VIII. HOSPITALS SERVING LOW-INCOME PATIENTS
DISPROPORTIONATE SHARE HOSPITALS (DSH)

A. Eligibility – A hospital will qualify for DSH payment if it meets the conditions of either paragraph 1 or 2.

1. Subject to the provisions of subparagraph c, a hospital will be deemed to qualify for DSH payment if it meets either of the conditions under subparagraphs a or b. The data used to determine eligibility is from the prior State Fiscal year ending June 30th. For example, eligibility for SFY 11 DSH is done in the third quarter of SFY 10, using data from SFY 09.

a. *A hospital's Medicaid inpatient utilization rate (MIUR) is at least one* standard deviation above the mean MIUR for hospitals receiving Medicaid payment in the State.

i. MIUR is the total number of inpatient days of Medicaid eligible patients, including patients who receive their Medicaid benefits through a health maintenance organization, divided by the total number of inpatient days of all patients during a fiscal year.

b. The hospital's low income utilization rate (LIUR) is at least 25%. LIUR is the sum (expressed as a percentage) of the fractions, calculated as follows:

i) Total Medicaid patient revenues paid to the hospital, plus the amount of the cash subsidies for patient service received directly from State and local governments in the cost reporting period, divided by the total amount of revenues of the hospital for patient services (including the amount of such cash subsidies) in the same cost reporting period; and,

ii) The total amount of the hospital's charges for inpatient hospital services attributable to charity care (care provided to individuals who have no source of payment, third-party or personal resources) in a cost reporting period, less the portion of any cash subsidies received directly from the state or local government for inpatient hospital services, divided by the total amount of hospital charges for inpatient services in the hospital in the same period. The total inpatient hospital charges attributed to charity care shall not include contractual allowances and discounts (other than for indigent patients not eligible for Medicaid assistance under an approved Medicaid State plan), that is, reductions in charges given to other third party payors, such as HMOs, Medicare, or Blue Cross Blue Shield.

c. A hospital must:

i. have a MIUR of not less than one percent;

ii. have at least two (2) obstetricians with staff privileges at the hospital who have agreed to provide obstetric services to individuals entitled to such services under State Medicaid plan. In the case of a hospital located in a rural area (that is, an area outside of a Metropolitan Statistical Area, as defined by the Executive Office of Management and Budget) the term "obstetrician" includes any physician with staff privileges at the hospital to perform non-emergency obstetric procedures. *This does not apply to a hospital in which:*

(a) the inpatients are predominantly individuals under 18 years of age; or

(b) non-emergency obstetric services were not offered as of December 21, 1987.

iii. not be an institution for mental disease or other mental health facility subject to the limitation on DSH expenditures under Section 4721 of the Balanced Budget Act of 1997.

2. Subject to the provisions of subparagraph 1c above, a hospital will qualify for DSH payments if it is:

a. public hospital (i.e., hospital owned or operated by a hospital district, county or other unit of local government); or

b. in counties which do not have a public hospital, the private hospital which provided the greatest number of Medicaid inpatient days in the previous year; or

c. *a private hospital - located in a county* which has a public hospital, if the public hospital has a MIUR greater than the average for all the hospitals receiving Medicaid payment in the State.

B. Distribution Pools: Hospitals qualified under paragraph 'A' above will be grouped into distribution pools on the following basis:

1. Distribution pools are established as follows:

a) All public hospitals qualifying under paragraph A above and in counties whose population is 400,000 or more, the total annual disproportionate share payments are $66,650,000 plus 90% of the total amount distributed by the DHCFP in that fiscal year that exceeds $76,000,000.

b) All private hospitals qualifying under paragraph A above and in counties whose population is 400,000 or more, the total annual disproportionate share payments are $1,200,000 plus 2.5% of the total amount distributed by the DHCFP in that fiscal year that exceeds $76,000,000.

c) All private hospitals qualifying under paragraph A above and in counties whose population is 100,000 or more but less than 400,000, the total annual disproportionate share payments are $4,800,000 plus 2.5% of the total amount distributed by the DHCFP in that fiscal year that exceeds $76,000,000.

d) All public hospitals qualifying under paragraph A above and in counties whose population is less than 100,000, the total annual disproportionate share payments are $900,000 plus 2.5% of the total amount distributed by the DHCFP in that fiscal year that exceeds $76,000,000.

e) All private hospitals qualifying under paragraph A above and in counties whose population is less than 100,000, the total annual disproportionate share payments are $2,450,000 plus 2.5% of the total amount distributed by the DHCFP in that fiscal year that exceeds $76,000,000.

f) Note: There is no public hospital in counties whose population is 100,000 or more but less than 400,000.

2. The total amount distributed to an individual hospital may not, under any circumstance, exceed the total uncompensated care costs for that facility.

3. Total annual uncompensated care costs equal the cost of providing services to Medicaid inpatients, Medicaid outpatients and uninsured patients, less the sum of:

Regular Medicaid FFS rate payments (excluding DSH payments);
Medicaid managed care organization payments;
Supplemental/enhanced Medicaid payments;
Uninsured revenues; and
Federal section 1011 payments for uncompensated services to eligible aliens with no source of coverage.

4. An "uninsured patient" is defined as an individual without health insurance or other source of third party coverage (except coverage from State or local programs based on indigency). A system must be maintained by the hospitals to match revenues on Medicaid and uninsured patient accounts to the actual billed charges of the accounts in the same fiscal year. Costs for Medicaid and

uninsured patients will be based upon the methodology used in the HCFA 2552 report. Revenue will be deducted from cost. The total costs on the report will be subject to an independent audit. The HCFA 2552 report must be submitted within six months of the hospital's fiscal year end.

