ADOPTED REGULATION OF THE

DIVISION OF HEALTH CARE FINANCING AND POLICY OF

THE DEPARTMENT OF HEALTH AND HUMAN SERVICES

LCB File No. R033-10

Effective June 30, 2010

EXPLANATION – Matter in ***italics*** is new; matter in brackets **[**~~omitted material~~**]** is material to be omitted.

AUTHORITY: §§1-16, NRS 422.390.

A REGULATION relating to public welfare; requiring certain governmental entities in larger counties to transfer to the Division of Health Care Financing and Policy of the Department of Health and Human Services certain percentages of the disproportionate share payments distributed to certain hospitals within the county; establishing methods for calculating, adjusting and redistributing disproportionate share payments to certain hospitals for the treatment of indigent patients; providing for audits of hospitals which receive disproportionate share payments; providing for the transfer of money to certain public hospitals that are not eligible to receive disproportionate share payments; and providing other matters properly relating thereto.

Section 1. Chapter 422 of NAC is hereby amended by adding thereto the provisions set forth as sections 2 to 15, inclusive, of this regulation.

Sec. 2. ***As used in this chapter, unless the context otherwise requires, the words and terms defined in sections 3 to 8, inclusive, of this regulation have the meanings ascribed to them in those sections.***

Sec. 3. ***"Distribution factor" means the value of the formula set forth in section 11 of this regulation calculated for a hospital.***

Sec. 4. ***"Division" means the Division of Health Care Financing and Policy of the Department of Health and Human Services.***

Sec. 5. *"Pool distribution factor" means the sum of each distribution factor for each hospital that is a member of the pool of hospitals for which a disproportionate share payment is being calculated.*

Sec. 6. *"Pool of hospitals" means a group of hospitals designated in a particular pool pursuant to subsection 1 of section 10 of this regulation.*

Sec. 7. *"Public hospital" means:*

1. A hospital owned by a state or local government, including, without limitation, a hospital district; or

2. A hospital that is supported in whole or in part by tax revenue, other than tax revenue received for medical care which is provided to Medicaid patients, indigent patients or other low income patients.

Sec. 8. *"Uncompensated care costs" means the total annual uncompensated care costs as defined in 42 C.F.R. § 447.299(c)(16).*

Sec. 9. *1. In a county whose population is 100,000 or more within which a public hospital is located, the state or local government or other entity responsible for the public hospital shall transfer to the Division an amount equal to:*

(a) Seventy percent of the total amount of disproportionate share payments distributed to all hospitals pursuant to this chapter and NRS 422.380 to 422.390, inclusive, for the current fiscal year, less $1,050,000; or

(b) Sixty-eight and fifty-four one hundredths percent of the total amount of disproportionate share payments distributed to all hospitals pursuant to this chapter and NRS 422.380 to 422.390, inclusive, for the current fiscal year,

➥ whichever is less.

2. In a county whose population is 100,000 or more within which a private hospital which receives a disproportionate share payment pursuant to paragraph (c) of subsection 1 of section 10 of this regulation is located, the county shall transfer to the Division 1.95 percent of the total amount of disproportionate share payments distributed to all hospitals pursuant to this chapter and NRS 422.380 to 422.390, inclusive, for the current fiscal year, but not more than $1,500,000.

3. If a county transfers to the Division the amount required pursuant to subsection 2, the county is discharged of the duty and is released from liability for providing medical treatment for indigent inpatients who are treated in the hospital in the county that receives a payment pursuant to paragraph (c) of subsection 1 of section 10 of this regulation.

