CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 2367	**Date: December 9, 2011**
	Change Request 6564

Transmittal 1828, dated October 9, 2009, is rescinded and replaced by Transmittal 2367 to restore information in section 20.3 of the manual from CR 6329, Transmittal 1695, dated March 6, 2009, erroneously overwritten by CR 6564. All other information remains the same.

Transmittal 1828, dated October 9, 2009 rescinds and replaces Transmittal 1811 dated September 4, 2009, to restore subsection E to Chapter 3, Subsection 20.3, which was inadvertently omitted. All other material remains the same.

Subject: Verification of Status for all Hospitals Qualifying for Disproportionate Share Hospital (DSH) Payments under 42 CFR Section 412.106(c)(2), also known as the "Pickle Amendment"

I. SUMMARY OF CHANGES: Beginning with Federal Fiscal Year (FY) 2011, we request that Fiscal Intermediaries (FIs) and Medicare Contracting Administrators (MACs) submit to CMS annually by February 28 documentation for the hospitals they determine meet the qualifying standards for receiving disproportionate share hospital (DSH) payments under section 42 CFR 412.106(c)(2).

New / Revised Material
Effective Date: October 5, 2009
Implementation Date: October 5, 2009

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	Chapter / Section / Subsection / Title
R	3/20.3/Additional Payment Amounts for Hospitals with Disproportionate Share of Low-Income Patients

III. FUNDING:
SECTION A: For Fiscal Intermediaries and Carriers:
No additional funding will be provided by CMS; Contractor activities are to be carried out within their operating budgets.

SECTION B: For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be

outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

Business Requirements

Manual Instruction

**Unless otherwise specified, the effective date is the date of service.*

Attachment - Business Requirements

Pub. 100-04	Transmittal: 2367	Date: December 9, 2011	Change Request: 6564

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SUBJECT: Verification of Status for all Hospitals Qualifying for Disproportionate Share Hospital (DSH) Payments under 42 CFR Section 412.106(c)(2), also known as the "Pickle Amendment"

Effective Date: October 5, 2009

Implementation Date: October 5, 2009

I. GENERAL INFORMATION

A. Background: Beginning with Federal Fiscal Year (FY) 2011, Fiscal Intermediaries (FIs) and Medicare Contracting Administrators (MACs) shall submit to CMS annually by February 28 documentation for the hospitals they determine meet the qualifying standards for receiving disproportionate share hospital (DSH) payments under section 42 CFR 412.106(c)(2).

B. Policy: For the annual hospital inpatient prospective payment system (IPPS) rate setting process, it is essential that CMS verify hospitals' status disproportionate share hospital (DSH) payments under 42 CFR 412.106(c)(2), also known as the "Pickle Amendment." The procedures for determining this status are described in subsection D of Medicare Claims Processing Manual, Publication 100-04, Chapter 3, Section 20.3.

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement

Number	Requirement	Responsibility									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
							FISS	MCS	VMS	CWF	
6564.1	Beginning with Federal Fiscal Year 2011, contractors shall submit to CMS annually by February 28 documentation for the hospitals they determine meet the qualifying standards for receiving disproportionate share hospital (DSH) payments under section 42 CFR 412.106(c)(2).	X		X							

Number	Requirement	Responsibility									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
							FISS	MCS	VMS	CWF	
6564.2	Contractors shall submit annually to JoAnn Cerne at JoAnn.Cerne@cms.hhs.gov, the list that includes all hospitals they service that qualify for DSH under the "Pickle Amendment" no later than February 28.	X		X							
6564.3	Contractors shall include on their list each provider, the provider name, provider number, determination (i.e., "APPROVED" or "DENIED"), and the date of the determination (mm/dd/yy).	X		X							
6564.4	Contractors shall include copies of their determination for all approved hospitals.	X		X							
6564.5	Contractors shall note any conflict regarding the status of a hospital as noted in the provider specific file used in the rate setting process and the status information they submit to CMS, we may need to contact them to attempt to resolve the discrepancy.	X		X							

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
							FISS	MCS	VMS	CWF	
	None										

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements:

X-Ref Requirement Number	Recommendations or other supporting information:
	N/A

Section B: All other recommendations and supporting information: N/A

V. CONTACTS

Pre-Implementation Contact(s): JoAnn Cerne at 410-786-4530 or JoAnn.Cerne@cms.hhs.gov

Post-Implementation Contact(s): JoAnn Cerne at 410-786-4530 or JoAnn.Cerne@cms.hhs.gov

VI. FUNDING

Section A: For *Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs),* and/or *Carriers*:

No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

Section B: *For Medicare Administrative Contractors (MACs)*:

The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

20.3 - Additional Payment Amounts for Hospitals with Disproportionate Share of Low-Income Patients

(Rev. 2367; Issued: 12-09-11; Effective: 10-05-09, Implementation Date: 10-05-09)

The Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985, (Public Law: 99-272), provides for an additional payment to an urban hospital of 100 or more beds that serves a disproportionate share of low-income patients.

