5101:3-2-08 Assessment policies for disproportionate share and indigent care adjustments for hospital services.

The provisions of this rule are applicable for the program year that ends in calendar year 2000 ~~1999~~ for all medicaid-participating providers of hospital services included in the definition of "hospital" as described in paragraph (A)(3) of this rule.

(A) Definitions.

(1) "Disproportionate share hospital" means a hospital which meets criteria for disproportionate share status as defined in rule 5101:3-2-075 of the Administrative Code.

(2) "Governmental hospital" means a county hospital with more than five hundred beds or a state-owned and -operated hospital with more than five hundred beds.

(3) "Hospital" means a hospital which is described under section 5112.01 of the Revised Code.

(4) "Hospital care assurance program fund" means the fund described under section 5112.18 of the Revised Code.

(5) "Hospital care assurance match fund" means the fund described under section 5112.18 of the Revised Code.

(6) "Intergovernmental transfer" means any transfer of money by a governmental hospital.

(7) "Legislative budget services fund" means the fund described under section 5112.19 of the Revised Code.

(8) "Medical assistance program" means the program of medical assistance established under section 5111.01 of the Revised Code and under Title XIX of the Social Security Act, 49 stat. 620 (1935), 42 U.S.C. 301, as amended.

(9) "Program year" means the twelve-month period beginning on the first day of October and ending on the thirtieth day of September.

(10) "Total facility costs" for each hospital means the amount from the ODHS 2930, schedule B, column 3, line 101.

(11) "Total skilled nursing facility costs" for each hospital means the amount on the ODHS 2930, schedule B, column 3, line 34.

(12) "Total home health facility costs" for each hospital means the amount on the ODHS 2930, schedule B, column 3, line 67.

(13) "Other non-hospital costs" for each hospital means separately identifiable non-hospital operating costs found on worksheet B, Part I of the medicare cost report, as determined by the department upon the request of the hospital, that are permitted to be excluded from the provider tax in compliance with section 1903 (w) of the Social Security Act.

(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 human 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 fund that has been paid by the hospital, plus any investment earnings on that amount.

(C) Source data for calculations.

The calculations described in this rule will be based on cost-reporting data described in rule 5101:3-2-23 of the Administrative Code which reflect the hospital's cost reporting period ending in state fiscal year 1999 ~~1998~~.

For new hospitals, the first available cost report filed with the department in accordance with rule 5101:3-2-23 of the Administrative Code will be used until a cost report which meets the requirements of this paragraph is available. If, for a new hospital, there is no available or valid cost report filed with the department, the hospital will be excluded until valid data is available. For hospitals which have changed ownership, the cost reporting data filed by the previous owner which reflects that hospital's cost reporting period ending in state fiscal year 1999 ~~1998~~ will be used. Cost reports for hospitals involved in mergers during the program year that result in the hospitals using one provider number will be combined and annualized by the department to reflect one full year of operation. For hospitals that close during the program year, no cost report data will be used.

Cost report data used in the calculations described in this rule will be the cost report data described in this paragraph and are subject to any adjustments made upon departmental review which is completed each year and subject to the provisions of paragraphs (G) to (G)(4) of this rule.

(D) Calculation of assessment amounts.

The source data described in paragraph (C) of this rule will be the data used in calculating assessment amounts as described in paragraphs (D)(1) to (D)(3) of this rule.

(1) Determine each hospital's total facility costs for services provided to all patients. Subtract from each hospital's total facility cost the hospital's total skilled nursing facility costs the hospital's total home health facility costs, and other non-hospital costs as determined by the department. The difference will be the hospital's adjusted total facility costs.

(2) For hospitals with adjusted total facility cost, as described in paragraph (D)(1) of this rule, that are less than or equal to $217,252,765 ~~$214,904,302~~, multiply the hospital's adjusted total facility costs as described in paragraph (D)(1) of this rule by 0.018 ~~0.02~~. The product will be each hospital's assessment amount. For hospitals with adjusted total facility costs, as described in paragraph (D)(1) of this rule, that are greater than $217,252,765

~~$214,904,302~~, multiply a factor of 0.018 ~~0.02~~ times the hospital's adjusted total facility costs as described in paragraph (D)(1) of this rule, up to $217,252,765 ~~$214,904,302~~. Multiply a factor of 0.01 times the hospital's adjusted total facility costs as described in paragraph (D)(1) of this rule, that are in excess of $217,252,765 ~~$214,904,302~~. The sum of the two products will be each hospital's assessment amount.

