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Ohio Administrative Code

Rule 5160-2-10 Payment policies for disproportionate share and indigent care adjustments for psychiatric hospitals.

Effective: January 12, 2024

This rule is applicable for each program year for all medicaid-participating psychiatric hospitals as described in paragraphs (B) to (D) of rule 5160-2-01 of the Administrative Code.

(A) Definitions for each psychiatric hospital.

(1) "Cash subsidies for inpatient services received directly from state and local governments" is the amount of cash subsidies each psychiatric hospital has received from state and local governments for inpatient services for the applicable state fiscal year. In accordance with paragraph (C) of this rule, each psychiatric hospital reports cash subsidies received from state and local government on "Ohio Medicaid Hospital Cost Report" ODM 02930, for the applicable state fiscal year, schedule F, section II, column 4.

(2) "Charges for charity care" is the total charges for inpatient services provided to indigent patients, which includes charges for services provided to individuals who do not possess health insurance for the service provided. Charity care does not include bad debts, contractual allowances, or uncompensated care costs rendered to patients with insurance as described in paragraph (A)(13) of this rule. Each psychiatric hospital reports charges for charity care on ODM 02930, schedule F, section II, column 3.

(3) "Inpatient days" is the sum of the number of inpatient fee for service (FFS) hospital days as reported on ODM 02930, schedule C, section I, column 4 and the number of inpatient managed care plan (MCP) hospital days as reported on ODM 02930, schedule C, section III, column 2.

(4) "Insurance revenues" are the revenues received in the same twelve months of the hospital's cost-reporting period for inpatient services provided to, billed to, and received from all sources other than medicaid or self-pay revenues as described in paragraph (A)(6) of this rule. Each psychiatric hospital reports insurance revenues on ODM 02930, schedule F, section II, column 1.

(5) "Medicaid inpatient utilization rate" is the ratio of the psychiatric hospital's number of inpatient days attributable to patients who were medicaid eligible as described in paragraph (A)(10) of this rule divided by the psychiatric hospital's total number of inpatient days as described in paragraph (A)(3) of this rule.

(6) "Self-pay revenues" are the revenues received in the same twelve months of the hospital's cost-reporting period for inpatient services provided to, billed to, and received from either the person that received inpatient services or the family of the person that received inpatient services. Each psychiatric hospital reports self-pay revenues on ODM 02930, schedule F, section II, column 2.

(7) "Total charges for inpatient services" for each psychiatric hospital, except for free-standing, state-owned psychiatric hospitals, is the sum of the amounts reported for inpatient hospital services on ODM 02930, schedule B, column 6. For free-standing, state-owned psychiatric hospitals, "total charges for inpatient services" equals "total inpatient allowable costs" as defined in paragraph (A)(9) of this rule.

(8) "Total facility inpatient revenues" is the sum of the hospital's insurance revenues as described in paragraph (A)(4) of this rule, self-pay revenues as described in paragraph (A)(6) of this rule, and total medicaid revenues as described in paragraph (A)(11) of this rule.

(9) "Total inpatient allowable costs" is the sum of the general service and capital related costs for inpatient hospital services. Each psychiatric hospital reports total inpatient allowable costs on ODM 02930 schedule B, column 7.

(10) "Total medicaid days" is the sum of the amounts that each psychiatric hospital reports on ODM 02930, schedule F, section II, columns 6 to 8.

(11) "Total medicaid revenues" are the revenues received in the same twelve months of the hospital's cost-reporting period for inpatient services provided to, billed to, and received from all sources other than insurance revenues as described in paragraph (A)(4) of this rule or self-pay revenues as described in paragraph (A)(6) of this rule. Each psychiatric hospital reports total FFS medicaid revenues on ODM 02930, schedule H, section I, column 1 and total MCP medicaid revenues on ODM 02930, schedule I, column 2.

(12) "Uncompensated care costs" is the amount calculated by subtracting the sum of the total facility inpatient revenue as described in paragraph (A)(8) of this rule and the uncompensated care costs rendered to patients with insurance as described in paragraph (A)(13) of this rule from the total inpatient allowable costs as described in paragraph (A)(9) of this rule. For hospitals with negative uncompensated care costs, the result is equal to zero.

(13) "Uncompensated care costs rendered to patients with insurance" is the costs for an individual that has insurance coverage for the service provided, but the full cost of the service was not reimbursed because of per diem caps or coverage limitations. Each psychiatric hospital reports uncompensated care costs rendered to patients with insurance on ODM 02930, schedule F, section II, column 5.

(B) Applicability.

The requirements of this rule are limited pursuant to section 1923 of the Social Security Act, 42 USC 1396r-4 (effective October, 11, 2020).

(C) Source data for calculations.

The calculations described in this rule will be based on cost-reporting data described in paragraph (B)(1) of rule 5160-2-08 of the Administrative Code.

(D) Determination of disproportionate share qualifications for psychiatric hospitals.

Psychiatric hospitals will be determined to be disproportionate share if based on data described in paragraph (C) of this rule, they meet the obstetric services requirements as described in paragraph (A)(33) of rule 5160-2-09 of the Administrative Code, and they meet both qualifications described in paragraphs (D)(1) and (D)(2) of this rule.

(1) The hospital's medicaid inpatient utilization rate, as described in paragraph (A)(5) of this rule, is greater than or equal to one per cent; and

(2) The hospital's uncompensated care costs, as described in paragraph (A)(12) of this rule is at least sixty per cent of the hospital's total inpatient allowable costs as described in paragraph (A)(9) of this rule.

(E) Distribution of funds.

The funds available to each psychiatric hospital qualifying as a disproportionate share hospital as described in paragraph (D) of this rule are distributed among the hospitals based on data described in paragraph (C) of this rule and according to the payment formulas as follows:

(1) For each hospital, calculate the uncompensated care costs as described in paragraph (A)(12) of this rule;

(2) For all hospitals, sum all hospitals' uncompensated care costs as described in paragraph (A)(12) of this rule;

(3) For each hospital, calculate the ratio of the amount described in paragraph (E)(1) of this rule to the amount described in paragraph (E)(2) of this rule;

(4) Multiply the ratio for each hospital calculated in paragraph (E)(3) of this rule by the disproportionate share funds available to psychiatric hospitals as described in paragraph (G) of this rule to determine each hospital's disproportionate share payment amount.

(5) Each hospital will be distributed a payment amount based on the lesser of;

(a) Uncompensated care costs as determined in paragraph (A)(12) of this rule; or

(b) The hospital's disproportionate share payment as determined in paragraph (E)(4) of this rule.

(F) Payments.

The department will make payments in accordance with paragraph (E) of this rule to qualifying hospitals in accordance with paragraph (D) of this rule.

(G) Disproportionate share funds.

The maximum amount of disproportionate share funds available for distribution to psychiatric hospitals will be determined by subtracting the funds distributed in accordance with rule 5160-2-09 of the Administrative Code from the state's disproportionate share limit payment allotment determined by the centers for medicare and medicaid services (CMS) for that program year.