METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES -INPATIENT HOSPITAL CARE

Citation

42 CFR 447, 434, 438, and 1902(a)(4), 1902(a)(6), and 1903

Payment Adjustment for Provider Preventable Conditions

The Medicaid agency meets the requirements of 42 CFR Part 447, Subpart A, and sections 1902(a)(4),1902(a)(6), and 1903 with respect to non-payment for provider-preventable conditions.

Health Care-Acquired Conditions

The State identifies the following Health Care-Acquired Conditions for non-payment under Section 4.19 (A) of this State plan.

__X__ Hospital-Acquired Conditions as identified by Medicare other than Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE) following total knee replacement or hip replacement surgery in pediatric and obstetric patients.

Other Provider-Preventable Conditions

The State identifies the following Other Provider-Preventable Conditions for non-payment under Section 4.19 (A) of this State plan.

__X__ Wrong surgical or other invasive procedure performed on a patient; surgical or other invasive procedure performed on the wrong body part; surgical or other invasive procedure performed on the wrong patient.
____ Additional Other Provider-Preventable Conditions identified below:

In compliance with 42 CFR 447.26(c), the DVHA assures that:

1. No reduction in payment for a PPC will be imposed on a provider when the condition defined as a PPC for a particular patient existed prior to the initiation of treatment for that patient by that provider.
2. Reductions in provider payment may be limited to the extent that the following apply:
    a. The identified PPC would otherwise result in an increase in payment.
    b. The State can reasonably isolate for non-payment the portion of the payment directly related to treatment for, and related to, the PPC.
3. Non-payment for PPCs does not prevent access to services for Medicaid beneficiaries.

In order to determine the non-payment amount, for services paid under Section 4.19 (A) of this State plan, the DVHA will utilize the diagnoses and present on admission indicator submitted by providers on claims. The DVHA utilizes the MS-DRG grouper in its methodology to pay for inpatient hospital services. As such, the MS-DRG grouper will identify the amount of non-payment for inpatient hospital services when a PPC is reported that was not present on admission. In the event of a Deep Vein Thrombosis diagnosis, DVHA will review and make an individual adjustment to the case.

This provision applies to all providers contracted with the DVHA.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES – INPATIENT HOSPITAL SERVICES

Effective with dates of admission on or after October 1, 2012, the Department of Vermont Health Access (DVHA) will reimburse qualified providers for inpatient hospital services under the prospective payment system as set forth in this plan.

I. Participating Hospitals

All in-state and out-of-state hospitals will be included in this payment methodology, regardless of any designation provided by Medicare. Hospitals may be eligible for special payment provisions in addition to payments made under this methodology as discussed in Section IV below.

II. Data Sources and Preparation of Data for Computation of Prospective Rates

A. Introduction

The calculation of prospective rates requires the use of claims data and cost report data. The historical claims data is obtained from a chosen base period and the cost for these claims is derived from Medicare cost report data for the corresponding period. Claim costs are adjusted to the year in which the rates are in effect to account for inflation. Claims are grouped together into a diagnostic related group (DRG) based upon the diagnoses present on the claim.

B. Data Sources- Initial Period

For the rate setting period effective October 1, 2012, hospital cost report data from all in-state Medicaid providers plus Dartmouth-Hitchcock Medical Center for the fiscal years ending 2009 and 2010 were used to assign cost values to claims used in the rate development process. All hospitals included in the analysis have a fiscal year end of September 30 with the exception of one hospital (Retreat Health Care) which has a fiscal year end of December 31. The claims used to assign relative weight values and to develop base rates were from the same hospitals for which cost data was collected and were from the hospital fiscal years ending 2009, 2010 and 2011.

C. Data Sources- Subsequent Periods

More recent cost report and claims data will be used to develop new base rates and relative weights no less than once every four fiscal years.

