

**TRANSMITTAL AND NOTICE OF APPROVAL OF
STATE PLAN MATERIAL**

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER:

0 2 - 0 0 7

2. STATE:

Ohio

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE

August 3, 2002

5. TYPE OF PLAN MATERIAL (Check One):

NEW STATE PLAN

AMENDMENT TO BE CONSIDERED AS NEW PLAN

AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)

6. FEDERAL STATUTE/REGULATION CITATION:

CFR Part 441-Subpart C; CFR Part 441-Subpart D;
CFR Part 447-Subpart C

7. FEDERAL BUDGET IMPACT:

a. FFY 2002 \$ 9,768,330.00

b. FFY 2003 \$ (52,023,330.00)

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Pages 13-22 of Attachment 4.19A,
Rules 5101:3-2-09 and 5101:3-2-10.

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable):

Pages 13-23 of Attachment 4.19-A,
Rules 5101:3-2-09 and 5101:3-2-10

10. SUBJECT OF AMENDMENT:

Disproportionate share and indigent care adjustments for general hospitals and psychiatric hospitals.

11. GOVERNOR'S REVIEW (Check One):

GOVERNOR'S OFFICE REPORTED NO COMMENT

COMMENTS OF GOVERNOR'S OFFICE ENCLOSED

NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL

OTHER, AS SPECIFIED:

Governor has delegated review to
ODJFS Director

12. SIGNATURE OF STATE AGENCY OFFICIAL:

Thomas Hayes

13. TYPED NAME:

Thomas Hayes

14. TITLE:

Director

15. DATE SUBMITTED:

April 30, 2002

16. RETURN TO:

Ohio Department of Job and Family Services
30. E. Board Street, 27th Floor
Columbus, Ohio 43215

Attention: Becky Jackson
Bureau of Health Plan Policy

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:

5/3/02

18. DATE APPROVED:

7/18/02

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:

AUGUST 3, 2002

20. SIGNATURE OF REGIONAL OFFICIAL:

Cheryl A. Harris

21. TYPED NAME:

Cheryl A. Harris

22. TITLE: Associate Regional Administrator
Division of Medicaid and Children's Health

23. REMARKS:

RECEIVED

MAY 03 2002

DMCH - IL/IN/OH

Disproportionate Share and Indigent Care for General Hospitals

This Section applies to all general hospitals eligible to participate in Medicaid who do not meet the criteria in paragraphs (B), (C) and (D) of Rule 5101:3-2-01.

(A) SOURCE DATA FOR CALCULATIONS

The calculations described for determining disproportionate share hospitals and in making disproportionate share and indigent care payments will be based on data provided in annual cost reports submitted to the department under the provisions of Rule 5101:3-2-23. The cost reports used will be for the hospital's cost reporting period ending in state fiscal year 2001. If specific program data is not available from these reports, the otherwise most recent, reviewed, cost report information will be used. The HCFA data used will be as reported by HCFA for federal fiscal year 2000.

(B) DETERMINATION OF DISPROPORTIONATE SHARE HOSPITALS

The department makes additional payments to hospitals that qualify for a disproportionate share adjustment. Hospitals that qualify (including Children's and DRG exempt hospitals) are those that meet at least one of the criteria described under (1) and (2) below, and that also meet the criteria described under (3) below:

- (1) Have a Medicaid utilization rate greater than or equal to one percent.
- (2) Have a low income utilization rate in excess of 25 percent, where low income utilization rate is:

Medicaid payments + Cash subsidies for patient services
received directly from state and local government
 Total hospital revenues
 (including cash subsidies for patient services received
 directly from state and local governments)

+

Total charges for inpatient services for charity care
 Total charges for inpatient services

- (3) Have at least two obstetricians who have staff privileges at the hospital and who have agreed to provide obstetric services to individuals who are entitled to Medicaid, except that:
 - (i) The provisions of (3) do not apply to hospitals the inpatients of which are predominantly individuals under 18 years of age; or
 - (ii) The provisions of (3) do not apply if the hospital does not offer non-emergency obstetric services to the general population as of December 22, 1987; or
 - (iii) In the case of hospitals located in a rural area (as defined for purposes of Section 1886 of the Social Security Act), the term "obstetrician" includes any physician with staff privileges at the hospital to perform non-emergency obstetric procedures.

