Disproportionate Share Hospital (DSH)

The Medicare DSH adjustment provision under [section 1886(d) (5) (F) of the Act](http://www.socialsecurity.gov/OP_Home/ssact/title18/1886.htm#act-1886-d-5) was enacted by section 9105 of the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985 and became effective for discharges occurring on or after May 1, 1986. According to section 1886(d) (5) (F) of the Act, there are two methods for a hospital to qualify for the Medicare DSH adjustment. The primary method is for a hospital to qualify based on a complex statutory formula that results in the DSH patient percentage. The DSH patient percentage is equal to the sum of the percentage of Medicare inpatient days attributable to patients eligible for both Medicare Part A and Supplemental Security Income (SSI), and the percentage of total inpatient days attributable to patients eligible for Medicaid by not Medicare Part A. The DSH patient's percentage is defined as:

Medicare SSI Days / Total Medicare Days + Medicaid, Non-Medicare Days / Total Patient Days = DSH Patient Percent

The alternate special exception method is for large urban hospitals that can demonstrate that more than 30 percent of their total net inpatient care revenues come from State and local governments for indigent care (other than Medicare or Medicaid).

Under the primary method to qualify for DSH adjustments, the first computation includes the number of hospital patient days used by patients who, for those days, were entitled to both Medicare Part A and SSI (excluding State supplementation). This number is divided by the number of patient days used by patients under Medicare Part A for that same period. The second computation includes hospital patient days used by patients who, for those days, were eligible for medical assistance under a state plan approved under title XIX (Medicaid), but who were not entitled to Medicare Part A. This number is divided by the total number of hospital patient days for that same period.

Hospitals whose DSH patient percentage exceeds 15 percent are eligible for a DSH payment adjustment based on another statutory formula. The formula varies for urban hospitals with 100 or more beds and rural hospitals with 500 or more beds, hospital that qualify as rural referral centers or sole community hospitals, and other hospitals.

The Medicare Fraction (Medicare Proxy)

The Medicare Fraction is computed by dividing the number of patient days that are furnished to patients who are entitled to both Medicare Part A and Supplemental Security Income (SSI) benefits by the total number of patient days furnished to patients entitled to benefits under Medicare Part A. This percentage is supplied to providers by CMS and is determined on the federal fiscal year. If a hospital prefers, it may request that CMS calculate the Medicare fraction based upon their cost reporting period, rather than the federal fiscal year. Instructions for requesting this recalculation can be found at [42 CFR 412.106(b)(3)](http://frwebgate.access.gpo.gov/cgi-bin/get-cfr.cgi?TITLE=42&PART=412&SECTION=106&TYPE=PDF) (scroll to section (b) then to number (3)).

The Medicaid Fraction (Medicaid Proxy)

The Medicaid Fraction is computed by dividing the number of patient days furnished to patients who, for those days, were eligible for Medicaid but were not entitled to benefits under Medicare Part A by the number of total hospital patient days in the same period. For purposes of counting patient days, as indicated in [PRM 15-2 § 3605.1](http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals-Items/CMS021935.html) (select chapter 36 then select file pr2\_3600\_to\_3609.3.doc and then scroll to section 3605.1 at page 32) providers should report days in the cost reporting period in which the discharge is reported.

Medicaid (Title XIX) Defined

Medicaid is a cooperative Federal-State program that provides health care to indigent persons who are aged, blind, disabled, or members of families with dependent children.

The Medicaid program is jointly financed by the Federal and State governments and administered by the States according to Federal guidelines. Medicaid, under Title XIX of the Social Security Act, establishes two eligibility groups for medical assistance: categorically needy and medically needy.

Participating states are required to provide Medicaid coverage to the “categorically needy”. These persons are eligible for cash assistance under two Federal programs: Temporary Assistance for Needy Families (TANF) which replaced the Aid to Families with Dependent Children (AFDC) program in 1996 and Supplemental Security Income (SSI).

Additionally, participating states may elect to provide for payment of medical services for “medically needy” individuals that are aged, blind or disabled. These individuals, whose incomes or resources, while exceeding the financial eligibility requirements for the categorically needy, are insufficient to pay for necessary medical care.

Included Medicaid Days

In calculating the number of Medicaid days, the hospital must determine whether the patient was eligible for Medicaid under a State plan approved under Title XIX on the day of service. If the patient was eligible, the day counts in the Medicare disproportionate share adjustment calculation. The statutory formula for "Medicaid days" reflects several key concepts. First, the focus is on the patient's eligibility for Medicaid benefits as determined by the State, not the hospital's "eligibility" for some form of Medicaid payment.