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES – INPATIENT HOSPITAL SERVICES (CONTINUED)

III. Payment for Inpatient Hospital Services

A. Payment Formulas

1. Non-Outlier DRG Payment Per Case = (Base Rate Assigned to Hospital x DRG Relative Weight)

2. Outlier DRG Payment Per Case = (Cost of Case – Outlier Threshold) x Outlier Payment Percentage

   where

   Cost of Case = Allowable Charges x Hospital-specific Cost to Charge Ratio and Outlier Threshold = (Base Rate x DRG Relative Weight) + Fixed Outlier Value

3. Psychiatric DRG Payment Per Case = (Base Per Diem Rate Assigned to Hospital x DRG Relative Weight x Factor Representing Length of Stay)

   where

   Factor Representing Length of Stay = The factors assigned by the Medicare Inpatient Psychiatric Facilities Prospective Payment System effective October 1, 2012

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES – INPATIENT HOSPITAL SERVICES (CONTINUED)

III. Payments Inpatient Hospital Services (Continued)

B. Discussion of Payment Components

1. Base Rates

The in-state Base Rate effective October 1, 2012 is based on claims with dates of discharge from October 1, 2008 to September 30, 2011 from all in-state hospitals plus Dartmouth-Hitchcock Medical Center. The cost values were assigned to each hospital claim on a claim-by-claim basis using data from each hospital's Medicare Cost Report (MCR). The cost report used to assign the cost for each claim was based on the discharge date of the claim. Claims with dates of discharge from October 1, 2008 to September 30, 2009 were assigned costs using the hospital's 2009 fiscal year end MCR. Claims with dates of discharge from October 1, 2009 to September 30, 2011 were assigned costs using the hospital's 2010 fiscal year end MCR.

Allowed charges on each detail line of the inpatient claim were multiplied by a hospital-specific cost to charge ratio (CCR). The CCR assigned to each detail line is based on the revenue code billed for the detail line. The mapping of revenue codes to CCRs followed the principles that were described in the Medicare Inpatient Prospective Payment System (IPPS) Final Rule for 2007 published in the Federal Register on August 18, 2006, with the following exceptions. The Medicare IPPS group for Routine Days was split into two groups—Adults & Peds and Nursery. The Medicare IPPS group for Intensive Days was split into three groups—ICU, Surgical ICU and NICU. The Medicare IPPS group for Other Services was split into four groups—Emergency Room, Clinic, Observation and Other Services.

The cost value of the claim is adjusted for inflation using Global Insight's Health Care Cost Review New CMS Hospital Prospective Reimbursement Market Basket moving average factors. Claim costs are inflated to the mid-point of the rate year.

The in-state base rate was derived by first computing the average inflated cost per case across all claims in the base period. This value is $8,682. Because of funding limits imposed by the Vermont Legislature, the in-state Base Rate effective November 1, 2013 for non-psychiatric DRGs is $7,611.45.

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES – INPATIENT HOSPITAL SERVICES (CONTINUED)

III. Payments Inpatient Hospital Services (Continued)

2. Relative Weights

Relative weights were assigned to each DRG in the CMS MS-DRG Grouper Version 29.0 based on Vermont hospital costs. The relative weight is the average cost of the claims grouped into the DRG divided by the average cost of all claims in the base period.

Before calculating the relative weight for a DRG, tests were conducted to ensure that there was sufficient volume and conformity among the cases in the DRG to set a stable relative weight. A DRG was found to have sufficient sample size to compute a relative weight if: (a) There was a minimum of 10 claims across the two years of data; and (b) There were sufficient claims to pass this statistical test: The standard error of the claims' costs is within 25% of the mean with a 90% level of confidence.

Before running the statistical test, low-cost and high-cost outliers were removed from each DRG, which are defined as any claim that was outside +/- two standard deviations from the geometric mean cost of the DRG.

This test yielded 228 stable DRGs, 403 unstable DRGs, and 119 empty DRGs (no Vermont claims volume in the base period utilized). The 522 unstable and empty DRGs were then collapsed into 12 tier groups based on the Medicare relative weight for each DRG. After the claims were collapsed into these categories, a new average cost was computed for the claims in each tier and a relative weight was set.

Effective with dates of admission on or after October 1, 2012, all DRGs that were collapsed into a tier will share the same relative weight.