Adjustments are made in the Federal portion of the operating cost DRG payment to increase payments to hospitals serving a disproportionate share of low-income patients. The additional payment equals the Federal portion of the operating cost DRG payment and outlier payments, but excludes any additional payments for the costs of indirect medical education multiplied by an adjustment percentage.

If a hospital meets the disproportionate share hospital (DSH) definition, an additional operating cost payment will be made for discharges occurring on or after May 1, 1986. The DSH adjustment is applied only to the Federal portion of the operating cost DRG payment (including outlier payments). It is basically a year-end lump sum adjustment. However, the FI will identify hospitals that are eligible to receive the DSH adjustment and make interim payments subject to a year-end settlement based upon the hospital's DSH percentage for the cost reporting period. The DRG payment a hospital receives includes the interim operating cost DSH payment and an interim operating indirect medical education adjustment.

For services on or after October 1, 1997, the DSH percentage is not applied to outlier payments. The Supplemental Security Income (SSI)/Medicare Beneficiary Data for IPPS hospitals is located at the following CMS Web address:
http://www.cms.hhs.gov/AcuteInpatientPPS/05_dsh.asp#TopOfPage
The data is used for settlement purposes for hospitals.

Note that CMS issues a Recurring Update Notification prior to the Federal Fiscal Year beginning date to provide contractors with the updated SSI file information.

A. Regular Calculation of DSH Percentage

The operating DSH percentage is the sum of:

- The percentage of the hospital's total Medicare Part A patient days attributable to Medicare patients who are also SSI recipients (this percentage will be supplied to the FI by CMS). Since the SSI/Medicare percentages are determined by CMS on a fiscal year basis, hospitals will be afforded the option (for settlement purposes) of determining their SSI/Medicare percentage based upon data from their own cost reporting period. If a hospital avails itself of this option, it must furnish its FI, in a manner and format prescribed by CMS, data on its Medicare patients for the cost reporting period. CMS will match these data to data supplied by SSA to determine the patients dually entitled to Medicare Part A and SSI for the hospital's cost reporting period. The hospital bears the full cost of this process, including the cost of verification by SSA.

Consistent with the regulations at 42 CFR 412.106(b)(2)(i) and 412.106(b)(2)(iii), patients who are enrolled in Medicare Advantage (administered through Medicare Part C) should also be included in the Medicare fraction. These days will be included in the Medicare/SSI fraction, but in order for them to be counted, the hospital must submit an informational only bill (TOB 111) which includes Condition Code 04 to their Medicare contractor. This will ensure that these days are included in the hospital's SSI ratio for Fiscal Year 2007 and beyond.

Acute Care hospitals that received DSH during FY 2006 are also required to submit informational only bills for their Medicare Advantage patients.

For MA patients, Long Term Care Hospitals are also required to submit informational only bills (TOB 111) with Condition Code 04. Refer to section 140.2.4.3 for the requirements for Inpatient Rehabilitation Facilities.

Informational Only Claim Elements:
-Covered 111 TOB
-Condition Code 04
-Medicare Fee-for-Service is the primary payer
-There is no MSP
-Beneficiary's Medicare HICN
-all other required claim elements

(Teaching hospitals do not need to submit additional claims with Condition Code 04 as they already submit claims for Indirect Medical Education for MA beneficiaries with Condition Codes 04 and 69. We will capture SSI information from these claims.)

- The percentage of total patient days attributable to patients entitled to Medicaid, but not to Medicare Part A. (Medicaid days and total days are available on the cost report.)

For operating DSH payments:

For discharges between May 1, 1986, and March 31, 1990, a hospital qualifies for an operating cost DSH adjustment if it has a DSH percentage of:

- At least 15 percent for an urban hospital with 100 or more beds;

- At least 40 percent for an urban hospital with less than 100 beds; or

- At least 45 percent for a rural hospital, with fewer than 500 beds.