Sec. 10. *1. Except as otherwise provided in subsection 2, the Division will initially distribute for:*

(a) Pool A, which consists of all public hospitals in counties whose population is 400,000 or more, total annual disproportionate share payments in the amount of $66,650,000 plus 90 percent of the total amount of disproportionate share payments distributed by the State in that fiscal year which exceeds $76,000,000;

(b) Pool B, which consists of all private hospitals in counties whose population is 400,000 or more, total annual disproportionate share payments in the amount of $1,200,000 plus 2.5 percent of the total amount of disproportionate share payments distributed by the State in that fiscal year which exceeds $76,000,000;

(c) Pool C, which consists of all private hospitals in counties whose population is 100,000 or more but less than 400,000, total annual disproportionate share payments in the amount of

$4,800,000 plus 2.5 percent of the total amount of disproportionate share payments distributed by the State in that fiscal year which exceeds $76,000,000;

(d) Pool D, which consists of all public hospitals in counties whose population is less than 100,000, total annual disproportionate share payments in the amount of $900,000 plus 2.5 percent of the total amount of disproportionate share payments distributed by the State in that fiscal year which exceeds $76,000,000; and

(e) Pool E, which consists of all private hospitals in counties whose population is less than 100,000, total annual disproportionate share payments in the amount of $2,450,000 plus 2.5 percent of the total amount of disproportionate share payments distributed by the State in that fiscal year which exceeds $76,000,000.

2. A hospital may not receive a disproportionate share payment unless the hospital meets all the requirements:

(a) Established by federal and state statutes and regulations; and

(b) As prescribed in the State Plan for Medicaid.

Sec. 11. *1. The Division will use the following formula to calculate the distribution factor for a hospital:*

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

where:

DF is the distribution factor.

UCC is the uncompensated care costs 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 report filed pursuant to subsection 1 of NAC 439B.230.

(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 reports filed pursuant to subsection 1 of NAC 439B.230 for each such hospital.

Sec. 12. *1. Except as otherwise provided in subsection 2, the Division will make an initial distribution of disproportionate share payments to a hospital by dividing the distribution factor for that hospital by the pool distribution factor and multiplying the result by the total amount of money available for initial distribution to the pool of hospitals pursuant to section 10 of this regulation.*

2. The Division will adjust the initial distribution for each hospital in a pool of hospitals to ensure that each hospital which is eligible to receive a disproportionate share payment receives not less than $10,000.

Sec. 13. *The Division will audit each hospital for each year in which the hospital received a disproportionate share payment pursuant to this chapter and NRS 422.380 to 422.390, inclusive. The audit must be conducted in accordance with the provisions of Title*

XIX of the Social Security Act, 42 U.S.C. §§ 1396 et seq., and the regulations adopted pursuant to those provisions.

Sec. 14. *1. After conducting an audit pursuant to section 13 of this regulation, 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 pool distribution factor and multiplying the result by the total amount of money available for final distribution to the pool of hospitals pursuant to section 10 of this regulation.

2. A hospital may receive as a final distribution of disproportionate share payments for a fiscal year an amount equal to:

(a) The uncompensated care costs calculated pursuant to paragraph (a) of subsection 1; or

(b) The disproportionate share payment for the hospital calculated pursuant to paragraph (c) of subsection 1,

➥ whichever is less.

3. If the amount of the final distribution payment calculated pursuant to subsection 2 is less than the amount of the initial distribution of disproportionate share payments received by the hospital pursuant to section 12 of this regulation, the hospital shall return to the Division the difference between the amount of the initial distribution and the amount of the final distribution.

4. Except as otherwise provided in subsection 5, the Division will, for each pool of hospitals, redistribute among the hospitals within the pool the money returned to the Division pursuant to subsection 3 by the hospitals within that pool.

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 pursuant to subsection 3 to pay additional disproportionate share payments as follows:

(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 D,

➥ or, if each hospital in a pool of hospitals to which additional payments would have been paid pursuant to this subsection has received the maximum allowable disproportionate share payments, to such other pool of hospitals as the Division determines appropriate.