Hospitals that do not qualify for a disproportionate share adjustment receive additional payments in the form of an indigent care adjustment.

(C) DISPROPORTIONATE SHARE AND INDIGENT CARE POOL

TN No. 02-007
 Supersedes
 TN No. 01-010

Approval Date: 8-18-2002
 Effective Date: 8-03-02

The disproportionate share and indigent care pool are created in compliance with the Medicaid Voluntary Contribution and Provider Specific Tax Amendments of 1991 and the regulations issued in the August 13, 1993 Federal Register. Furthermore, it is an assurance of this plan that the amount of payments made to disproportionate share hospitals will not exceed, in the aggregate, the limits prescribed under subparagraph (f)(2)(A) of Section 1923.

(D) DISTRIBUTION FORMULAS FOR INDIGENT CARE PAYMENT POOLS.

(1) Hospitals meeting the high federal disproportionate share hospital definition, are eligible to receive funds from the high federal disproportionate share indigent care payment pool. A high federal disproportionate share hospital is defined as one whose ratio of total Medicaid days and Medicaid MCP days to total days is greater than the statewide mean ratio of total Medicaid days and Medicaid MCP days to total days plus one standard deviation. Funds are distributed to hospitals which meet this definition according to the following formula.

- (a) For each hospital that meets the definition of high disproportionate share, calculate the ratio of the hospital's total Medicaid costs and total Medicaid MCP costs to the sum of total Medicaid costs and Medicaid MCP costs for all hospitals which meet the definition of high federal disproportionate share described in paragraph (D)(1).
- (b) For each hospital, multiply the ratio calculated in paragraph (D)(1)(a) by ~~thirty FIVE million dollars~~ **\$41,441,812**. This is the hospital's federal high disproportionate share hospital payment amount.

(2) Hospitals are eligible to receive funds from the Medicaid indigent care payment pool according to the following formulas.

- (a) For each hospital, calculate Medicaid shortfall by subtracting from total Medicaid costs total Medicaid payments. For hospitals with a negative Medicaid shortfall, the Medicaid shortfall amount is equal to zero.
- (b) For each hospital, calculate Medicaid MCP inpatient payments by multiplying Medicaid fee-for-service (FFS) inpatient payment-to-cost ratio by Medicaid MCP inpatient costs.
- (c) For each hospital, calculate Medicaid MCP outpatient payments by multiplying Medicaid FFS outpatient payment-to-cost ratio by Medicaid MCP outpatient costs.
- (d) For each hospital, calculate Medicaid MCP inpatient shortfall by subtracting from the total Medicaid MCP inpatient costs, Medicaid MCP inpatient payments, as calculated in paragraph (D)(2)(b). For hospitals with a negative Medicaid MCP inpatient shortfall, the Medicaid MCP inpatient shortfall amount is equal to zero.
- (e) For each hospital, calculate Medicaid MCP outpatient shortfall by subtracting from the total Medicaid MCP outpatient costs, Medicaid MCP outpatient payments, as calculated in paragraph (D)(2)(c). For hospitals with a negative Medicaid MCP outpatient shortfall, the Medicaid MCP outpatient shortfall amount is equal to zero.
- (f) For each hospital, calculate Medicaid MCP shortfall as the sum of the amount calculated in paragraph (D)(2)(d), and the amount calculated in paragraph (D)(2)(e).
- (g) For each hospital, sum the hospital's Medicaid shortfall, Medicaid MCP shortfall, total Medicaid costs, total Medicaid MCP costs, and total Title V costs.
- (h) For all hospitals, sum all hospitals Medicaid shortfall, Medicaid MCP shortfall, total Medicaid costs, Total Medicaid MCP costs, and total Title V costs.

