

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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Medicare Disproportionate Share Hospital

RURAL HEALTH SERIES



Please note: The information in this publication applies only to the Medicare Fee-For-Service Program (also known as Original Medicare).

This publication provides the following information about the Medicare Disproportionate Share (DSH) adjustment and Medicare Disproportionate Share Hospitals (DSHs):

- ❖ Background;
- ❖ Methods to qualify for the Medicare DSH adjustment;
- ❖ Medicare Prescription Drug, Improvement, and Modernization Act (MMA) provisions that impact Medicare DSHs;
- ❖ Affordable Care Act provision that impacts Medicare DSHs;
- ❖ Counting number of beds and patient days in hospital;
- ❖ Medicare DSH payment adjustment formulas;
- ❖ Resources; and
- ❖ Lists of helpful websites and Regional Office Rural Health Coordinators.

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A review of this product in August 2016 indicates that no changes are necessary. The content remains current.

BACKGROUND

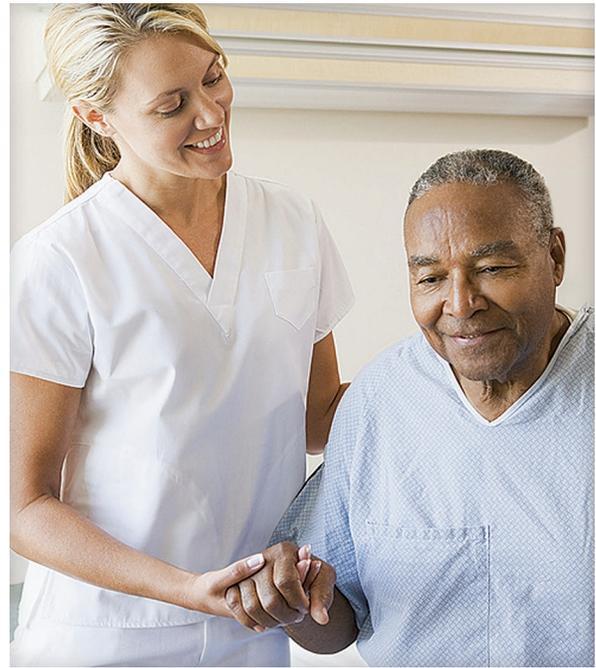
Section 9105 of the Consolidated Omnibus Budget Reconciliation Act of 1985 (Public Law 99-272) amended Section 1886(d)(5) of the Social Security Act (the Act) to add new subparagraph (F), known as the DSH adjustment provision, which is effective for discharges occurring on or after May 1, 1986.

METHODS TO QUALIFY FOR THE MEDICARE DSH ADJUSTMENT

A hospital can qualify for the Medicare DSH adjustment by using one of the following methods:

1. Primary method; or
2. Alternate special exception method.

Each method is described in more detail below.



1. Primary Method

The primary method for qualifying for the Medicare DSH adjustment:

- ❖ Applies to hospitals that serve a significantly disproportionate number of low-income patients; and
- ❖ Is based on the disproportionate patient percentage (DPP).

The DPP is equal to the sum of the percentage of Medicare inpatient days (including Medicare Advantage inpatient days) attributable to patients entitled to both Medicare Part A and Supplemental Security Income (SSI) (including patient days not covered under Part A and patient days in which Part A benefits are exhausted) and the percentage of total inpatient days attributable to patients eligible for Medicaid but not entitled to Medicare Part A. The chart below provides the Medicare DPP.

Medicare DPP

Medicare DPP	Medicare/Supplemental Security Income Days	+	Medicaid, Non-Medicare Days
	_____		_____
	Total Medicare Days		Total Patient Days

If a hospital's DPP equals or exceeds a specified threshold amount, the hospital qualifies for the Medicare DSH adjustment. The Medicare DSH adjustment is determined by using a complex formula (the applicable formula is also based on a hospital's particular DPP).

2. Alternate Special Exception Method

The alternate special exception method for qualifying for the Medicare DSH adjustment applies to hospitals that:

- ❖ Are located in an urban area;
- ❖ Have 100 or more beds; and
- ❖ Can demonstrate that more than 30 percent of their total net inpatient care revenues come from State and local government sources for indigent care (other than Medicare or Medicaid).

These hospitals are also known as Pickle hospitals as defined under Section 1886(d)(5)(F)(i)(II) of the Act. If a hospital qualifies under this method, it is eligible for a specific Medicare DSH adjustment.