Sec. 15. *To the extent that money is available from the amount transferred to the Division pursuant to section 9 of this regulation, the Division will distribute $50,000 from that amount each fiscal year to each public hospital which:*

1. Is located in a county that does not have any other hospital; and

2. Is not eligible for a disproportionate share payment pursuant to sections 2 to 14, inclusive, of this regulation.

Sec. 16. NAC 422.020, 422.030, 422.040, 422.050, 422.060, 422.070, 422.080, 422.090, 422.100, 422.110, 422.120, 422.130, 422.140, 422.150, 422.160, 422.170, 422.180, 422.190, 422.200 and 422.210 are hereby repealed.

TEXT OF REPEALED SECTIONS

422.020 Rate of tax. The rate of the tax imposed pursuant to NRS 422.389 is the lesser of:

1. The amount billed less the Medicaid rates approved by the State Welfare Board at its meeting held on July 26, 1991; or

2. The amount listed on the following table:

PROVIDER TYPE		PROVIDER DESCRIPTION	TAX RATE
12	Hospital, Outpatient	Medicine	$2.34
		Anesthesia*	20.08

PROVIDER TYPE		PROVIDER DESCRIPTION	TAX RATE
		Surgery	42.30
		Radiology	7.52
		Pathology	1.00
		Therapy*	1.60
14	State Mental Hospital, Outpatient	Medicine	2.34
17	Clinic	Medicine	.55
		Surgery	57.45
		Radiology	7.19
20	Physician	Anesthesiology	20.08
		Medicine	2.34
		Surgery	42.31
		Radiology	7.52
		Pathology	1.01
21	Podiatrist	Medicine	1.47
		Surgery	43.60
		Radiology	6.07

PROVIDER TYPE	PROVIDER DESCRIPTION	TAX RATE
22 Dentist	American Dental Association	4.70
	Common Procedure Terminology	2.34
23 Hearing Aids	Per hearing aid	99.37
24 Certified Registered Nurse Practitioner/Physician Assistant	Medicine	1.56
	Anesthesia	20.08
	Surgery	47.67
25 Optometrist	Common Procedure Terminology	2.34
	Per frame	9.00
26 Psychologist	Medicine	1.22
27 Radiology Only	Medicine	2.34
	Radiology	7.19
28 Pharmacy	Prescription fee	.40

PROVIDER TYPE		PROVIDER DESCRIPTION	TAX RATE
		Unit dose professional fee	.40
29	Home Health Agency	RN, per visit	21.71
		RN, hourly	11.19
		LPN, per visit	16.17
		LPN, hourly	8.32
		Therapist, per visit	17.09
		Aid, first hour	9.24
		Aid, each additional 1/2 hour	3.93
30	Home Care: Personal Care Aid	Personal care aid I	2.85
		Personal care aid II	3.88
31	Early Periodic Screening, Diagnosis and Treatment	Per Exam	25.74
32	Ambulance	Base rate:	
		ground rural	31.05
		ground urban	41.40
		air	62.09

PROVIDER TYPE	PROVIDER DESCRIPTION	TAX RATE
	Sit-up rate:	
	rural	15.52
	urban	20.07
	Mileage:	
	ground	2.07
	air	3.10
	Special equipment	33.60
	Oxygen	4.66
	Night rate	5.69
	Emergency rate	8.28
	RN	15.52
	Paramedic, per hour	20.70
34 Therapy	Common Procedure Terminology	1.60
36 Chiropractor	Medicine	1.02
	Radiology	4.18
40 Prepaid Health Plans	Monthly, per client:	
ADC Reno	Age under 1	32.64

PROVIDER TYPE	PROVIDER DESCRIPTION	TAX RATE
	Age 1-17	11.63
	Age 18-64	48.43
ADC Las Vegas	Age under 1	33.89
	Age 1-17	11.88
	Age 18-64	42.47
Aged Community, Reno		28.00
Aged Community, Las Vegas		33.70
Aged Institution, Reno		38.03
Aged Institution, Las Vegas		38.74
41 Optical Business	Common Procedure Terminology	2.34
	Per frame	9.00
42 Psychiatric Hospital Outpatient (Private)	Medicine	2.34
43 Clinical Laboratory (Pathology)	Medicine	1.42
	Laboratory	1.00
	Pathology	.15