Then the focus is on the patient's eligibility for medical assistance under an approved Title XIX State plan, not the patient's eligibility for general assistance under a State-only program. Additionally, it should be emphasized that allowable medical assistance is limited to an approved Title XIX State plan, not medical assistance under a State-only program or other program. Thus, for a day to be counted, the patient must be eligible on that day for medical assistance benefits under the Federal-State cooperative program known as Medicaid (under an approved Title XIX State plan).  
  
In other words, for purposes of the Medicare disproportionate share adjustment calculation, the term "Medicaid days" refers to days on which the patient is eligible for medical assistance benefits under an approved Title XIX State plan. The term "Medicaid days" does not refer to all days that have some relation to the Medicaid program, through a matching payment or otherwise; if a patient is not eligible for medical assistance benefits under an approved Title XIX State plan, the patient day cannot become a "Medicaid day" simply by virtue of some other association with the Medicaid program.

Effective for cost reports settled after February 27, 1997, Medicaid days, for purposes of the Medicare disproportionate share adjustment calculation, includes all days during which a patient is eligible, under a State plan approved under Title XIX, for Medicaid benefits, even if Medicaid did not make payment for any services. Thus, Medicaid days includes, but are not limited to, days that are determined to be medically necessary but for which payment is denied by Medicaid because the provider did not bill timely, days that are beyond the number of days for which a State will pay, days that are utilized by a Medicaid beneficiary prior to an admission approval but for which a valid enrollment is determined within the prescribed period, and days for which payment is made by a third party.

In addition, the calculation recognizes days that are utilized by a Medicaid beneficiary who is eligible for Medicaid under a State plan approved under Title XIX through a managed care organization (MCO) or health maintenance organization (HMO).

However, in accordance with [42 CFR 412.106(b)(4)](http://frwebgate.access.gpo.gov/cgi-bin/get-cfr.cgi?TITLE=42&PART=412&SECTION=106&TYPE=PDF) (scroll to section (b) then to number (4)), a day does not count in the Medicare disproportionate share adjustment calculation if the patient was entitled to both Medicare Part A and Medicaid on that day. Therefore, once the eligibility of the patient for Medicaid under a State plan approved under Title XIX has been verified, you must determine whether any of the days are dual entitlement days and, to the extent that they are, subtract them from the other days in the calculation.

Included Title XIX Eligible Days

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| --- | --- |
| Actual 1902(r)(2) and 1931(b) Days | Days for patients eligible under a State plan based on a 1902(r)(2) or 1931(b) election. These patients are Medicaid-eligible under the Title XIX State plan under the authority of these provisions, which is exercised by the State in the context of the approved State plan. |
| Medicaid Optional Targeted Low Income Children (CHIP-related) Days | Days for patients who are Title XIX-eligible and who meet the definition of "optional targeted low income children" under section 1905(u)(2). The difference between these children and other Title XIX children is the enhanced FMAP rate available to the State. These children are fully Medicaid-eligible under the State plan. |
| 1915(c) Eligible Patient (the "217" group) Days | Days for patients in the eligibility group under the State plan for individuals under a Home and Community Based Services waiver. This group includes individuals who would be Medicaid-eligible if they were in a medical institution. Under this special eligibility group, they are Medicaid-eligible under the State plan. |
| Retroactive Eligible Days | Days for patients not enrolled in the Medicaid program at the time of service, but found retroactively eligible for Medicaid benefits for the days at issue. These patients are Medicaid-eligible under the State plan. |
| Medicaid Managed Care Organization Days | Days for patients who are eligible for Medicaid under a State plan when the payment to the hospital is made by an MCO for the service. An MCO is the financing mechanism for Medicaid benefits, and payment for the service through the MCO does not affect eligibility. |

Excluded Days

Many States operate programs that include both State-only and Federal-State eligibility groups in an integrated program. For example, some States provide medical assistance to beneficiaries of State-funded income support programs. These beneficiaries, however, are not eligible for Medicaid under a State plan approved under Title XIX, and, therefore, days utilized by these beneficiaries do not count in the Medicare disproportionate share adjustment calculation. If a hospital is unable to distinguish between Medicaid beneficiaries and other medical assistance beneficiaries, then it must contact the State for assistance in doing so.

In addition, if a given patient day affects the level of Medicaid DSH payments to the hospital but the patient is not eligible for Medicaid under a State plan approved under Title XIX on that day, the day is not included in the Medicare DSH calculation.

It should be noted that the types of days discussed above are not necessarily the only types of excluded days.

To provide consistency in both components of the calculation, any days that are added to the Medicaid day count must also be added to the total day count, to the extent that they have not been previously added.

Regardless of the type of allowable Medicaid day, the hospital bears the burden of proof and must verify with the State that the patient was eligible under one of the allowable categories during each day of the patient's stay. The hospital is responsible for and must provide adequate documentation to substantiate the number of Medicaid days claimed. Days for patients that cannot be verified by State records to have fallen within a period wherein the patient was eligible for Medicaid cannot be counted.