TN No. 02-007
Supersedes
TN No. 01-010

Approval Date: _____
Effective Date: 8-03-02

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- (i) For each hospital, calculate the ratio of the amount in paragraph (D)(2)(g) to the amount in paragraph (D)(2)(h).
 - (j) For each hospital, multiply the ratio calculated in paragraph (D)(2)(i) by **\$90,810,067** to determine each hospital's Medicaid indigent care payment amount.
- (3) Hospitals are eligible to receive funds from the disability assistance medical and uncompensated care indigent care payment pool.
- (a) For each hospital, sum total disability assistance medical costs and total uncompensated care costs under one hundred per cent.
 - (b) Each hospital's disability assistance medical and uncompensated care under one hundred per cent payment amount is equal to the amount calculated in paragraph (D)(3)(a).
 - (c) For all hospitals, sum the amounts calculated in paragraph (D)(3)(b).
 - (d) For each hospital, multiply a factor of 0.30 by the hospital's total uncompensated care costs above one hundred percent without insurance.
 - (e) For all hospitals, sum the amounts calculated in paragraph (D)(3)(d).
 - (f) For each hospital, calculate the ratio of the amount in paragraph (D)(3)(d) to the amount in paragraph (E)(3)(e).
 - (g) Subtract the amount calculated in paragraph (D)(3)(c) from ~~three hundred ten million dollars~~ **\$316,441,812**.
 - (h) For each hospital, multiply the ratio calculated in paragraph (D)(3)(f) by the amount calculated in paragraph (D)(3)(g), to determine each hospital's uncompensated care above one hundred percent without insurance payment amount.
 - (i) For each hospital, sum the amount calculated in paragraph (D)(3)(b), and the amount calculated in paragraph (D)(3)(h). This amount is the hospital's disability assistance medical and uncompensated care indigent care payment amount.
- (E) DISTRIBUTION OF FUNDS THROUGH THE DISPROPORTIONATE SHARE LIMIT POOL.
- (1) For each hospital, calculate the hospital's specific disproportionate share limit as defined in paragraph (I).
 - (2) For each hospital, sum the hospital's total payments allocated in paragraphs (D)(1)(b), (D)(2)(j), AND (D)(3)(i).
 - (3) Multiply each hospital's adjusted total facility costs that are less than or equal to ~~\$236,977,539~~ **\$214,904,130** by ~~0.0177~~ **0.0178**. For hospitals with adjusted total facility costs that are greater than ~~\$236,977,539~~ **\$214,904,130**, multiply a factor of 0.01 times the hospital's adjusted total facility costs that are in excess of ~~\$236,977,539~~ **\$214,904,130**. For each hospital, multiply a factor of 0.50 by the amount calculated.
 - (4) For each hospital, sum the amounts calculated in paragraphs (E)(2) and (E)(3).
 - (5) Funds in the disproportionate share limit pool will be distributed as described in paragraphs (E)(5)(a) to (E)(5)(c).

TN No. 02-007
Supersedes
TN No. 01-010

Approval Date: JUL 18 2002
Effective Date: 8-03-02

- (a) For each hospital, if the amount calculated in paragraph (E)(2) is greater than the amount calculated in (E)(1), the hospital will receive no payment from the disproportionate share limit pool.
- (b) For each hospital, if the amount calculated in paragraph (E)(4) is less than the amount calculated in paragraph (E)(1), the amount in paragraph (E)(3) will be the hospital's disproportionate share limit pool payment amount.
- (c) For each hospital, if the amount calculated in paragraph (E)(4) is greater than the amount calculated in paragraph (E)(1) and the amount calculated in paragraph (E)(2) is less than the amount calculated in paragraph (E)(1), then the hospital's disproportionate share limit pool payment amount will be the difference between the amounts in paragraphs (E)(1) and (E)(2).

(F) DISTRIBUTION OF FUNDS THROUGH THE RURAL AND CRITICAL ACCESS PAYMENT POOLS

The funds are distributed among the hospitals according to rural and critical access payment pools described in paragraphs (F)(1) to (F)(2).

