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

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

Effective October 1, 2008, 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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HOSPITAL CARE (CONTINUED)

VI. Eligible Hospitals

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; or
2. The hospital has a low income utilization rate exceeding 25 percent.

C. State-Defined Criteria

Hospitals that meet the minimum requirements in VI.A. but do not meet the criteria for VI.B may still qualify, subject to the availability of funds, for disproportionate share payments based on:

1. The hospital's status as a state-owned facility;
2. The hospital's status as an institution for mental disease;
3. The hospital's proportion of statewide Medicaid inpatient days; or
4. The hospital's Medicaid inpatient utilization rate.

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VII. Data Sources for Computation of Disproportionate Share Payments

The calculation of disproportionate share payments requires the use of data from multiple sources. Data sources, and the data that will be used from them, include the following:

- A. Hospital inpatient and outpatient claims data, including sub providers
  - 1. Hospital Medicaid charges
  - 2. Medicaid inpatient days - Excluded data includes Medicare crossover claims, Title XXI days and days attributable to Medicaid patients between 21 and 65 years of age in Institutions for Mental Disease. Days for OVHA members eligible under Medicaid expansion programs are included.
  - 3. Title XIX payments
- B. Hospital Medicare Cost Reports
  - 1. Hospital cost-to-charge ratios
  - 2. Total hospital inpatient days and total Medicaid days
  - 3. Total inpatient charges from all payers
- C. A state-designed survey
  - 1. Attestation of federal obstetrical requirement
  - 2. Medicaid patient services revenue
  - 3. Total revenue for hospital patient services, including inpatient and outpatient services and services by sub provider
  - 4. Total state and local cash subsidies for inpatient services
  - 5. Total state and local cash subsidies for outpatient services
  - 6. Total inpatient charges attributable to charity care. This excludes contractual allowances and bad debt.
  - 7. Total outpatient charges attributable to charity care. This excludes contractual allowances and bad debt.

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VIII. Disproportionate Share Payments

Each year of the program, OVHA will determine the DSH Eligibility Group(s) that each hospital is eligible for. The DSH pool for each DSH Eligibility Group shall be assigned based upon the proportion of Medicaid days for the hospitals within the DSH Eligibility Group to the total Medicaid days statewide. If a hospital is eligible for more than one DSH Eligibility Group, for the purposes of computing the DSH pool amount, the hospital will be placed in only one DSH Eligibility Group in the following sequence:

- DSH Eligibility Group #1
- DSH Eligibility Group #2
- DSH Eligibility Group #3
- DSH Eligibility Group #4
- DSH Eligibility Group #5
- DSH Eligibility Group #6

The percentage of statewide Medicaid days computed for each DSH Eligibility Group shall be multiplied by the total DSH allotment for the year to derive the DSH pool for each DSH Eligibility Group. Within a DSH Eligibility Group, funds will be assigned to each hospital using the formulas described in VIII.A.

When qualifying hospitals are eligible for more than one eligibility group, the hospital will be assigned to the eligibility group that maximizes their disproportionate share payment.

If disproportionate share payments are made to any hospital in a given year, then every qualifying disproportionate share hospital will receive a minimum of \$100,000 in this year.

DSH payments will be made once per year. At the time that DSH payments are disbursed, OVHA will publish the DSH pools and a schedule showing the DSH payment made to each eligible hospital.

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HOSPITAL CARE (CONTINUED)

VIII. Disproportionate Share Payments (Continued)

A. Payment Formulas

1. DSH Eligibility Group #1 (VI.B.1) is based on the Medicaid utilization rate. Eligible hospitals will be paid proportionally for the funds allocated to this group based upon the amount that their Medicaid utilization rate exceeds one standard deviation above the mean of the Medicaid inpatient utilization rate for all hospitals receiving Medicaid payments in the state. 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.
2. DSH Eligibility Group #2 (VI.B.2) is based on the low income utilization rate. Eligible hospitals will be paid proportionally for the funds allocated to this group based upon the amount that their low income utilization rate exceeds 25 percent. The low income utilization rate is calculated as the sum of the values from two formulas.

The first formula is:

(Total Medicaid Patient Services Revenue + Total State and Local Cash Subsidies for Patient Services) divided by Total Revenue for Patient Services

The second formula is:

(Total Inpatient Charges Attributable to Charity Care – Cash Subsidies Attributable to Inpatient Services) divided by Total Inpatient Charges

3. DSH Eligibility Group #3 (VI.C.1) is based on the facility's status as a state-owned facility. Subject to meeting the minimum federal requirements and to federal disproportionate share payment limitations, facilities in this group receive a payment up to 100 percent of the cost of providing services to Medicaid patients, less the amount paid under non-disproportionate share payment provisions, and to uninsured patients, less payments made.

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VIII. Disproportionate Share Payments (Continued)

A. Payment Formulas (Continued)

4. DSH Eligibility Group #4 (VI.C.2) is based on the facility's status as an institution for mental diseases. Subject to meeting the minimum federal requirements and to federal disproportionate share payment limitations, facilities in this group receive a payment up to 100 percent of the cost of providing services to Medicaid patients, less the amount paid under non-disproportionate share payment provisions, and to uninsured patients, less payments made.
5. DSH Eligibility Group #5 (VI.C.3) is based on a hospital's percentage of statewide days. Eligible hospitals will be paid proportionally for the funds allocated to this group based upon their Medicaid inpatient days.
6. DSH Eligibility Group #6 (VI.C.4) is based on a hospital's Medicaid utilization rate. Eligible hospitals will be paid proportionally for the funds allocated to this group based upon their Medicaid utilization.

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).

The OVHA will test the calculated disproportionate share payments allocated to each hospital in each year to ensure that payments do not exceed federal limits. In the event that the initial calculation determines that a hospital's calculated disproportionate share payment exceeds the OBRA limit, the amount of funds above the limit will be redistributed to the other eligible hospitals in its DSH Eligibility Group.

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