C. Calculation of Hospital DSH Payments

1. Using the same period of data as outlined on page 21, A 1, the Division will use the following formula to calculate the distribution factor of a hospital:

$$DF = UCC \times \left(\frac{UCPH}{UCPP} \right)^4$$

where:
DF is the distribution factor.
UCC is the uncompensated care cost of the hospital.
UCPH is the uncompensated care percentage of the hospital.
UCPP is the uncompensated care percentage of the pool of hospitals of which the hospital is a designated member.

2. As used in this section:

a) "Uncompensated care percentage of the hospital" means the uncompensated care costs of a hospital divided by the net patient revenues of the hospital, as reported on the Medicare Cost Report, which is required to be filed with the State.

i) Net patient revenues are total patient revenues less contracted allowances and discounts.

b) "Uncompensated care percentage of the pool of hospitals" means the sum of the uncompensated care costs for all hospitals in the pool divided by the sum of the net patient revenues of all hospitals in the pool, as reported on the Medicare Cost Report, which is required to be filed with the State.

3. The Division will make an initial distribution to a hospital by dividing the distribution factor for that hospital by the sum of the distribution factors for all hospitals in that pool and multiplying the result by the total amount of money available for initial distribution within the pool.

4. The Division will adjust the initial distribution for each hospital within each pool of hospitals to ensure that each hospital which is eligible to receive a DSH payment receives not less than $10,000, not to exceed their UCC. If a distribution amount would exceed an individual hospital's UCC, that hospital's payment would be capped, and the excess distributed through another round if distribution. Each round would follow the same methodology; excluding any hospital with UCC already met.

5. The DSH payments will be made monthly to the hospitals if the total DSH distribution is over $35,000 and quarterly if it is under $35,000. Payments will be based on the State Fiscal Year.

D. Adjusting DSH payments based on audit results

1. The Division will audit each hospital for each year in which the hospital received a disproportionate share payment pursuant to NRS, NAC and in accordance with the provisions of Title XIX of the Social Security Act, 42 U.S.C. §§ 1396 et seq.

2. After conducting an audit, the Division will recalculate, based upon the results of the audit, the:

   a) Uncompensated care costs for each hospital in this State;
   b) Distribution factor for each hospital and each pool of hospitals; and
   c) Disproportionate share payments for each hospital by dividing the recalculated distribution factor for that hospital by the sum of the distribution factors for all hospitals in that pool and multiplying the result by the total amount of money available for final distribution within the pool, not to exceed each hospital's UCC.

3. If the amount of the final distribution payment calculated is less than the amount of the initial distribution of disproportionate share payments received by the hospital, the hospital shall return to the Division the difference between the amount of the initial distribution and the amount of the final distribution.

4. The Division will redistribute among the hospitals within each pool the money returned to the Division by the hospitals within that pool. The redistribution will be in accordance with the recomputed payments from subparagraph 2, above, in the method described in paragraph C4 above.

5. If each hospital within a pool of hospitals has received the maximum amount of disproportionate share payments allowable by federal and state statutes and regulations, the Division will use the money returned to pay additional disproportionate share payments as follows in the method described in paragraph C4 above:
   a) If the money was returned by a hospital that is a member of pool A, to hospitals in pool B;
   b) If the money was returned by a hospital that is a member of pool B, to hospitals in pool C;
   c) If the money was returned by a hospital that is a member of pool C, to hospitals in pool D;
   d) If the money was returned by a hospital that is a member of pool D, to hospitals in pool E; or
   e) If the money was returned by a hospital that is a member of pool E, the Division will distribute to another pool as it determines appropriate.

OS Notification

State/Title/Plan Number: Nevada State Plan Amendment 10-008

Type of Action: SPA Approval

Effective Date of SPA: July 1, 2010

Required Date for State Notification: September 29, 2010

Fiscal Impact: $0 federal

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

Number of Potential Newly Eligible People: 0
or
Eligibility Simplification:

Provider Payment Increase or Decrease: N/A

Delivery System Innovation: No

Number of People Losing Medicaid Eligibility: 0

Reduces Benefits: No

Detail: This State Plan Amendment revises Nevada's disproportionate share hospital (DSH) payment methodology. The State's revised methodology groups qualifying hospitals into five payment pools, establishes the allocation of total available DSH fund to the five pools, and sets forth a formula for distributing each pool's total fund to the hospitals within the pool. This amendment further allows for a redistribution of DSH overpayments. The revised methodology complies with all Federal DSH statutory and regulatory requirements. Nevada's DSH payments are 100% funded from intergovernmental transfers, just as they were prior to the Recovery Act; therefore, there is no Recovery Act political subdivision contribution percentage increase issue. Public process requirements have been met, and all funding questions have been adequately answered.

Other Considerations: We do not recommend the Secretary contact the Governor.

Recovery Act Impact: We've reviewed this SPA in conjunction with Section 5001(g)(2) of the Recovery Act (political subdivision contribution). Nevada's DSH payments are 100% funded from intergovernmental transfers, just as they were prior to the Recovery Act; therefore, there is no Recovery Act political subdivision contribution percentage increase issue. Additionally, we are not aware at this time of any other violations of the Recovery Act requirements, including eligibility maintenance of effort, prompt payment, and rainy day funds.

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