- (1) Hospitals that are certified as critical access hospitals by the ~~Health Care Financing Administration~~ Centers for Medicare and Medicaid Services, and that have notified the Ohio Department of Health and the Ohio Department of Job and Family Services of such certification, shall receive funds from the critical access hospital (CAH) payment pool.
 - (a) For each hospital with CAH certification, calculate the Medicaid shortfall by adding Medicaid FFS shortfall described paragraph (D)(2)(a), to the Medicaid MCP shortfall described in paragraph (D)(2)(f).
 - (b) For each hospital with CAH certification, each hospital's CAH payment amount is equal to the amount calculated in paragraph (F)(1)(a).
 - (c) For all hospitals with CAH certification, sum the amounts calculated in paragraph (F)(1)(b).
 - (d) For each hospital with CAH certification, if the amount described in paragraph (f)(1)(a) of this rule is equal to zero, the hospital shall be included in the RAH payment pool described in paragraph (F)(2)(a).
- (2) Hospitals that are classified as a rural hospitals by the ~~Health Care Financing Administration~~ Centers for Medicare and Medicaid Services, but do not meet the definition described in paragraph (F)(1), shall receive funds from the rural access hospital (RAH) payment pool.
 - (a) For each hospital with RAH classification, as qualified by paragraph (F)(2) And (F)(1)(d), sum the hospital's total payments allocated in paragraphs (D)(1)(b), (D)(2)(j), AND (D)(3)(i), and (E)(5)(c).
 - (b) For each hospital with RAH classification, as qualified by paragraph (F)(2) and (F)(1)(d) of this rule subtract the amount calculated in paragraph (F)(2)(a), from the amount calculated in paragraph (E)(1). If this difference for the hospital is negative, then for the purpose of this calculation set the difference equal to zero.
 - (c) For all hospitals with RAH classification, as qualified by paragraph (F)(2) and (F)(1)(d), sum the amounts calculated in paragraph (F)(2)(b).
 - (d) For each hospital with RAH classification, as qualified by paragraph (F)(2) and (F)(1)(d), determine the ratio of the amounts in paragraph (F)(2)(b) and (F)(2)(c).
 - (e) Subtract the amount calculated in paragraph (F)(1)(c) from ~~\$8,098,914~~ \$14,540,726.

TN No. 02-007
Supersedes
TN No. 01-010

Approval Date: JUL 16 2008
Effective Date: 8-03-02

- (f) For each hospital with RAH classification, as qualified by paragraph (F)(2) and (F)(1)(d), multiply the ratio calculated in paragraph (F)(2)(d), by the amount calculated in paragraph (F)(2)(e), to determine each hospital's rah payment pool amount.
- (g) For each hospital, sum the amount calculated in paragraph (F)(1)(b), and the amount calculated in paragraph (F)(2)(f). This amount is the hospital's rural and critical access payment amount.

(G) DISTRIBUTION OF FUNDS THROUGH THE COUNTY REDISTRIBUTION OF CLOSED HOSPITALS PAYMENT POOLS.

- (1) Closed hospitals with unique Medicaid provider numbers.

For a hospital facility, identifiable to a unique Medicaid provider number, that closes during the program year, the cost report data used shall be adjusted to reflect the portion of the year the hospital was open during the program year. That partial year data shall be used to determine the distribution to that closed hospital. The difference between the closed hospital's distribution based on the full year cost report and the partial year cost report shall be redistributed to the remaining hospitals in accordance with paragraph (G)(2).

For a hospital facility identifiable to a unique Medicaid provider number that closed during the immediate prior program year, the cost report data shall be used to determine the distribution that would have been made to that closed hospital. This amount shall be redistributed to the remaining hospitals in accordance with paragraph (G)(2).

If funds are available in accordance with paragraph (G)(1) of this rule, the funds are distributed among the hospitals according to the county redistribution of closed hospitals payment pools described in paragraphs (G)(2) to (G)(4).