Excluded State Program Days

|  |  |
| --- | --- |
| General Assistance Patient Days | Days for patients covered under a State-only (or county-only) general assistance program (whether or not any payment is available for health care services under the program). These patients are not Medicaid-eligible under the State plan. |
| Other State-Only Health Program Patient Days | Days for patients covered under a State-only health program. These patients are not Medicaid-eligible under the State plan. |
| Charity Care Patient Days | Days for patients not eligible for Medicaid or any other third-party payer, and claimed as uncompensated care by a hospital. These patients are not Medicaid-eligible under the State plan. |
| Separate CHIP Days | Days for patients who are eligible for benefits under a non-Medicaid State program furnishing child health assistance to targeted low-income children. These children are, by definition, not Medicaid-eligible under a State plan. |
| Medicaid DSH Days | Days for patients who are not eligible for Medicaid benefits, but are considered in the calculation of Medicaid DSH payments by the State. These patients are not Medicaid-eligible. Sometimes Medicaid State plans specify that Medicaid DSH payments are based upon a hospital's amount of charity care or general assistance days. This, however, is not "payment" for those days, and does not mean that the patient is eligible for Medicaid benefits or can be counted as such in the Medicare formula. |

Other Excluded Days

Labor & Delivery Room Days

A day for which a Medicaid patient is in the labor and delivery area at census taking hour is excluded from Medicaid days unless the patient has occupied an inpatient routine bed at some time since admission. Hospitals that maintain a single multipurpose labor, delivery and postpartum (LDP) room may apportion both the days and available beds associated with LDP rooms between ancillary labor and delivery and the routine adults and pediatrics based upon the portion of the patient’s stay in the LDP room between ancillary and routine. For pro-ration purposes any time subsequent to the birth of the child is considered routine it may be burdensome for a hospital to determine on a per patient basis the amount of time spent in labor/delivery and the amount of time spent receiving routine care. A hospital may calculate an average percentage of time patients receive ancillary services, as opposed to routine inpatient care in the LDP room(s) during a typical month, and apply that percentage through the rest of the year as identified in 68 Fed. Reg. 45419. The days for Medicaid eligible patients in the LDP room apportioned to routine are added to both the numerator and the denominator of the Medicaid fraction. For compliance purposes, hospitals should ensure that all routine LDP days are included in the total day count, not solely Medicaid eligible days.

Unverifiable State Days

Represents days for patients that cannot be verified by State records to have fallen within a period wherein the patient was eligible for Medicaid.

Days in Excluded Units

This represents days in the psychiatric, skilled nursing or rehabilitation units of PPS hospitals. PPS Rehab units should submit separate listings and report the days separately on the Cost Report. Some State “paid claims” listings fail to separately identify the Title XIX excluded unit days but have the capability to do so. The hospital bears the burden of proof, therefore it’s the hospital responsibility to have the State identify the days and remove them from eligible Title XIX days.

Dual Entitlement Days

This represents patients that are entitled to both Medicare Part A and Medicaid on that day. [42 CFR 412.106(b)(4)](http://frwebgate.access.gpo.gov/cgi-bin/get-cfr.cgi?TITLE=42&PART=412&SECTION=106&TYPE=PDF) (scroll to section (b) then to number (4)) precludes the counting of any patient days furnished to patients having both Medicare Part A and Medicaid. These dual-eligible patients are included in the Medicare fraction but not the Medicaid fraction as CMS indicated in 69 Fed. Reg. 49098. Additionally, patients who exhaust coverage for inpatient hospital services remain entitled to other Medicare Part A benefits, therefore these days are not included in the Medicaid fraction. Effective for discharges occurring on or after October 1, 2004, these days would be included by CMS in the Medicare fraction, whether or not the beneficiary has exhausted their Medicare Part A hospital coverage.

Qualifying for DSH Payments

The Statutory Formula

The most commonly used method for a hospital to qualify, is based on a complex statutory formula under which payment adjustments are based on the level of the hospital’s DSH patient percentage.  
  
Under these formulas a hospital is classified as a “disproportionate share” hospital under any of the following circumstances.  Starting with discharges occurring on or after April 1, 2001, the hospital's disproportionate patient percentage is at least equal to one of the following:

* 15%, if the hospital is located in an urban area, and has 100 or more beds, or is located in a rural area and has 500 or more beds; or
* 15% if the hospital is located in a rural area and either has more than 100 beds and fewer than 500 beds or is classified as a sole community hospital under §412.92; or
* 15% if the hospital is located in an urban area and has fewer than 100 beds; or
* 15% if the hospital is located in a rural area and has 100 or fewer beds

Pickle Method

Another methodology a hospital can utilize to qualify for DSH payments is referred to as the “Pickle Method.”   Under this method, hospitals that are located in an urban area and have 100 or more beds may receive a DSH payment adjustment if the hospital can demonstrate that, during its cost reporting period, more than 30 percent of its net inpatient care revenues are derived from State and local government payments for care furnished to indigent patients.  
  
