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Ohio Administrative Code

Rule 5160-2-08 Data policies for disproportionate share and indigent care adjustments for hospital services.

Effective: June 13, 2016

This rule sets forth the data used to determineassessments and adjustments, and the data policies that are applicable for eachprogram year for all providers of hospital services included in the definitionof "hospital" as described under section 5168.01 of the RevisedCode.

(A) Definitions.

(1) "Disproportionate share hospital" means a hospital that meets the requirements for disproportionate share status as defined in rule 5160-2-09 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 that is described under section 5168.01 of the Revised Code.

(4) "Hospital care assurance program fund" means the fund described under section 5168.11 of the Revised Code.

(5) "Hospital care assurance match fund" means the fund described under section 5168.11 of the Revised Code.

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

(7) "Health care services administration fund" means the fund described under section 5162.54 of the Revised Code.

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

(9) "Total facility costs" for each hospital means the amount from the ODM 02930, "Ohio Medicaid Hospital Cost Report," for the applicable state fiscal year, schedule B, column 3, line 202. For non-medicaid participating hospitals, total facility costs shall be determined from the medicare cost report.

(10) "Total skilled nursing facility costs" for each hospital means the amount on the ODM 02930, schedule B, column 3, line 44. For non-medicaid participating hospitals, total skilled nursing facility costs shall be determined from the medicare cost report.

(11) "Total home health facility costs" for each hospital means the amount on the ODM 02930, schedule B, column 3, line 98. For non-medicaid participating hospitals, total home health facility costs shall be determined from the medicare cost report.

(12) "Total hospice facility costs" for each hospital means the amount on ODM 02930, schedule B, column 3, line 99. For non-medicaid participating hospitals, total hospice facility costs shall be determined from the medicare cost report.

(13) "Total ambulance costs" for each hospital means the amount on ODM 02930, schedule B, column 3, line 95. For non-medicaid participating hospitals, total ambulance costs shall be determined from the medicare cost report.

(14) "Total Durable Medical Equipment (DME) rental costs" for each hospital means the amount on ODM 02930, schedule B, column 3, line 96. For non-medicaid participating hospitals, total DME rental costs shall be determined from the medicare cost report.

(15) "Total DME sold costs" for each hospital means the amount on ODM 02930, schedule B, column 3, line 97. For non-medicaid participating hospitals, total DME sold costs shall be determined from the medicare cost report.

(16) "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.

(17) "Adjusted total facility costs" means the result of subtracting the sum of the amounts defined in paragraphs (A)(10), (A)(11), (A)(12), (A)(13), (A)(14) and (A)(15) of this rule from the amount defined in paragraph (A)(9) of this rule.

(B) Source data for calculations.

(1) The calculations described in this rule for each program year will be based on cost-reporting data described in rule 5160-2-23 of the Administrative Code that reflects the completed interim settled medicaid cost report (ODM 02930) for each hospital's cost reporting period ending in the state fiscal year that ends in the federal fiscal year preceding each program year. For non-medicaid participating hospitals, the calculations will be based on the medicare cost report for the same time period.

(a) For new hospitals, the first available cost report filed with the department in accordance with rule 5160-2-23 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.

(b) Data for hospitals that have changed ownership shall be treated as described in paragraphs (B)(1)(b)(i) to (B)(1)(b)(ii) of this rule.

(i) 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.

(ii) For a change of ownership that occurred in the 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.

(c) For hospitals involved in mergers during the program year that result in the hospitals using one provider number, the cost reports from the merged providers will be combined and annualized by the department to reflect one full year of operation.

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 that is completed each year and subject to the provisions of paragraph (D) of this rule.

(2) Closed hospitals with unique medicaid provider numbers.

For a hospital facility, identifiable to a unique medicaid provider number, that closes during the current program year as defined in paragraph (A) of this rule, the cost report data shall be adjusted to reflect the portion of the year that the hospital was open during the current program year. That partial year data shall be used to determine the assessment owed by that closed hospital.

Hospitals identifiable to a unique medicaid provider number that closed during the immediate prior program year will not owe an assessment for the current program year.

(3) Replacement hospital facilities.

(a) 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 this rule, the cost report data from the original facility shall be used to determine the assessment for the new replacement facility if the following conditions are met:

(i) Both facilities have the same ownership,

(ii) There is appropriate evidence to indicate that the new facility was constructed to replace the original facility,

(iii) The new replacement facility is so located as to serve essentially the same population as the

original facility, and

(iv) The new replacement facility has not filed a cost report for the current program year.

(b) For a replacement hospital facility that opened in the immediate prior program year, the assessment 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.

(C) Deposits into the health care services administration fund.

From the first installment of assessments paid under rule 5160-2-08.1 of the Administrative Code and intergovernmental transfers made under rule 5160-2-08.1 of the Administrative Code during each program year, the department shall deposit into the state treasury to the credit of the health care services administration fund, a total amount equal to the amount allocated by the appropriations act from assessments paid under section 5168.06 of the Revised Code and intergovernmental transfers made under section 5168.07 of the Revised Code during each program year.

(D) Finalization of data used for disproportionate share and indigent care adjustments.

During each program year, the department may provide any data the department may choose to use for disproportionate share and indigent care adjustments, described in rule 5160-2-09 of the Administrative Code, to each hospital. The department may mail the data or may make the data available on the medicaid provider portal. The department will notify each hospital of the availability of the data via regular or electronic mail (e-mail). Not later than thirty days after the department mails or e-mails the notification, 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.

(1) For each program year, thirty-days after the expiration of all hospitals' thirty-day data correction periods, the department shall consider the data correction period closed and all data final, subject to review and acceptance by the department.

(2) Any hospital that requests to correct data after the expiration of its thirty-day correction period but before the data correction period is closed for all hospitals as described in paragraph (D)(1) of this rule, shall be subject to an administrative fee. The administrative late fee shall be 0.03 per cent of the hospital's adjusted total facility cost as calculated in paragraph (A)(17) of this rule. The hospital shall include payment of the administrative late fee with the written request to correct data.

(3) All amounts received by the department under this paragraph shall be deposited into the state treasury to the credit of the health care services administration fund, described under paragraph (A)(7) of this rule.

(4) The department shall accept at any time, data from any hospital that has misstated its reported data used to make disproportionate share and indigent care adjustments and that resulted in a disproportionate share and indigent care payment that was greater than the payment would have been with the corrected data.

(E) Confidentiality.

Except as specifically required by the provisions of this rule and rule 5160-2-24 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 medicaid or by any person under contract with the department who has access to such information.