- (2) If a hospital facility that is identifiable to a unique Medicaid provider number closes during the current program year, the payments that would have been made to that hospital under paragraphs (D), (E), (F), and (H) for the portion of the year it was closed, less any assessment amounts that would have been paid by the closed hospital for the portion of the year it was closed, shall be distributed to the remaining hospitals in the county where the closed hospital is located. If another hospital does not exist in such a county, the funds shall be distributed to hospitals in bordering counties within the state.

For each hospital identifiable to a unique Medicaid provider number that closed during the immediate prior program year, the payments that would have been made to that hospital under paragraphs (D), (E), (F), and (H), less any assessment amounts that would have been paid by the closed hospital, shall be distributed to the remaining hospitals in the county where the closed hospital was located. If another hospital does not exist in such a county, the funds shall be distributed to hospitals in bordering counties within the state.

If the closed hospital's payments under paragraphs (D), (E), (F), and (H) of this rule does not result in a net gain, nothing shall be redistributed under paragraphs (g)(3) and (g)(4) of this rule.

- (3) Redistribution of closed hospital funds within the county of closure.

- (a) For each hospital within a county with a closed hospital as described in paragraph (G)(2), sum the amount calculated in paragraph (D)(3)(a), and the amount calculated in paragraph (D)(3)(d).
- (b) For all hospitals within a county with a closed hospital, sum the amounts calculated in paragraph (G)(3)(a).

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Approval Date: _____
Effective Date: 8-03-02

- (c) For each hospital within a county with a closed hospital, determine the ratio of the amounts in paragraph (G)(2)(a) and (G)(2)(b).
- (d) For each hospital within a county with a closed hospital, multiply the ratio calculated in paragraph (G)(2)(c), by the amount calculated in paragraph (G)(2) of this rule, to determine each hospital's county redistribution of closed hospitals payment amount.
- (4) Redistribution of closed hospital funds to hospitals in a bordering county.
- (a) For each hospital within a county that borders a county with a closed hospital where another hospital does not exist, as described in paragraph (G)(2), sum the amount calculated in paragraph (D)(3)(a), and the amount calculated in paragraph (D)(3)(d).
- (b) For all hospitals within counties that border a county with a closed hospital where another hospital does not exist, sum the amounts calculated in paragraph (G)(4)(a).
- (c) For each hospital within a county that borders a county with a closed hospital where another hospital does not exist, determine the ratio of the amounts in paragraph (G)(4)(a) and (G)(4)(b).
- (d) For each hospital within a county that borders a county with a closed hospital where another hospital does not exist, multiply the ratio calculated in paragraph (G)(3)(c), by the amount calculated in paragraph (G)(2), to determine each hospital's county redistribution of closed hospitals payment amount.
- (H) DISTRIBUTION MODEL ADJUSTMENTS AND LIMITATIONS THROUGH THE STATEWIDE RESIDUAL POOL.
- (1) For each hospital, subtract the hospital's specific disproportionate share limit as defined in paragraph (I) from the payment amount as calculated in paragraphs (E)(2), (E)(5), (F)(2)(g) and (G)(3)(d) AND (G)(4)(d) to determine if a hospital's calculated payment amount is greater than its disproportionate share limit.
- If a hospital's calculated payment amount is greater than its disproportionate share limit, then the hospital's payment is equal to the hospital's disproportionate share limit. The portion of the calculated amount above the disproportionate share limit, referred to as residual payment funds, is subtracted from the hospital's calculated payment amount and is applied to the statewide residual payment pool as described in paragraph (H)(2).
- (2) RE-DISTRIBUTION OF RESIDUAL PAYMENT FUNDS IN THE STATEWIDE RESIDUAL PAYMENT POOL.
- (a) For each hospital with a calculated payment amount that is not greater than the disproportionate share limit, as described in paragraph (I), subtract the payment amount described in paragraph (H)(1) from the amount of the disproportionate share limit.
- (b) For all hospitals with calculated payment amounts that are not greater than the disproportionate share limit, sum the amounts calculated in paragraph (H)(2)(a).
- (c) For each hospital with a calculated payment amount that is not greater than the disproportionate share limit, determine the ratio of the amounts in paragraph (H)(2)(a) and (H)(2)(b).
- (1) For each hospital with a calculated payment amount that is not greater than the disproportionate share limit, multiply the ratio calculated in paragraph (H)(2)(c) of this rule

TN No. 02-007
Supersedes
TN No. 01-010

Approval Date: JUL 18 2002
Effective Date: 8-03-02

by the total amount distributed through the statewide residual pool described in paragraph (H)(1). This amount is the hospital's statewide residual payment pool payment amount.