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IV. Special Payment Provisions

A. Rehabilitation DRG

In-state hospitals with a claim that groups into the Rehabilitation DRGs (DRGs 945 and 946 in MS-DRG Grouper Version 30.0) will be paid an additional $300 per diem for the entire length of the patient's stay for the single episode of care. Border Teaching Hospitals will be paid an additional $200 per diem. This payment is in addition to the Non-Outlier and Outlier DRG Payments per Case.

The Rehabilitation DRGs paid under this methodology are those Rehabilitation DRGs as assigned by the Grouper being utilized by DVHA. Effective October 1, 2012, this included the following DRGs:
DRG 945: Rehabilitation W CC/MCC
DRG 946: Rehabilitation W/O CC/MCC

B. Neonate DRGs

In-state hospitals that do not serve a disproportionate number of neonate cases that have a claim that groups into a Neonate DRG will be paid an additional $300 per diem for the entire length of the patient's stay for the single episode of care. Border Teaching Hospitals will be paid an additional $200 per diem. This payment is in addition to the Non-Outlier and Outlier DRG Payments per Case.

In-state hospitals that do serve a disproportionate number of neonate cases that have a claim that groups into a Neonate DRG will be paid an additional $400 per diem for the entire length of the patient's stay for the single episode of care. This payment is in addition to the Non-Outlier and Outlier DRG Payments per Case. A hospital with a disproportionate share of neonate cases is a hospital that had more than 50% of all of the neonate DRG cases in the rate setting claims period.

The Neonate DRGs paid under this methodology are those Neonate DRGs as assigned by the Grouper being utilized by DVHA. Effective October 13, 2012, this included the following DRGs:

DRG 789: Neonates, Died or Transferred to another Acute Care Facility
DRG 790: Extreme Immaturity or Respiratory Distress Syndrome, Neonate
DRG 791: Prematurity with Major Problems
DRG 792: Prematurity without Major Problems
DRG 793: Full Term Neonate with Major Problems
DRG 794: Neonate with Other Significant Problems

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES – INPATIENT HOSPITAL SERVICES (CONTINUED)

IV. Special Payment Provisions (Continued)

C. Psychiatric DRG Cases Provided by In-State Hospitals

In-state hospitals will be paid for psychiatric cases under a DRG per diem methodology instead of a DRG per case methodology using the formula shown in III.A above.

The Psychiatric DRGs paid under this methodology are those Psychiatric DRGs as assigned by the Grouper being utilized by DVHA. Effective October 1, 2012, this included the following DRGs:

DRG 56: Degenerative Nervous System Disorders w MCC
DRG 57: Degenerative Nervous System Disorders w/o MCC
DRG 80: Nontraumatic Stupor and Coma w MCC
DRG 81: Nontraumatic Stupor and Coma w/o MCC
DRG 876: O.R. Procedure with Principal Diagnosis of Mental Illness
DRG 880: Acute Adjustment Reaction & Psychosocial Dysfunction
DRG 881: Depressive Neuroses
DRG 882: Neuroses Except Depressive
DRG 883: Disorders of Personality & Impulse Control
DRG 884: Organic Disturbances & Mental Retardation
DRG 885: Psychoses
DRG 886: Behavioral & Developmental Disorders
DRG 887: Other Mental Disorder Diagnoses
DRG 894: Alcohol/Drug Abuse or Dependence, Left AMA
DRG 895: Alcohol/Drug Abuse or Depend. with Rehabilitation Therapy
DRG 896: Alcohol/Drug Abuse or Depend. w/o Rehabilitation Therapy w MCC
DRG 897: Alcohol/Drug Abuse or Depend. w/o Rehabilitation Therapy w/o MCC

On an ongoing basis, the factors applied representing the length of stay will be the same as those utilized by Medicare in its Inpatient Psychiatric Prospective Payment System. The factors applied are additive by length of stay.

The psychiatric base per diem rate was set to ensure that there is sufficient access to services for Medicaid beneficiaries in the state. Effective November 1, 2013, the Base Per Diem Rate for in-state hospitals is $1,104.60 per diem.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES – INPATIENT HOSPITAL SERVICES (CONTINUED)

IV. Special Payment Provisions (Continued)

D. One-Day Stays

Claims for patients admitted as an inpatient but for which the length of stay is not overnight are paid as the lesser of the cost of the case or the Non-Outlier DRG Payment Per Case. The exception is if the patient is classified as a Normal Newborn (DRG 795). In this case, payment will always be the Non-Outlier DRG Payment.