(3) The assessment amounts calculated in paragraph (D)(2) of this rule are subject to adjustment under the provisions of paragraphs (G) to (G)(4) of this rule.

(E) Determination of intergovernmental transfer amounts.

The department of human services may require governmental hospitals to make intergovernmental transfers each program year.

The department shall notify each governmental hospital of the amount of the intergovernmental transfer it is required to make during the program year.

Each governmental hospital shall make intergovernmental transfers in periodic installments, executed by electronic funds transfer.

(F) Deposits into the legislative budget services fund.

From the first installment of the assessments paid under paragraph (D) of this rule and intergovernmental transfers made under paragraph (E) of this rule during each program year beginning in an odd-numbered calendar year, the department shall deposit into the state treasury to the credit of the legislative budget services fund a total amount equal to the amount by which the biennial appropriation from that fund exceeds the amount of the unexpended, unencumbered monies in that fund.

(G) Notification and reconsideration procedures.

The department will conduct the notification and reconsideration procedures described in paragraphs (G)(1) to (G)(4) of this rule.

(1) The department shall mail by certified mail, return receipt requested, the results of the determinations made under paragraph (D)(3) of this rule to each hospital. If no hospital submits a request for reconsideration as described in this rule, the preliminary determinations constitute the final reconciliation of the amounts that each hospital must pay under this rule.

(2) Not later than fourteen days after the department mails the preliminary determinations as described in paragraph (D)(3) of this rule; any hospital may submit to the department a written request for reconsideration of the preliminary determination made under paragraph (D)(3) of this rule. The request must be accompanied by written materials setting forth the basis for the reconsideration.

If one or more hospitals submit such a request, the department shall hold a public hearing in Columbus, Ohio not later than thirty days after the preliminary determinations have been mailed by the department for the purpose of reconsidering its preliminary determinations. The department shall mail written notice of the date, time, and place of the hearing to every hospital at least ten days before the date of the hearing.

On the basis of the evidence submitted to the department or presented at the public hearing, the department shall reconsider and may adjust the preliminary determinations. The result of the reconsideration is the final reconciliation of the amounts that each hospital must pay under the provisions of this rule.

(3) The department shall mail each hospital written notice of the amount it must pay under the final reconciliation as soon as practical. Any hospital may appeal the amount it must pay to the court of common pleas of Franklin county.

(4) In the course of any program year, the department may adjust the assessment rate defined in paragraph (D)(2) of this rule or adjust the amount of the intergovernmental transfers required under paragraph (E) of this rule, and, as a result of the adjustment , adjust each hospital's assessment and intergovernmental transfer, to reflect refinements made by the United States health care financing administration during that program year to the limits prescribed under subparagraph (f) of section 1923 of the Social Security Act, 42 U.S.C.A. 1396R-4(f), as amended.

(5) Finalization of data

(a) The department may ~~shall~~ mail any data the department may choose to use for disproportionate share and indigent care adjustments, described in rule 5101:3-2-09 of the Administrative Code to each hospital. Not later than fourteen days after the department mails the data, any hospital may submit to the department a written request to correct data. Any documents, data, or other information that supports the hospital's request to correct data must be submitted with the request. On the basis of the information submitted to the department, the department may adjust the data.

~~(b) For the program year that ends in calendar year 1999, the department may notify hospitals of an extended opportunity to submit a written request to correct data. Not later than seven days after the department mails the data, any hospital may submit to the department a written request to correct data. Any documents, data, or other information that supports the hospital's request to correct data must be submitted with the request. On the basis of the information submitted to the department, the department may adjust the data and will then consider all data final.~~

(H) 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 human services or by any person under contract with the department who has access to such information.

Effective Date: 28 SEPT 2000

Rule Review Dates: August 26, 1999, August 26, 2004

Certification:

18 SEPT 2000
Date

Promulgated under Chapter 119.

Statutory Authority RC Section 5112.03

Rule Amplifies RC Chapter 5112.

Prior Effective Date: 7/1/94, 2/27/95 (Emer.), 5/18/95, 6/26/96 (Emer.), 8/13/96, 7/24/97 (Emer.), 8/21/97 (Emer.), 11/1/97, 6/26/98 (Emer.), 9/1/98, 4/16/99 (Emer.), 6/10/99 (Emer.), 7/16/00 (Emer.), 8/26/99, 7/14/00 (Emer.)