still has room under their hospital specific limit. Funding the non-Federal share of these payments comes from State appropriations and provider tax.**

Ohio makes disproportionate share hospital payments to eligible hospitals through the use of multiple policy payment pools. These pools are allocated a percentage of Ohio's DSH allotment. This amendment revises the percentages for each of the pools.

These DSH payment pools each have methodology that limits payment, from the pool to individual hospitals, by each hospital's specific DHS limit. This amendment adds methodology for several of the pools so that even if some of the hospitals reach their hospital-specific limit as a result of payments from that particular DSH pool, the entire amount allocated to that particular DSH pool will be distributed to all the hospitals that haven't reached their hospital-specific limit.

Other Considerations: This plan amendment has not generated significant outside interest and we do not recommend the Secretary contact the governor.

Recovery Act Impact:

The Regional office has reviewed this state plan amendment in conjunction with the Recovery Act and, based on the available information provided by the State regarding 1) MOE; 2) local match; 3) prompt pay; 4) rainy day funds, and 5) eligible expenditures, the Regional Office believes that the State is not in violation of the Recovery Act requirements noted above.

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