E. Transfer Cases

For claims in which the patient is transferred from one inpatient general acute care facility to another, the payment to the transferring hospital is the lesser of the cost of the case or the DRG Payment Per Case, including any outlier payment or DRG Add-on payment, if applicable. Payment to the receiving hospital will follow the payment guidelines of non-transfer cases.

F. Sub-acute Care

Swing bed, awaiting placement and inappropriate level of care days are reimbursed at a per diem rate established by the Division of Rate Setting equal to the average statewide rate per patient day paid for services furnished in nursing facilities during the previous calendar year.

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IV. Special Payment Provisions (Continued)

G. Out of State Facilities

Out-of-state facilities will receive payments using the same payment formulas as stated in III.A.1 and III.A.2. However, the values of components of the formulas differ from those used to pay in-state hospitals.

1. A Base Rate will be assigned to each participating out-of-state hospital based upon its peer group.

   a. Border Teaching Hospitals: Defined as hospitals within 10 miles of the Vermont border that operate post-graduate training programs. For payments on or after November 1, 2013, the base rate will equal $5,224.80.
   b. Non-Border Teaching Hospitals: Defined as hospitals greater than 10 miles of the Vermont border that operate post-graduate training programs. For payments on or after November 1, 2013, the base rate will equal $3,122.70.
   c. Other Out-of-State Hospitals: Defined as hospitals not meeting the criteria of G.1.a or G.1.b. For payments on or after November 1, 2013, the base rate will equal $2,882.25.

H. Outlier Payments

Using the formula for outlier payments described in III.A.2, a Fixed Outlier Value, an Outlier Payment Percentage, and a Cost to Charge Ratio will be assigned to each participating hospital based upon its peer group.

1. Fixed Outlier Value
   a. In-state Hospitals: $24,000
   b. Border Teaching Hospitals: $40,000
   c. Non-Border Teaching Hospitals: $50,000
   d. Other Out-of-State Hospitals: $50,000

2. Outlier Payment Percentage
   a. In-state Hospitals: 80%
   b. Border Teaching Hospitals: 50%
   c. Non-Border Teaching Hospitals: 50%
   d. Other Out-of-State Hospitals: 50%

Hospitals that are eligible for payment under the per diem methodology for psychiatric stays are not eligible to receive an outlier payment for cases in the psychiatric DRGs listed in IV.C.

IV. Special Payment Provisions (Continued)

3. The Cost to Charge Ratio (CCR) to be applied for calculating the outlier cost of the case will be assigned to each participating in-state hospital specifically on an annual basis based on a recently filed MCR. Each out-of-state hospitals will be assigned a CCR based upon its peer group.

   a. Border Teaching Hospitals: The CCR to apply will be assigned to each participating hospital specifically on an annual basis based on a recently filed MCR for each hospital in the peer group.
   b. Non-Border Teaching Hospitals: The CCR that will be assigned will be the average CCR of all in-state hospitals.
   c. Other Out-of-State Hospitals: The CCR that will be assigned will be the average CCR of all in-state hospitals.

I. Extraordinary Access Issues

In order to ensure access to non-Vermont hospitals providing unusual and highly complex services, the DVHA has the authority to establish rates on a case by case basis or by hospital.

J. New Facilities

New facilities under the DRG system will receive payments using the same payment formulas as stated in III.A.1 and III.A.2. If the new facility is an in-state hospital, it will receive the same base rate as other in-state hospitals and all other payment policies for in-state hospitals will apply. If it is an out-of-state hospital, it will receive a base rate based upon the out-of-state peer group it is assigned to. All other payment provisions will follow the policies for the out-of-state hospital peer group to which it is assigned or the authority as outlined in IV.G and IV.H above.