For discharges on and after October 1, 1986, the hospital qualifies for an operating cost DSH adjustment if it has a DSH percentage of at least 15 percent, is located in a rural area, and has 500 or more beds.

For discharges between April 1, 1990 and December 31, 1995, a hospital qualifies for an operating DSH adjustment if it has a DSH percentage of:

- At least 15 percent for an urban hospital with 100 or more beds, or a rural hospital with 500 or more beds;
- At least 40 percent for an urban hospital with fewer than 100 beds;
- At least 45 percent for a rural hospital with 100 beds or fewer, if it is not also classified as a sole community hospital; or
- At least 30 percent for a rural hospital with more than 100 beds which is classified as a sole community hospital.

A hospital qualifies for a capital DSH adjustment if it is located in a large urban or other urban area, has at least 100 beds, and has a DSH percentage greater than 0.

For the DSH determination, the number of beds in a hospital is determined by counting the number of inpatient care bed days available during the cost reporting period, excluding beds assigned to newborns, custodial care, and PPS excluded distinct part hospital units, and dividing that number by the number of days in the cost reporting period. Inpatient care bed days available should be the same as Indirect Medical Education (IME) bed days. Available beds may not match the number of licensed beds.

B. Determination of Operating DSH Adjustment Percentage

Hospitals that meet the DSH percentage criteria are entitled to adjustments to the Federal portion of their operating cost DRG payments (including the Federal portion of outlier payments) as follows. For hospitals that qualify for DSH payment, Pricer calculates the DSH adjustment percentage. (See §20.2.3.) The following procedures are used to calculate the DSH adjustment.

For the period May 1, 1986 - September 30, 1988:

Urban hospitals with 100 or more beds and rural hospitals with 500 or more beds - The lesser of 15 percent or the percentage determined by using the following formula:

(DSH % - 15)(.5) + 2.5

EXAMPLES:

Hospital A is an urban hospital with 200 beds and has a DSH percentage of 21. Its DSH payment factor is computed:

(21 - 15)(.5) + 2.5 = 5.5%

DSH adjustment factor = 5.5% (.0550)

Hospital B is an urban hospital with 250 beds and has a DSH percentage of 45. Its DSH payment adjustment factor is computed:

(45 - 15)(.5) + 2.5 = 17.5%

DSH adjustment factor = 15% (.1500) (the maximum adjustment under the law)

- **Urban hospitals with fewer than 100 beds** - 5 percent.

- **Rural hospitals with fewer than 500 beds** - 4 percent.

For the period October 1, 1988 - March 31, 1990:

- **Urban hospitals with 100 or more beds and rural hospitals with 500 or more beds** - the following formula is used:

  (DSH % - 15) (.5) + 2.5

EXAMPLES:

Hospital A is an urban hospital with 200 beds and has a DSH percentage of 21 percent. Its DSH payment factor is computed:

(21-15)(.5) + 2.5 = 5.5%

DSH adjustment factor = 5.5% (.0550)

Hospital B is an urban hospital with 250 beds and has a DSH percentage of 45 percent. Its DSH payment adjustment factor is computed:

(45-15) (.5) + 2.5 = 17.5%

DSH adjustment factor = 17.5% (.1750, the limit was removed effective 10/1/88)

- **Urban hospitals with fewer than 100 beds** - 5 percent.

- **Rural hospitals with fewer than 500 beds** - 4 percent.

For the period April 1, 1990 - December 31, 1995:

- **Urban hospitals with 100 or more beds and rural hospitals with 500 or more beds whose DSH percentage is greater than 20.2** - the following formula is used:

  Through December 31, 1990 - (DSH % - 20.2) (.65) + 5.62

January 1, 1991, and later - (DSH % - 20.2) (.7) + 5.62

EXAMPLES:

Hospital A is an urban hospital with 200 beds and has a DSH percentage of 21 percent. Its December 1990 DSH payment factor is computed:

(21 - 20.2) (.65) + 5.62 = 6.14%

DSH adjustment factor = 6.14% (.0614)

Hospital B is an urban hospital with 250 beds and has a DSH percentage of 45 percent. Its December 1990 DSH payment adjustment factor is computed:

(45 - 20.2) (.65) + 5.62% = 21.74%

DSH adjustment factor = 21.74% (.2174)

Urban hospitals with 100 or more beds and rural hospitals with 500 or more beds whose DSH percentage is equal to or less than 20.2 - the following formula is used:

(DSH % - 15) (.6) + 2.5

- **Urban hospitals with fewer than 100 beds** - 5 percent.