(I) LIMITATIONS ON DISPROPORTIONATE SHARE AND INDIGENT CARE PAYMENTS MADE TO HOSPITALS

- (1) For each hospital calculate Medicaid shortfall by subtracting from total Medicaid costs, total Medicaid payments. (NOTE: FOR HOSPITALS WITH A NEGATIVE MEDICAID SHORTFALL, THE MEDICAID SHORTFALL AMOUNT IS NOT EQUAL TO ZERO). For hospitals exempt from the prospective payment system, Medicaid shortfall equals zero. For each hospital, add Medicaid MCP shortfall as calculated in paragraph (D)(2)(f).
- (2) For each hospital, calculate total inpatient costs for patients without insurance by multiplying the hospitals' inpatient Medicaid cost-to-charge ratio, by the sum of hospital's reported charges for inpatient disability assistance medical, inpatient uncompensated care under one hundred per cent, and inpatient uncompensated care above one hundred per cent.
- (3) For each hospital, calculate total outpatient costs for patients without insurance by multiplying the hospitals' outpatient Medicaid cost-to-charge ratio, by the sum of hospital's reported charges for outpatient disability assistance medical, outpatient uncompensated care under one hundred per cent, and outpatient uncompensated care above one hundred per cent.
- (4) For each hospital, calculate the hospital disproportionate share limit by adding the Medicaid shortfall and Medicaid MCP shortfall as described in paragraph (I)(1), inpatient uncompensated care as described in paragraph (I)(2), and outpatient uncompensated care as described in paragraph (I)(3).
- (5) The hospital will receive the lessor of the disproportionate share limit as described in paragraph (I)(4) or the disproportionate share and indigent care payment as calculated in paragraphs (D), (E), (F), (G) and (H).

Payments are made to each hospital in installments based on the amount calculated for the annual period. The annual period used in performing disproportionate share/indigent care adjustments is the hospital's fiscal year ending state fiscal year 2001. Payments are subject to reconciliation if errors have been made in calculating the amount of disproportionate share or indigent care adjustments or if adjustments must be made in order to comply with the federal regulations issued under H.R. 3595.

Expenses associated with payment of hospital assessments are allowable as a Medicaid cost for cost reporting purposes.

TN No. 02-007
Supersedes
TN No. 01-010

Approval Date: JUL 18 2002
Effective Date: 8-03-02

Disproportionate share and indigent care payment policies for psychiatric hospitals

This section applies to hospitals eligible to participate in Medicaid only for the provision of inpatient psychiatric services to eligible recipients:

- 1. Age 65 and older; and
- 2. Under age 21, or if the recipient was receiving services immediately before he/she reached age 21, services are covered until the earlier of the date he/she no longer requires the services or the date he/she reaches age 22.

The payment policies described below are in accordance with rule 5101:3-2-10. Hospitals eligible to participate only for the provision of inpatient psychiatric services are limited, in accordance with rule 5101:3-2-01, to psychiatric hospitals, and certain alcohol and drug abuse rehabilitation hospitals, that are certified by Medicare for reimbursement of services and are licensed by the Ohio Department of Mental Health or operated under the state mental health authority.

A. Source data for calculations

The calculations described in determining disproportionate share psychiatric and certain alcohol and drug abuse rehabilitation hospitals (hospitals) and in making disproportionate share and indigent care payments will be based on financial data and patient care data for psychiatric inpatient services provided for the hospital fiscal year ending in state fiscal year 2001.