MMA PROVISIONS THAT IMPACT MEDICARE DSHs

Section 402 of the MMA also amended Section 1886(d)(5)(F) of the Act so that under the primary qualifying method, for discharges occurring on or after April 1, 2004, the Medicare DSH payment adjustment percentage formulas for large, urban hospitals apply to additional types of hospitals (thereby increasing the DSH payment adjustment percentage for hospitals such as rural hospitals with fewer than 500 beds and urban hospitals with fewer than 100 beds).

In addition, Section 402 of the MMA imposed a 12 percent cap on the DSH payment adjustment for certain hospitals. Hospitals classified as Rural Referral Centers (RRCs), urban hospitals with 100 or more beds, and hospitals located in rural areas with 500 or more beds are exempt from the cap.

Under the primary qualifying method, the formulas to establish a hospital's Medicare DSH payment adjustment percentage are based on certain hospital-specific information, including its:

- ❖ Geographic designation (urban or rural);
- ❖ Number of beds; and
- ❖ Status as a RRC.



AFFORDABLE CARE ACT PROVISION THAT IMPACTS MEDICARE DSHs

Section 3133 of the Affordable Care Act amends the Act to revise the method for computing the Medicare DSH adjustment for discharges occurring on or after October 1, 2013. The computation includes the following:

1. Instead of the amount that would otherwise be paid as the DSH adjustment, hospitals receive 25 percent of the amount determined under the current Medicare DSH payment method beginning in fiscal year (FY) 2014 (for discharges occurring on or after October 1, 2013); and
2. The remainder, equal to 75 percent of what otherwise would have been paid as Medicare DSH, becomes available for an uncompensated care payment after the amount is reduced for changes in the percentage of individuals who are uninsured. Each hospital eligible for Medicare DSH payments receives an uncompensated care payment based on its relative share of the total amount of uncompensated care reported by Medicare DSHs. The Centers for Medicare & Medicaid Services (CMS) is currently using insured low income days (the sum of Medicaid days and Medicare SSI days) as a proxy for uncompensated care until better data regarding hospital uncompensated care costs are available.

COUNTING NUMBER OF BEDS AND PATIENT DAYS IN HOSPITAL

Under the “Code of Federal Regulations” (CFR) at 42 CFR 412.106(a)(1)(i), the number of beds in a hospital is determined, in accordance with the regulation at 42 CFR 412.105(b), by dividing the number of available bed days during the cost reporting period by the number of days in the cost reporting period. Effective October 1, 2012, beds used for inpatient ancillary labor/delivery services are included in the bed count available for Inpatient Prospective Payment System (IPPS)-level acute care hospital services.

In addition, for purposes of Medicare DSH, the number of patient days in a hospital includes only those days attributable to units or wards of the hospital furnishing acute care services generally payable under the Acute Care Hospital IPPS and excludes patient days associated with beds in:

- ❖ Excluded distinct part hospital units;
- ❖ Counted as outpatient observation, skilled nursing swing bed, or inpatient hospice services;
- ❖ Units or wards that are not occupied to furnish a level of care under the IPPS at any time during the 3 preceding months; and
- ❖ Units or wards otherwise occupied that could not be made available for inpatient occupancy within 24 hours for 30 consecutive days.

MEDICARE DSH PAYMENT ADJUSTMENT FORMULAS

Under Section 1886(d)(5)(F) of the Act, additional Medicare DSH payments are made under the IPPS to acute care hospitals that serve a large number of low-income patients or to hospitals that qualify as Pickle hospitals. The disproportionate share adjustment percentage for a Pickle hospital is equal to 35 percent. The adjustment formulas under the primary qualifying method, which are provided in the chart below, are not applicable to Pickle hospitals. A hospital is eligible for a Medicare DSH payment under the primary qualifying method when its DPP meets or exceeds 15 percent. The chart on page 5 shows Medicare DSH payment adjustment formulas for hospitals qualifying under the primary method.

**Summary of Medicare DSH Payment Adjustment Formulas – Primary Qualifying Method
(for a complete list of rules and adjustments, refer to 42 CFR 412.106(d))**