PROVIDER TYPE		PROVIDER DESCRIPTION	TAX RATE
45	End Stage Renal Disease	Medicine	2.34

* Common Procedure Terminology

422.030 Definitions. As used in NAC 422.030 to 422.210, inclusive, unless the context otherwise requires, the words and terms defined in NAC 422.040 to 422.090, inclusive, have the meanings ascribed to them in those sections.

422.040 "Fiscal year" defined. Fiscal year means a period beginning on July 1 and ending June 30 of the following calendar year.

422.050 "Inpatient" defined. "Inpatient" means a patient who is admitted into a hospital, occupies a bed and remains hospitalized for at least 1 night.

422.060 "Medicare billed charge" defined. "Medicare billed charge" means a charge which is applied by a hospital to a program of insurance for Medicare. The term includes a charge which is applied to a patient of a program of insurance for Medicare for a health maintenance organization.

422.070 "Medicare patient" defined. "Medicare patient" means a patient for whom a payment is received directly by a hospital from a program of insurance for Medicare. The term includes a patient for whom a payment is received by the hospital pursuant to a program of insurance for Medicare for a health maintenance organization.

422.080 "Medicare revenues" defined. "Medicare revenues" means the revenue received directly by a hospital from a program of insurance for Medicare. The term includes payments

received by the hospital pursuant to a program of insurance for Medicare for a health maintenance organization.

422.090 "Outpatient" defined. "Outpatient" means a patient who receives health care services from a hospital but who is not admitted to that hospital as an inpatient.

422.100 Applicability of provisions of NRS 422.383 to particular hospitals.

1. The following hospitals, which have no more than 45 beds or are owned by a federal, state or local government, including hospital districts, are exempt from the tax imposed pursuant to NRS 422.383:

(a) Battle Mountain Hospital.

(b) Boulder City Hospital.

(c) Carson-Tahoe Hospital.

(d) Churchill Community Hospital.

(e) Elko General Hospital.

(f) Grover C. Dils Medical Center.

(g) Humboldt General Hospital.

(h) Ioannis A. Lougaris Veterans Administration Medical Center.

(i) Mt. Grant General Hospital.

(j) Nye Regional Medical Center.

(k) Pershing General Hospital.

(l) South Lyon Medical Center.

(m) University Medical Center.

(n) William Bee Ririe Hospital.

(o) The 554 Medical Group.

2. The following hospitals are subject to the tax imposed by NRS 422.383:

(a) Desert Springs Hospital.

(b) Lake Mead Hospital Medical Center.

(c) St. Mary's Hospital.

(d) St. Rose Dominican Hospital.

(e) Sparks Family Medical Center.

(f) Sunrise Hospital and Medical Center.

(g) Valley Hospital Medical Center.

(h) Washoe Medical Center.

(i) Womens Hospital.

3. The following hospitals shall pay an intergovernmental transfer pursuant to NRS 422.383:

(a) Carson-Tahoe Hospital.

(b) Elko General Hospital.

(c) University Medical Center.

4. The following facilities, which are licensed by the Health Division of the Department, shall not be deemed to be a hospital and are excluded from the program of tax and intergovernmental transfer imposed pursuant to NRS 422.383:

(a) Charter Hospital of Las Vegas.

(b) El Jen Medical Speciality Hospital.

(c) Horizon Speciality Hospital.

(d) Montevista Centre.

(e) Rehabilitation Hospital of Nevada, Las Vegas.

(f) Rehabilitation Hospital of Nevada, Reno.

(g) West Hills Hospital

(h) Willow Springs Hospital.