K. New Medicaid Providers

Prospective payment rates for established facilities which had not been an OVHA participating provider prior to October 1, 2012 will receive payments based on the same provisions that apply to new facilities as described in IV.J.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES – INPATIENT HOSPITAL SERVICES (CONTINUED)

IV. Special Payment Provisions (Continued)

J. Teaching Hospitals Payments

Effective on or after 7/1/2011, teaching hospitals located in the State of Vermont shall be eligible for a Teaching Hospital Payment for their direct graduate medical education (DGME) and indirect medical education (IME) costs. The payment will be based on the most recent hospital year end where both cost and payment data are available for both scenarios listed below (the base year). An annual payment will be made which shall equal the lesser of:

1. 95 per cent of the sum of:

   a. DGME Payments: The product of (i) the total number of full time equivalent (FTE) medical residents working in the teaching hospital and in non-provider settings recognized for Medicare DGME payment purposes on the base year cost report, without regards to any Medicare adjustments in the number of FTE residents, including weighting factors and caps set forth in 42 C.F.R. §§ 413.79-413.80, (ii) the per-resident DGME payment amounts, calculated as set forth at 42 C.F.R. § 413.77, and (iii) the ratio of Medicaid inpatient hospital days to total inpatient hospital days; and

   b. IME Payments: The product of (i) total Medicaid DRG revenue for inpatient operating costs and (ii) the hospital-specific education adjustment factor for IME payments, calculated as set forth at 42 C.F.R. § 412.105 for purposes of determining Medicare IME payments for inpatient hospital services; or

2. The difference between the teaching hospital's Hospital Specific Limit as described in Section VIII.B. of this Attachment and DSH payments made to the teaching hospital in the current State Fiscal Year (SFY) pursuant to Section VIII.A.

During each SFY, DVHA shall make quarterly Teaching Hospital Payments equal to one-fourth of the annual payment amount projected at the beginning of the SFY based on the payment amount identified in J.1or J.2 above. In the event that it is subsequently determined, based on audited cost report data, that DSH payments made to the teaching hospital exceeded the hospital's Hospital Specific Limit described in Section VIII.B, then the State will recoup from the Teaching Hospital Payments an amount equal to the excess DSH payment. The amount will be recouped in the next quarterly payment scheduled to be made to the Teaching Hospital.

The aggregate FFS Medicaid hospital payments, including Teaching Hospital Payments covered in this section, will not exceed the amount that would be paid for the services furnished under Medicare payment principles in compliance with UPL regulations at 42 C.F.R. 447.272.

Total Teaching Hospital Payments in any period shall not exceed the sum of (a) Intergovernmental Transfers ("IGTs") received by the State of Vermont to fund the non-federal portion of such Teaching Hospital Payments, plus (b) corresponding federal medical assistance payments. The calculated teaching hospital supplemental payment amount is $9,886,559 per year.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES – INPATIENT HOSPITAL SERVICES (CONTINUED)

V. Ongoing Maintenance

As a part of ongoing maintenance of the payment system, the DVHA will change the following rate setting components either separately or in combination:

A. Annually
   1. The DRG Grouper used to group claims. If a new DRG grouper includes a new DRG for which the OVHA does not have a relative weight assigned, the DVHA will use the Medicare relative weight to assign the DRG to a Vermont tier weight until such time as all DRG relative weights are updated.
   2. The factors representing length of stay in payments for psychiatric cases made to eligible hospitals.
   3. The Cost to Charge Ratio assigned to each hospital for use in establishing claim outlier status

B. At least once every four years
   1. The base period of claims and Medicare Cost Report(s) used to establish DRG relative weight values
   2. The DRG Relative Weight Values
   3. The inflation factor used to best represent current costs
   4. The Fixed Outlier Value
   5. The Outlier Payment Percentage

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - INPATIENT HOSPITAL SERVICES (CONTINUED)

Methods and Standards for Payment Adjustments to Hospitals Qualifying as Disproportionate Share Hospitals

Effective October 1, 2009, the Office of Vermont Health Access (OVHA) will make disproportionate share payments to hospitals as set forth in this plan.