STATUS/ LOCATION	NUMBER OF BEDS	THRESHOLD	ADJUSTMENT FORMULA
URBAN HOSPITALS	0–99 Beds	≥15%, ≤20.2%	2.5% + [.65 x (DPP – 15%)] Not to Exceed 12%
URBAN HOSPITALS	0–99 Beds	≥20.2%	5.88% + [.825 x (DPP – 20.2%)] Not to Exceed 12%
URBAN HOSPITALS	100 or More Beds	≥15%, ≤20.2%	2.5% + [.65 x (DPP – 15%)] No Cap
URBAN HOSPITALS	100 or More Beds	≥20.2%	5.88% + [.825 x (DPP – 20.2%)] No Cap
RURAL REFERRAL CENTERS	N/A	≥15%, ≤20.2%	2.5% + [.65 x (DPP – 15%)] No Cap
RURAL REFERRAL CENTERS	N/A	≥20.2%	5.88% + [.825 x (DPP – 20.2%)] No Cap
OTHER RURAL HOSPITALS	0–499 Beds	≥15%, ≤20.2%	2.5% + [.65 x (DPP – 15%)] Not to Exceed 12%
OTHER RURAL HOSPITALS	0–499 Beds	≥20.2%	5.88% + [.825 x (DPP – 20.2%)] Not to Exceed 12%
OTHER RURAL HOSPITALS	500 or More Beds	≥15%, ≤20.2%	2.5% + [.65 x (DPP – 15%)] No Cap
OTHER RURAL HOSPITALS	500 or More Beds	≥20.2%	5.88% + [.825 x (DPP – 20.2%)] No Cap

Using the example provided below, the Medicare DPP chart shows the Medicare DPP calculation and corresponding payment adjustment calculation under the primary qualifying method.

Hospital A has 62 beds and is located in an urban area. In FY 2003, it had 5,000 total patient days, 1,000 Medicaid/non-Medicare days, 2,000 Medicare Part A days, and 300 Medicare Part A/SSI days. Hospital A's Medicare DPP is 35 percent.

Medicare DPP

Medicare DPP	300 Medicare/Supplemental Security Income Days	1,000 Medicaid, Non-Medicare Days	+ = .35
	2,000 Total Medicare Days	5,000 Total Patient Days	

Because Hospital A is located in an urban area, has fewer than 100 beds, and has a DPP of more than 20.2 percent, the formula for determining the Medicare DSH adjustment is:

$$5.88\% + [.825 \times (\text{DPP} - 20.2\%)]$$

$$5.88\% + [.825 \times (35\% - 20.2\%)]$$

$$5.88\% + 12.21\% = 18.09\%$$

Urban hospitals with fewer than 100 beds are subject to a maximum DSH adjustment of 12 percent. Hospital A's Medicare DSH adjustment is 12 percent.

DSHs may also qualify for a low-volume hospital payment adjustment.



RESOURCES

The chart below provides Medicare DSH resource information.

Medicare DSH Resources

For More Information About...	Resource
Medicare DSH	https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/dsh.html on the CMS website Chapter 3 of the “Medicare Claims Processing Manual” (Publication 100-04) located at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c03.pdf on the CMS website
All Available Medicare Learning Network® (MLN) Products	“ MLN Catalog ” on the CMS website or scan the Quick Response (QR) code 
Provider-Specific Medicare Information	MLN publication titled “ MLN Guided Pathways: Provider Specific Medicare Resources ” on the CMS website
Medicare Information for Patients	https://www.medicare.gov on the CMS website

HELPFUL WEBSITES

American Hospital Association Rural Health Care

<http://www.aha.org/advocacy-issues/rural>

Critical Access Hospitals Center

<https://www.cms.gov/Center/Provider-Type/Critical-Access-Hospitals-Center.html>

Disproportionate Share Hospitals

<https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/dsh.html>

Federally Qualified Health Centers Center

<https://www.cms.gov/Center/Provider-Type/Federally-Qualified-Health-Centers-FQHC-Center.html>

Health Resources and Services Administration

<http://www.hrsa.gov>

Hospital Center

<https://www.cms.gov/Center/Provider-Type/Hospital-Center.html>

Medicare Learning Network®

<http://go.cms.gov/MLNGenInfo>

National Association of Community Health Centers

<http://www.nachc.org>

National Association of Rural Health Clinics

<http://narhc.org>

National Rural Health Association

<http://www.ruralhealthweb.org>

Rural Assistance Center

<https://www.raconline.org>

Rural Health Clinics Center

<https://www.cms.gov/Center/Provider-Type/Rural-Health-Clinics-Center.html>

Swing Bed Providers

<https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/SwingBed.html>

Telehealth

<https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth>

U.S. Census Bureau

<http://www.census.gov>

REGIONAL OFFICE RURAL HEALTH COORDINATORS

To find contact information for CMS Regional Office Rural Health Coordinators who provide technical, policy, and operational assistance on rural health issues, refer to <https://www.cms.gov/Outreach-and-Education/Outreach/OpenDoorForums/Downloads/CMSRuralHealthCoordinators.pdf> on the CMS website.



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