B. Determination of disproportionate share hospitals

The department makes additional payments to hospitals that qualify for a disproportionate share adjustment. Hospitals that qualify are those that meet at least one of the criteria described under (1) and (2) below, and that also meet the criteria described under (3) below:

- (1) The hospital's Medicaid inpatient utilization rate is at least one standard deviation above the mean Medicaid inpatient utilization rate for all hospitals receiving Medicaid payments in the state.

The Medicaid inpatient utilization rate is the ratio of the hospital's number of inpatient days attributable to patients who were eligible for medical assistance and who are age twenty-one and under or age sixty-five and older, divided by the hospitals total inpatient days.

- (2) The hospital's low-income utilization rate is in excess of twenty-five percent.

The low-income utilization rate is the sum of:

- (a) The sum of total Medicaid revenues for inpatient services and cash subsidies for inpatient services received directly from state and local governments, divided by the sum of total facility inpatient revenues and cash subsidies for patient services received directly from state and local governments, plus
- (b) Total charges for inpatient services for charity care (less cash subsidies above, and not including contractual allowances and discounts other than for indigent patients ineligible for Medicaid) divided by the total charges for inpatient services.

- (3) A Medicaid inpatient utilization rate greater than or equal to one percent.

C. Determination of hospital disproportionate share groups for payment distribution

Hospitals determined to be disproportionate share as described above will be classified into one of four tiers for payment distribution based on the data described in paragraph a above. The tiers are described below:

TN No. 02-007
Supersedes
TN No. 01-010

Approval Date: JUL 18 2002
Effective Date: 8-03-02

- (1) Tier one includes all hospitals deemed to be disproportionate share hospitals based on a low-income utilization rate greater than 25% but less than 40%, or deemed a disproportionate share hospital based on a Medicaid inpatient utilization rate that is one standard deviation above the mean Medicaid inpatient utilization rate for all hospitals receiving Medicaid payments in the state.
- (2) Tier two includes all hospitals deemed to be disproportionate share hospitals based on a low-income utilization rate greater than or equal to 40% but less than 50%.
- (3) Tier three includes all hospitals deemed to be disproportionate share hospitals based on a low-income utilization rate greater than or equal to 50% but less than 60%.
- (4) Tier four includes all hospitals deemed to be disproportionate share hospitals based on a low-income utilization rate greater than or equal to 60% .

D. Distribution of funds within each hospital tier

The funds available in a tier are distributed among hospitals in that tier according to the payment formulas described below. Hospitals will be distributed a payment amount based on the lesser of their uncompensated care costs or their disproportionate share payment. Uncompensated care costs are defined as total inpatient allowable costs less insurance revenues, self-pay revenues, total Medicaid revenues and uncompensated care costs rendered to patients with insurance for the service provided. Each hospital's disproportionate share payment is calculated on a tier-specific basis as follows:

Hospital specific uncompensated care <u>Costs</u> x sum of uncompensated care costs for all hospitals in the tier	Disproportionate share funds available for distribution in the tier
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- (1) Funds available for distribution by tier.
 - (a) Tier 1. A maximum of 5% of the disproportionate share funds will be distributed to the hospitals in tier one.

If no hospitals fall into tier one, or all funds are not distributed, then undistributed funds from tier one will be added to the funds available for distribution in tier four.
 - (b) Tier 2. A maximum of 25% of the disproportionate share funds will be distributed to hospitals in tier two.

If no hospitals fall into tier two, or all funds are not distributed, then undistributed funds will be added to the funds available for distribution in tier four.
 - (c) Tier 3. A maximum of 45% of the disproportionate share funds will be distributed to hospitals in tier three.

If no hospitals fall into tier three, or all funds are not distributed, then undistributed funds will be added to the funds available for distribution in tier four.
 - (d) Tier 4. A minimum of 40% of the disproportionate share funds will be distributed to hospitals in tier four.
- (2) Payment distribution

Each hospital will be distributed a payment amount based on the lesser of their:

TN No. 02-007
Supersedes
TN No. 01-010

Approval Date: JUL 18 2002
Effective Date: 8-03-02