- **Rural hospitals that are RRCs and sole community hospitals** - the greater of 10 percent or the percentage determined using the following formula:

  (DSH % - 30) (.6) + 4.0

EXAMPLES:

Hospital C is a rural hospital that is an RRC and a sole community hospital, and has a DSH percentage of 35 percent. Its DSH payment factor is computed:

(35 - 30) (.6) + 4.0 = 7%

DSH adjustment factor = 10% (.1000)

Hospital D is a rural hospital which is a RRC and a sole community hospital. It has a DSH percentage of 45 percent. Its DSH payment factor is computed:

(45 - 30) (.6) + 4.0 = 13%

DSH adjustment factor is 13% (.1300)

- **Rural hospitals that are RRCs, but are not sole community hospitals**-the following formula is used:

  (DSH % - 30) (.6) + 4.0

- **Rural hospitals that are sole community hospitals, but are not RRCs** - 10 percent.

- **Rural hospitals not described above with 100 beds or less** - 4 percent if DSH percentage is 45 percent or more.

- **Rural hospitals not described above with more than 100 beds but fewer than 500 beds** - 4 percent if DSH percentage is 30 percent or more.

- **Urban hospitals with 100 or more beds whose DSH percentage is less than or equal to 20.2** - the following formula is used:

  (DSH % - 15) (.6) + 2.5

For the period October 1, 1993, through September 30, 1994:

- **Urban hospitals with 100 or more beds whose DSH percentage is greater than 20.2**- the following formula is used:

  (DSH % - 20.2) (.8) + 5.88

- **Urban hospitals with 100 or more beds whose DSH percentage is less than or equal to 20.2** - the following formula is used:

  (DSH % - 15) (.6) + 2.5
- **Rural hospitals that are RRCs and sole community hospitals** - the greater of 10 percent or the percentage determined using the following formula:

  (DSH % - 30) (.6) + 4.0

EXAMPLES:

Hospital C is a rural hospital that is a RRC and a sole community hospital. It has a DSH percentage of 35 percent. The DSH payment factor is computed:

(35 - 30) (.6) + 4.0 = 7%

DSH adjustment factor = 10% (.1000), the greater payment

Hospital D is a rural hospital that is a RRC and a sole community hospital. It has a DSH percentage of 45 percent. Its DSH payment factor is computed:

(45 - 30) (.6) + 4.0 = 13%

DSH adjustment factor = 13% (.1300)

Rural hospitals that are RRCs and are not sole community hospitals - the percentage is determined using the following formula:

(DSH % - 30) (.6) + 4.0

- **Rural hospitals that are sole community hospitals and are not RRCs** - 10 percent.

- **Rural hospitals not described above** - 4 percent.

For discharges after September 30, 1994:

- **Urban hospitals with 100 or more beds and rural hospitals with 500 or more beds whose DSH percentage is greater than 20.2** - the percentage is determined using the following formula:

  (DSH % - 20.2) (.825) + 5.88

- **Urban hospitals with 100 or more beds whose DSH percentage is less than or equal to 20.2** - the following formula is used:

  (DSH % - 15) (.65) + 2.5

- **Rural hospitals that are RRCs and sole community hospitals** - the greater of 10 percent or the percentage determined with the following formula:

  (DSH % - 30) (.6) + 4.0

EXAMPLES:

Hospital C is a rural hospital that is an RRC and a sole community hospital. It has a DSH percentage of 35 percent. Its October 1994 DSH payment factor is computed:

(35 - 30) (.6) + 4.0 = 7%

DSH adjustment factor = 10% (.1000), the greater rate

Hospital D is a rural hospital that is an RRC and a sole community hospital. It has a DSH percentage of 45 percent. Its October 1994 DSH payment factor is computed:

(45 - 30) (.6) + 4.0 = 13%

DSH adjustment factor = 13% (.1300)

- **Rural hospitals that are RRCs, but not sole community hospitals** - Use the following formula:

  (DSH % - 30) (.6) + 4.0

- **Rural hospitals that are sole community hospitals and are not RRCs** - 10 percent.

