Ohio Administrative Code

Rule 5160-2-08.1 Assessment rates.

Effective: November 11, 2018

(A) Applicability.

The requirements of this rule apply as long as the United States centers for medicare and medicaid services (CMS) determines that the assessment imposed under section 5168.06 of the Revised Code is a permissible health care related tax. Whenever the department of medicaid 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 match fund that has been paid by the hospital, plus any investment earnings on that amount.

(B) Definitions

(1) "Program year" - The period beginning the first day of October of a calendar year and ending on the thirtieth day of September of the following calendar year.

(2) "Current program year" - The program year beginning the first day of October of the most recent calendar year and ending on the thirtieth day of September the following calendar year.

(3) "Past program year" - Any program year beginning the first day of October in a calendar year preceding the current program year and ending the thirtieth day of September the following calendar year.

(C) The program years to which this rule applies are identified in paragraphs (C)(1) to (C)(3) of this rule. When the department is notified by the CMS that an additional disproportionate share allotment is available for a past program year, the department may amend the assessment rates for the past program year.

(1) The assessment rates applicable to the current program year are specified in paragraph (D) of this rule.

(2) The assessment rates applicable to the past program year when federal allotment is increased are specified in paragraph (E)(1) of this rule.

(3) The revised assessment rates applicable to the past program year when federal allotment is decreased are specified in paragraph (E)(2) of this rule.

(D) Calculation of assessment amounts.

The calculations described in this rule will be based on the cost-reporting data described in rule 5160-2-23 of the Administrative Code that reflect the most recently completed interim settled medicaid cost report for all hospitals. For non-medicaid participating hospitals, the calculations shall be based on the most recent as-filed medicare cost report.

The assessment is calculated as follows:

(1) Determine each hospital's adjusted total facility costs as the amount calculated in paragraph (A)(17) of rule 5160-2-08 of the Administrative Code.

(2) For hospitals with adjusted total facility costs, as described in paragraph (D)(1) of this rule, that are less than or equal to $216,372,500, multiply the hospital's adjusted total facility costs as described in paragraph (D)(1) of this rule by one and one half per cent. 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 $216,372,500, multiply a factor of one and one half per cent times the hospital's adjusted total facility costs as described in paragraph (D)(1) of this rule, up to $216,372,500. Multiply a factor of one per cent times the hospital's adjusted total facility costs as described in paragraph (D)(1) of this rule, that are in excess of $216,372,500. 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 paragraph (G) of this rule.

(4) The department may establish a rate lower than the rates described in paragraph (D)(2) of this

rule based on the assessment necessary to maximize the disproportionate share allotment for the current program year.

(E) Federal allotment adjustment.

(1) For past program years in which the federal disproportionate share allotment has increased, the department shall recalculate the assessment rate for that program year and notify each hospital via rate letter of the additional amount to be paid by the hospital to collect the state share necessary to expend the additional allotment. The adjusted assessment rate described in this paragraph will be calculated in accordance with paragraph (D) of this rule. The assessment collected will then be matched with federal funds and distributed to hospitals based upon the distribution model for the applicable past program year. Notwithstanding paragraph (D)(3) of this rule, the provisions outlined in paragraph (G)(2) of this rule are not applicable to any past program year.

(2) When the department is notified by the CMS of a decrease in the federal disproportionate share allotment for a past program year, the department shall recalculate the distribution for that program year and notify each hospital via recoupment letter of the amount to be recouped. Of the total amount recouped, the portion that was funded with federal funding shall be returned to the CMS. The portion of the recoupment that is state funds shall be applied toward the required assessment for a future program year. Notwithstanding paragraph (D)(3) of this rule, the provisions outlined in paragraph (G)(2) of this rule are not applicable to any past program year.

(F) Determination of intergovernmental transfer amounts.

The department may require governmental hospitals, as described in paragraph (A)(2) of rule 5160-2-08 of the Administrative Code, 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.

(G) Notification and reconsideration procedures.

(1) The department shall mail by certified mail, return receipt requested, the results of the determinations made under paragraphs (D) and (E) of this rule to each hospital. If no hospital submits a request for reconsideration as described in paragraph (G)(2) of 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 paragraphs (D) and (E) of this rule, any hospital may submit to the department a written request for reconsideration of the preliminary determination made under paragraphs (D) and (E) 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 paragraphs (D) and (E) of this rule or adjust the amount of the intergovernmental transfers required under paragraph (F) of this rule, and, as a result of the adjustment, adjust each hospital's assessment and intergovernmental transfer, to reflect refinements made by the CMS during that program year.