422.110 Total amount to be collected. The total amount to be collected pursuant to NRS 422.383 for:

1. Fiscal year 1994-1995 is $38,350,000.

2. Fiscal year 1995-1996 is $40,300,000.

422.120 Tax rate for billed charges for inpatients. The tax rate for billed charges for inpatients is equal to:

1. Six percent of the net revenues, excluding Medicare revenues, from inpatients, for all hospitals which are subject to the tax pursuant to subsection 1 of NRS 422.383, as listed in subsection 2 of NAC 422.100, divided by the amount for billed charges, excluding Medicare billed charges, for inpatients for those hospitals; or

2. The amount for the appropriate fiscal year, as set forth in NAC 422.110, divided by the amount for billed charges for inpatients, excluding Medicare billed charges, for all hospitals which are subject to the tax pursuant to subsection 1 of NRS 422.383 or the intergovernmental transfer pursuant to subsection 6 of NRS 422.383,

➥ whichever is less.

422.130 Tax rate for outpatients.

1. If the amount generated from the tax rate specified in NAC 422.120, plus the amount of intergovernmental transfers specified in NAC 422.170, is less than the amount for the appropriate fiscal year, as set forth in NAC 422.110, the tax rate for outpatients is:

(a) The amount for the appropriate fiscal year, as set forth in NAC 422.110, less the amount calculated for the annual taxes and intergovernmental transfers for inpatients, divided by the amount of total billed charges, excluding Medicare billed charges, for outpatients, for those hospitals paying taxes or intergovernmental transfers; or

(b) Six percent of the net revenues, excluding Medicare revenues, for outpatients, divided by the billed charges, excluding Medicare billed charges, for outpatients for all hospitals subject to the tax pursuant to subsection 1 of NRS 422.383, as listed in subsection 2 of NAC 422.100,

➥ whichever is less.

2. If the amount generated from the tax rate specified in NAC 422.120 plus the amount of intergovernmental transfers, as specified in NAC 422.170, is equal to or greater than the amount for the appropriate fiscal year, as set forth in NAC 422.110, the tax rate for outpatients must not be calculated.

422.140 Annual calculation of amount of taxes and intergovernmental transfers for inpatients for each hospital; monthly estimate of taxes for each hospital.

1. The Department will calculate annually the amount of taxes and intergovernmental transfers for inpatients for each of the hospitals.

2. Each month, the Department will estimate the taxes for each hospital that is required to pay the tax pursuant to NRS 422.383. The estimated taxes will be calculated as follows:

(a) The annual billed charges for each hospital will be estimated based on the quarterly reports required pursuant to NAC 439B.220, for the latest 4 quarters, increased by 2.5 percent per quarter, or 10 percent per year.

(b) The annual net revenues for each hospital will be estimated based on the quarterly reports required pursuant to NAC 439B.220, for the latest 4 quarters:

(1) Increased by 1.25 percent per quarter, or 5 percent per year; and

(2) For revenues from inpatients, adjusted to include a full year of payments for disproportionate share.

(c) The amount of the monthly tax payment will be determined by computing the annual tax based on the latest quarterly reports available, subtracting an amount equal to the amount of taxes which were previously billed, and dividing the balance by the number of payments left in the year.

422.150 Estimated taxes: Billing; date when payment is due. The Department will send the bills for the estimated taxes on or before the 10th day of each month, beginning in August 1993. The payment for the estimated tax is due on or before the 25th day of each month. If the 25th day is a Saturday, Sunday or holiday, the estimated taxes are due on the next business day.

422.160 Estimated taxes: When payment is deemed delinquent; assessment of penalty and interest on late payment.

1. A payment for estimated taxes which is received by the Department after the date on which it was due shall be deemed delinquent, unless the payment is postmarked at least 3 days, not including Sunday, before the due date.

2. The department will assess a penalty on an outstanding balance at a rate of 1 percent for each day that the payment of the tax is late, up to 10 days. Interest will accrue at a rate of 1.5 percent per month or any portion thereof.