- **Rural hospitals not described above** - 4 percent.

The amount of the operating cost DSH adjustment is computed by multiplying the Federal portion of the hospital's operating cost DRG revenues by the appropriate DSH adjustment factor.

EXAMPLE: Hospital A's DSH payment adjustment factor is 5.5 percent (.0550). The Federal portion of its DRG revenues including appropriate outlier payments, but excluding any payments for indirect medical education costs, equals $100,000.

Federal DRG revenues x DSH adjustment factor = DSH adjustment amount $100,000 x .055 = $5,500

The FI will accumulate a record of the DSH amount paid, the Federal portion of the operating cost DRG and any outlier amount for hospital discharges after April 30, 1986, to use at cost settlement.

C. Computation of DSH Adjustment

Compute the amount of the DSH adjustment by multiplying the Federal portion of the hospital's DRG revenues by the appropriate DSH adjustment factor.

EXAMPLE: Hospital A's DSH payment adjustment factor is 5.5 percent (or .0550). The Federal portion of its DRG revenues (including appropriate outlier payments, but excluding any payments for indirect medical education costs) equals $100,000.

Federal DRG revenues x DSH adjustment factor = DSH adjustment amount $100,000 x .055 = $5,500

D. DSH Exception

The law contains a provision whereby a hospital can qualify for an operating cost DSH adjustment of:

15 percent for discharges prior to October 1, 1988;

25 percent for discharges between October 1, 1988, and April 1, 1990;

30 percent for discharges from April 1, 1990, through September 31, 1991;

35 percent for discharges on or after October 1, 1991, if:

It is located in an urban area and has 100 or more beds; and

It demonstrates that, during its cost reporting period, more than 30 percent of its total inpatient care revenues were derived from State and local government payments for indigent care furnished to patients not covered by Medicare or Medicaid.

It is incumbent upon the hospital to demonstrate that more than 30 percent of its total inpatient care revenues are from State and local government sources and that they are specifically earmarked for the care of indigents (that is, none of the money may be used for any purpose other than indigent care). The following are the types of care that are not included as indigent care:

Free care furnished to satisfy a hospitals Hill-Burton obligation. Free care or care a hospital furnished at reduced rates to its employees or by a government hospital to any category of public employee.

Funds furnished to a hospital to cover general operating deficits.

The adjustment is not automatic from year to year but must be applied for on an annual basis.

Documentation to support the application includes the hospital's complete audited financial statements and their accompanying notes. The hospital must provide detailed schedules related to State and local revenue appropriations and outline their purpose.

Unless the appropriations are specifically earmarked for indigent patient care, the FI *and/or A/B MAC shall* assume that a portion of the funds was intended to cover the costs of other uncompensated care, such as bad debts for non-indigent patients, free care to employees, etc., as well as to cover general operating deficits. The FI *and/or A/B MAC shall* calculate the percentage of charity care included in all uncompensated care and apply the percentage to the appropriate funds to determine the amount appropriated for charity care.

Hospitals must submit documentation to support amounts claimed as indigent patient care. This includes a copy of their procedures for determining indigence, steps used to verify a patient's financial information, and methods used to distinguish bad debts from indigence.

The FI *and/or A/B MAC shall review* the documentation submitted in support of the provider's request for a disproportionate share adjustment under 42 CFR 412.106(c)(2) of the regulations. *Beginning with Federal Fiscal Year (FY) 2011 FIs and/or MACs shall submit to CMS annually by February 28 documentation for the hospitals they determine meet the qualifying standards for receiving disproportionate share hospital (DSH) payments under section 42 CFR 412.106(c)(2).* This review can be accomplished in conjunction with the audit/settlement of the cost report for the period subject to the adjustment. At a minimum, the FI *and/or A/B MAC shall*:

Verify total inpatient revenues;

Verify that State and local government appropriations on the financial statements are consistent with amounts contained in governmental appropriations bills;

Review, on the basis of a sample of cases, the provider's implementation of procedures for identifying indigent patients. Ensure that amounts for "indigent" patients do not include charges associated with:

Titles XIX and XVIII patient care;

Hill-Burton care;

Free care to employees; and

Bad debts for patients who are not indigent

E. Reporting for PS&R and CWF

The FI's PPS Pricer identifies the amount of the DSH adjustment on each bill. The FI reports this amount with value code 18 to its PS&R, and to CWF.