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

A. Eligibility – A Nevada 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 Nevada 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 14 DSH is done in the third quarter of SFY 13, using data from SFY 12.

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

b. in Nevada 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 Nevada 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 700,000 or more, the total annual disproportionate share payments will be 87.97% of the total computable DSH allotment for the State Fiscal Year.

   b. All private hospitals qualifying under paragraph A above and in counties whose population is 700,000 or more, the total annual disproportionate share payments will be 1.69% of the total computable DSH allotment for the State Fiscal Year.

   c. All private hospitals qualifying under paragraph A above and in counties whose population is 100,000 or more but less than 700,000, the total annual disproportionate share payments will be 5.86% of the total computable DSH allotment for the State Fiscal Year.

   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 will be 1.34% of the total computable DSH allotment for the State Fiscal Year.

   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 will be 3.14% of the total computable DSH allotment for the State Fiscal Year.

   f. Note: There is no public hospital in counties whose population is 100,000 or more but less than 700,000.

2. The total amount distributed to an individual hospital may not, under any circumstance, exceed the total uncompensated care costs (DSH limit) 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 report revenues on Medicaid and uninsured patient accounts to determine uncompensated care cost consistent with Section 1923 (g) of the Social Security Act and implementing regulations at 42 CFR 447 Subpart E. 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 subparagraph A 1, the Division will calculate the DSH payments for each hospital as follows:

   a. 50% of the pool amount will be distributed based on the percent to total of the uncompensated care percentage of the hospitals within the pool.

      i. Uncompensated Care Percentage is the uncompensated care cost of the 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.

         (a) Net patient revenues are total patient revenues less contracted allowances and discounts. This comes from Medicare cost report, Worksheet G-3 line 3, less any net patient revenue from non-hospital inpatient and non-hospital outpatient services.

   b. The remaining 50% of the pool amount will be distributed based on the percent to total of the uncompensated care cost of the hospitals within the pool.

2. The DSH payments will be made monthly to the eligible hospitals. Payments will be based on the State Fiscal Year. DSH payment will in no instance exceed a hospital's DSH limit. If any hospital's calculated DSH payment exceeds its DSH limit, the excess will be redistributed to the remaining hospitals within the pool using the same formula above.

D. Adjusting DSH payments based on DSH Independent Certified 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, if a hospital's eligibility changes or its initial DSH payment exceeded its audited DSH limit, the Division will recalculate the

following for all hospitals in the affected pool:

a. Audited uncompensated care costs

b. Audited uncompensated care percentages

c. Final DSH payment amounts using the same methodology as defined in paragraph C. Final DSH payment amounts are calculated using the audited amounts in subparagraph D 2a and b.

d. The amount of monies available for redistribution within each pool based on a comparison of each hospital's final DSH payment amount and the initial DSH payment received by each hospital in the pool.

3. For all hospitals in the affected pool(s), the Division will reconcile each hospital's initial DSH payment to its final DSH payment as calculated in paragraph D 2. Any hospital whose initial DSH payment is greater than the final DSH payment will return the difference to the Division, and any hospital whose initial DSH payment is less than the final DSH payment will be paid the difference. The final DSH payment amount for an individual hospital, as calculated in paragraph D 2 and in accordance with the methodology in paragraph C, will in no instance exceed that hospital's audited DSH limit.

4. 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 C 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, to hospitals in pool A.