422.170 Intergovernmental transfers: Payment; notification of amount due; assessment of interest on late payment.

1. A hospital which is owned by a county or a hospital district and has more than 45 beds, as listed in subsection 3 of NAC 422.100, shall make an intergovernmental transfer to the hospital

tax and intergovernmental transfer account. The amount of the transfer must be equal to the amount calculated pursuant to NAC 422.140 for that hospital.

2. The Department will notify a hospital which must pay the intergovernmental transfer of the amount due by sending the hospital a statement no later than the 10th day of the month. Except as otherwise provided in this subsection, payment of the intergovernmental transfer is due before the 30th day of the month. If the 30th day is a Saturday, Sunday or holiday, the payment is due on the next business day. The payment of the intergovernmental transfer for the month of February is due before March 1. If March 1 is a Saturday, Sunday or holiday, the payment is due on the next business day.

3. If a payment of the intergovernmental transfer is received after the date on which it was due, the Department will assess interest at a rate of 1.5 percent per month or any portion thereof.

422.180 Assessment of penalty and interest: Appeal; waiver; request for hearing.

1. A hospital may appeal an assessment of a penalty or interest, or both, imposed pursuant to NAC 422.160 and 422.170, by providing, in writing to the Director of the Department, justification for the request to waive or lessen the assessed penalty or interest, or both. The Director of the Department, or a person designated by the director, may waive the assessed penalty or interest, or both, based upon the appeal of the hospital.

2. If the appeal is not granted, the Director shall notify the hospital of the reasons for the denial of the appeal. If the hospital disagrees with the reasons for the denial of the appeal, the hospital may request a hearing before a hearing officer in accordance with the procedures set forth in chapter 233B of NRS.

422.190 Interlocal contracts with Department for medical treatment of indigent patients: Release of county from liability; maintenance and availability of county records.

1. A county which enters into an interlocal contract with the Department to pay for the provision of medical treatment to indigent patients is released from liability pursuant to the contract for any completed claim filed after June 30, 1993, for an indigent patient who is discharged from that hospital on or before June 30, 1993.

2. A county may apply a claim for an indigent inpatient who was discharged on or before June 30, 1993, to the obligation of the hospital for indigent care imposed pursuant to NRS 439B.320 with the approval of the hospital, even if the claim is not complete as of June 30, 1993.

3. The liability of a county which enters into an interlocal agreement pursuant to subsection 1 for completed claims filed after June 30, 1995, for a patient who is discharged on or before June 30, 1995, is limited to the amount for which the county was released from liability pursuant to subsections 1 and 2.

4. The county shall:

(a) Maintain a record of each claim described by this section; and

(b) Make those records available for examination or audit by the Department.

422.200 Payments for treatment of disproportionate share of indigent patients: Calculation of days of hospitalization; claims for days of hospitalization for birth of child or psychiatric care.

1. Except as otherwise provided in this section, the number of days of hospitalization of an indigent patient used in the calculation of the payments to a hospital for treating a disproportionate share of indigent patients must be based on the determinations of indigency made by the county using the standards of eligibility of that county which were in existence on January 1, 1993.

2. If the hospital receives partial payment from a source other than the county for a claim for a patient who has been determined to be an indigent by the county, the number of days of hospitalization of the indigent patient must be calculated as follows:

(a) For a claim which the county could submit to the Supplemental Account for Medical Assistance to Indigent Persons for reimbursement pursuant to NRS 428.335 and 428.345, the number of days must be:

(1) Twenty-five days; or

(2) The actual number of days which have been approved for the claim,

➥ whichever is less.

(b) For a claim for which the payment from another source is less than 25 percent of the amount that the county would have paid and for claims for which the county would have paid at least $1,000 for each approved day, the number of days must be counted as the actual number of days that have been approved for the claim.