Under the Pickle Method net inpatient revenue represents the total pool and consists of gross inpatient revenue minus revenue deductions where revenues received are less than full charges such as bad debts, contractual allowances, and charity care.   The threshold percentage is derived by dividing state and local government payments for care furnished to inpatients (excluding Medicare and Medicaid revenues and revenues that are unrelated to indigent care) by net inpatient revenues (including Medicare and Medicaid revenues).

Classification of Urban vs. Rural  
As stated in 71 Fed. Reg. 48139 the hospital's location, in an urban or rural area, is determined in accordance with the definitions in 42 CFR 412.64, except that a reclassification that results from an urban hospital reclassified as rural as set forth in [42 CFR 412.103](http://frwebgate.access.gpo.gov/cgi-bin/get-cfr.cgi?TITLE=42&PART=412&SECTION=103&TYPE=PDF) is classified as rural.

Required Supporting Documentation

Novitas Solutions will require the following documentation in order to allow Medicaid days to be included in the DSH calculation:

A log(s) listing the patient name and dates of service which shows the total MA/MA-eligible days claimed in the Medicaid fraction.   If you are receiving DSH payments you must submit a MA/MA eligible log regardless of whether your facility is subject to a desk review or an audit.  This log(s) should be sent to Novitas Solutions with your cost report submission.  If you fail to submit a log you risk your DSH reimbursement being removed until a log is submitted.

If the patient's care is covered by and paid by the Medicaid program on the dates of service then a copy of the MA remittance advice will suffice. Otherwise, proof of Medical Assistance and the beneficiary’s category code for the covered days must be provided.   For example, in Pennsylvania the Electronic Verification System (EVS) slip or the Medical Benefits History for the District of Columbia show the category codes for the patient during their stay.  It is the responsibility of the provider to be able to prove eligibility for every day being counted in the Medicaid fraction.

The provider must also be able to prove that each patient was not entitled to Medicare Part A on the days being claimed.

The patient's UB-92 or UB-04 or other financial/medical history must be made available to the auditor to ensure that days are not being claimed for services incurred in excluded units.

General Assistance Category Codes

While the below listings should not be considered all inclusive and may change over time, they are being provided as a reference.   It is the responsibility of the provider to work with the State to determine Medicaid (Title XIX) eligibility.   Additionally, if a beneficiary has an allowable category code that does not necessarily indicate that they are automatically included in the Medicaid fraction.  Many of the codes indicate that the beneficiary qualifies for Medicaid because of special provisions.  These provisions include the person being a Medicare beneficiary such as the Qualified Medicare Beneficiary (QMB) Program, the Specified Low Income Medicare Beneficiary (SLMB) Program, or the Qualified Individual (QI) Program.

According to the Department of Public Welfare (DPW) the state funded General Assistance codes in Pennsylvania are B00, B80, D00, N00, PD00, PD21, PD22, PD29 and its replacement code PD00H, TB00, TB80, TD00, TD22, TD55.

In New York the following Recipient Category Codes are federally non-participating (general assistance) and are not allowable:  02, 20, 28, 35, 37, 38 (if recipient is aged 21 to 64), 40, 47, 59, 76, 77, 00.  Additionally, the following Recipient Medicaid Coverage codes are non-allowable:  0 (zero), K, N, Y.

In New Jersey recipients with a 70 in the third and fourth digit of the beneficiary number are state-only general assistance and are not includable.

In Virginia, the Department of Medical Assistance Services has indicated that the following eligibility codes are general assistance:   001, 002, 003, and 004.

In the District of Columbia, the following Program Codes are general assistance or not includable:  460, 470, 606, 607, 609, 618, 628, 638, 648, 658, and 668.

Additional information:

* [DSH](http://www.cms.gov/AcuteInpatientPPS/05_dsh.asp#TopOfPage)
* [DSH Fact Sheet](http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/Disproportionate_Share_Hospital.pdf) (then scroll down to downloads and select MLN Products Catalog, updated on November 2009 (PDF), after opening, scroll down to Medicare Disproportionate Share Fact Sheet and open PDF file.)
* Under [section 1886(d)(5)(F) of the Social Security Act](http://www.socialsecurity.gov/OP_Home/ssact/title18/1886.htm#act-1886-d-5), the Medicare disproportionate share patient percentage is made up of two computations. The first computation is known as the Medicare Fraction, while the second computation is referred to as the Medicaid Fraction. The calculation can be found at [42 CFR 412.106(b)](http://frwebgate.access.gpo.gov/cgi-bin/get-cfr.cgi?TITLE=42&PART=412&SECTION=106&TYPE=PDF). (scroll to section (b))