VI. Eligible Hospitals

A. Minimum Requirements

In order to be eligible for disproportionate share payment, a hospital must:

1. Have at least two obstetricians with staff privileges at the hospital who have agreed to provide obstetric services to individuals entitled to such services under the Medicaid state plan. For hospitals outside of the Burlington-South Burlington Core Based Statistical Area (CBSA), the term "obstetrician" includes any physician with staff privileges at the hospital to perform non-emergency obstetric procedures.

   The above obstetric-related criteria do not apply to hospitals in which the inpatients are predominantly individuals under 18 years of age, or to hospitals which did not offer non-emergency obstetric services as of December 21, 1987.

2. Have a Medicaid inpatient utilization rate of at least one percent. The Medicaid inpatient utilization rate is defined as a hospital's total Medicaid inpatient days (including managed care days) divided by the total number of inpatient days.

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - INPATIENT HOSPITAL SERVICES (CONTINUED)

VI. Eligible Hospitals (Continued)

B. Federally Deemed Hospitals

Additionally, the OVHA recognizes those hospitals deemed by federal law to be disproportionate share hospitals. The OVHA deems a hospital to be a disproportionate share hospital if:

1. The hospital has a Medicaid inpatient utilization rate that is at least one standard deviation above the mean Medicaid inpatient utilization rate for hospitals receiving Medicaid payments in the state (herein named DSH Eligibility Group #1); or

2. The hospital has a low income utilization rate exceeding 25 percent (herein named DSH Eligibility Group #2).

C. State-Defined Criteria

Hospitals that meet the minimum requirements in VI.A. but do not meet the criteria for VI.B will still qualify for disproportionate share payments based on:

1. The hospital's status as an in-state post-graduate teaching facility (herein named DSH Eligibility Group #3); or

2. The hospital's proportion of statewide Medicaid inpatient days (herein named DSH Eligibility Group #4).

(Continued)

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - INPATIENT HOSPITAL SERVICES (CONTINUED)

VII. Data Sources for Computation of Disproportionate Share Payments

A Base Year is established each year for collecting the data used to set disproportionate share payments in each State Plan Year (SPY). For payments in SPY 2014 (effective October 1, 2013), the Base Year used is the fiscal year ending September 30, 2011. The Base Year will advance one year for each subsequent SPY. Data sources, and the data that will be used from them, include the following:

A. From the State's Medicaid Management Information System (MMIS)
   1. Vermont Medicaid inpatient and outpatient hospital charges
   2. Vermont Medicaid inpatient days - Excluded from this figure are Title XXI days and days attributable to Medicaid patients between 21 and 65 years of age in Institutions for Mental Disease (IMD).
   3. Vermont Medicaid payments

B. Hospital Medicare Cost Reports
   1. Hospital cost-to-charge ratios
   2. Total hospital inpatient days and total Medicaid inpatient days
   3. Medicaid inpatient accommodation per diem costs

C. Hospital Attestation. Federal statute, specifically 42 CFR 447 and 455 requires that hospitals provider certain information for the DSH calculation. The Department of Vermont Health Access (DVHA) collects this federally required information in the form of an attestation from hospitals. Hospitals are required to complete this attestation each year to allow the DVHA the ability to collect data that is not available from any other sources. The DVHA will establish the due date for hospitals to complete this attestation each year and will provide hospitals at least 60 calendar days to complete the attestation. The due date will be on or before May 1. Hospitals who do not submit a completed attestation by the due date waives its right to be eligible for a DSH payment for that DSH plan year.

   1. Attestation of federal obstetrical requirement.
   2 Total state and local cash subsidies for inpatient and outpatient services
   3. Disproportionate share payments from other states and Section 1011 payments
   4. Inpatient days for Medicare/Medicaid dual eligibles, out of state Medicaid beneficiaries, and individuals with no third party coverage
   5. Inpatient and outpatient hospital charges for Medicare/Medicaid dual eligibles, out of state Medicaid beneficiaries, and individuals with no third party coverage
   6. Payments for claims from Medicare/Medicaid dual eligibles, out of state Medicaid beneficiaries, and individuals with no third party coverage

D. Department of Banking, Insurance, Securities and Health Care Administration, Report 5, Net Patient Care Revenue by Payer
   1. Net Medicaid patient services revenue
   2. Gross Inpatient Charges

E. Audited hospital financial statements and hospital accounting records.
   1. Total revenue for hospital patient services, including inpatient and outpatient services and services by sub provider

VIII. Disproportionate Share Payments (DSH)

Each year of the program, DVHA will determine the DSH Eligibility Group that each hospital is eligible for before calculating payments. If a hospital is eligible for more than one DSH Eligibility Group, for the purposes of computing the funding for each DSH group, the hospital will be placed in the DSH Eligibility Group that maximizes the hospital's DSH payment.