(c) For a claim for which the payment from another source is 25 percent or more of the amount that the county would have paid and the remaining liability is less than $1,000 per approved day, the number of days must be computed on the basis of 1 day for each $1,000 of remaining liability that the county would have had the obligation to pay. In computing the number of days pursuant to this paragraph, the liability of all such claims included on a report must be aggregated, the total amount must be divided by $1,000, and the quotient must be rounded to the nearest whole number.

3. A claim, which is identified as having any days of hospitalization for the birth of a child or for psychiatric care for which the county would have had an obligation to pay, must receive an

amount of consideration which is equal to the amount of consideration that a day of hospitalization for a patient on Medicaid would receive.

422.210 Validation of financial information provided by hospital; submission by hospital of information regarding annual treatment of indigent patients; annual settlement of underpayment or overpayment by hospital.

1. The Department may review any record of a hospital for validating the financial information included on the quarterly reports filed pursuant to NAC 439B.220 and used in the calculation of:

(a) Taxes or intergovernmental transfers imposed pursuant to NRS 422.383; or

(b) The payments made to the hospital for treating a disproportionate share of indigent patients which are made in accordance with the State Plan, "Payment for Inpatient Hospital Services," as established in accordance with NRS 422.381.

2. Each hospital shall submit the amount of billed charges and the total number of days of hospitalization provided by that hospital to indigent patients for each fiscal year in such form as the Department may require. The data must be submitted within 6 months after the close of the fiscal year and must be certified as being accurate and complete by an independent certified public accountant.

3. Upon receipt of the data specified in subsection 2, the Department will calculate the annual hospital tax and the amount of intergovernmental transfers for the preceding fiscal year. The Department will make a final billing for any underpayment or a refund for any overpayment within 30 days after the completion of the final calculation.

INFORMATIONAL STATEMENT
LCB File No. R033-10

1. Description of how public comment was solicited, a summary of public response, and an explanation how other interested persons may obtain a copy of the summary.

Between July and November 2009, the Division of Health Care Financing and Policy conducted stakeholder meetings to gather input from affected parties on the following dates:

July 21, 2009
August 18, 2009
September 22, 2009
October 20, 2009
November 17, 2009

The meetings were held at the Division in Carson City with provisions for remote participation by either teleconference or by videoconference to the Las Vegas District Office. The meetings were attended by 20 to 40 representatives of hospitals, state and local governments, and provider associations. DHCFP solicited oral comment at the meetings and requested that stakeholders submit written comments, including submitting their own proposals. Minutes were taken at each of the five meetings and three alternative proposals were submitted by various stakeholders. These are available by contacting DHCFP administration. The stakeholders agreed nearly universally that the existing funding mechanisms for the nonfederal share of DSH payments must remain in effect. However, stakeholders opinions varied considerably on how the funds would be distributed among hospitals.

On January 7, 2010, DHCFP submitted a written draft of the regulations to stakeholders and requested comments. There no requests for material changes.

On April 29, 2010, a public hearing was held for the final draft of the DSH regulations.

2. The number of persons who:

3.

(a) Attended each hearing:

18 people attended the public hearing on April 29, 2010.

(b) Testified at each hearing:

One person, a DHCFP employee, presented the proposed changes to the DHS regulations. There was no other testimony.

(c) Submitted written comments:

No written comments were submitted during or after the public hearing.

4. A description of how comment was solicited from affected businesses, a summary of their response, and an explanation how other interested persons may obtain a copy of the summary.

Comment was solicited from affected businesses at the series of stakeholder meetings described in #1. DHCFP solicited written proposals for the regulations from all stakeholders, and three proposals submitted. DHCFP provided its proposal to the stakeholders on September 22, 2009. A comparison of the three stakeholder proposals and the proposals themselves are available from DHCFP administration.

5. If the regulation was adopted without changing any part of the proposed regulation, a summary of the reasons for adopting the regulation without change.

The proposed regulation differs from the existing regulation in the following material ways:

- The regulation defines initial DSH payments as interim payments which are subject to audit and recovery of overpayments. DSH audits and recovery of overpayments are now required by federal regulation. There is currently no provision in DHCFP regulations that stipulate that DSH hospitals must be audited and no provisions for recovery of overpayments. This revision should be retained because it gives DHCFP the authority to do the audits and to require the hospitals to repay any overpayments.
- The regulation provides a methodology for redistribution of DSH payments that are recovered through the audit process. Without this provision, DHCFP would have no methodology for redistributing these monies to the hospitals, so recovered overpayments would have to be returned to the federal government.
- The regulation eliminates hospital specific payments guarantees that are currently in Nevada Revised Statutes. It is necessary to retain this revision because the current payment guarantees have, under certain circumstances, placed the State in a position where statute guarantees a payment to a hospital that no longer qualifies for DSH payments under federal or Nevada Medicaid State Plan eligibility criteria. Federal funds are not available to make payments to hospitals that do not qualify for the program.
- The regulation revises the way that DSH funds are distributed within the pools. The purpose of this revision was to comply with the intent of SB 382 Section 7.5 passed by the 2009 Legislature which instructs DHCFP to consider the role of rural and public hospitals in providing health care and to provide resources to the hospitals that have demonstrated a commitment to serving uninsured and Medicaid patients. The revision should be retained to comply with the intent of the Legislature as expressed in SB 382.

6. The estimated economic effect of the regulation on the business which it is to regulate and on the public.

(a) Estimated economic effect on the businesses which they are to regulate.

The total amount of DSH distribution is determined annually by the federal government. This regulation does not affect the amount of DSH available to distribute. However, the distribution formula has been changed so that some hospitals will receive more in DSH payments and others will receive less to comply with the intent of the Legislature to consider the role of public and rural hospitals and hospitals that demonstrate commitment to serving uninsured and Medicaid patients.

(b) Estimated economic effect on the public which they are to regulate.

There is no anticipated economic effect on the public. The regulations do not regulate the public.

7. The estimated cost to the agency for enforcement of the proposed regulation: N

There is no enforcement of this regulation except through the general administration of the DSH program and through DSH audits conducted by an independent contractor that are required by federal regulation. DHCFP does not anticipate that costs for administering the DSH program will change materially with the adoption of this regulation. Because the audits are now a federal requirement, they must continue whether they are included in the regulation or not, if Nevada is to continue receiving federal DSH distributions.

8. A description of any regulations of other State or governmental agencies which the regulation overlaps or duplicates and a statement explaining why the duplication or overlap is necessary.

No part of this regulation is duplicated by or overlaps with the regulations of other State agencies or political subdivisions of the State.

9. If the regulation overlaps or duplicates a federal regulation, the name of the regulating federal agency.

The federal government, through the Centers for Medicare and Medicaid Services, regulates how DSH funds are distributed to the States and the minimum requirements hospitals must meet to receive DSH funds. The State regulations are required to provide a distribution methodology that best meets its own needs in assuring that hospital care is available to indigent and Medicaid patients. While some of the State's regulation is simply a restatement of federal regulations, the hospital distribution formula is unique to Nevada. Additionally, the methodology for recovering and redistributing DSH overpayments is different from federal regulation, because DHCFP would have no provisions for redistribution if the methodology is not included in State regulations.

10. If the regulation includes provisions that are more stringent than a federal regulation that regulates the same activity, a summary of such provisions.

The regulations do not include requirements that are more stringent that federal regulations. The regulations amplify federal regulations by providing methodologies for distribution of DSH payments and recovery and redistribution of overpayments.

11. If the regulation provides a new fee or increases an existing fee, the total annual amount the agency expects to collect and the manner in which the money will be used.

The regulation does not include a new fee or increase to an existing fee.