Within a DSH Eligibility Group, funds will be assigned to each hospital using the formulas described in VIII.A. Hospitals may only receive funds from one DSH Eligibility Group each year.

The Total DSH Funding for the DSH State Plan Year 2014 is $37,448,781. At the time that DSH payments are disbursed, DVHA will publish the funding for each DSH Eligibility Group and a schedule showing the DSH payment made to each eligible hospital.

A. Payment Formulas

Before the calculation of funding by DSH Eligibility Group occurs, the calculation of each Hospital Specific Limit is completed as described in VIII.B. Funding for each Group is then completed as follows:

1. Funding for DSH Group #3 is done first. The amount funded for Group #3 is the lesser of 50% of the of the Total DSH Funding for the DSH SPY or 50% of the combined Hospital Specific Limit for all hospitals in the Group.

2. Subtract the amount funded for DSH Group #3 from the Total DSH Funding for the DSH SPY to derive the remaining amount to be allocated between DSH Groups #1, #2 and #4.

3. Calculate for each hospital its percentage of Title XIX statewide days in the Base Year.

(Continued)

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - INPATIENT HOSPITAL SERVICES (CONTINUED)

VIII. Disproportionate Share Payments (DSH) (Continued)

A. Payment Formulas (Continued)

a. The total statewide days value used in the calculation excludes the Title XIX days for any hospitals in DSH Group #3.

b. The total statewide days does not include days from any in-state hospitals that were paid for Title XIX days in the Base Year if they are not eligible for a DSH payment.

4. Sum the percentage of statewide days in the DSH Group.

5. Calculate the DSH Allotment by DSH Eligibility Group using the following formula:

*Total Remaining DSH Funding Available (computed in Step 2) **
*Total Percentage of Statewide Days in the DSH Group (computed in Step 4)*

6. The DSH payments to each hospital in DSH Groups #1, #2 and #4 are made using the following methodology:

a. For each DSH Group, compute an Aggregate Hospital Limit that is the sum of the individual Hospital Specific Limits within the DSH Group for hospitals that are eligible for a DSH payment.

b. Determine each hospital's limit as a percentage of the Aggregate Hospital Limit.

c. Multiply the percentage computed in (b) by the DSH Group Allotment in VIII.A.5.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - INPATIENT HOSPITAL SERVICES (CONTINUED)

VIII. Disproportionate Share Payments (Continued)

B. Payment Limitations

The Omnibus Budget Reconciliation Act of 1993 established rules limiting the total disproportionate share payment that a hospital can receive. Disproportionate share payments are limited to no more than the cost of providing hospital services to patients who are either eligible for medical assistance under a state plan or have no health insurance for the services provided, less payments received under Title XIX (other than DSH payment adjustments).

When all cost reports are available, the State will recalculate each hospital's specific payment limit starting with Medicaid State Plan Year (SPY) FY 2011 using audited Medicare Cost Reports. The State will then compare the hospital specific limit against DSH payments made for the SPY to determine if any hospital was paid in excess of its specific limit. The same procedure will occur in subsequent SPYs.

If the recalculated hospital specific limits show that the State made a payment to a hospital in excess of its hospital specific limit, the State will recoup any excess payment and redistribute the funds to other hospitals using the payment formula set forth in VIII.A using the applicable DSH State Plan for the year of the overpayment.

Furthermore, if the State's DSH auditor has findings demonstrating that DSH payments made for SPY 2011 or subsequent years exceed the documented hospital specific limits, the State will recoup and redistribute to other hospitals using the payment formula set forth in VIII.A that was in place for the applicable DSH state plan year under audit.