CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 1695	**Date: March 6, 2009**
	Change Request 6329

Subject: Providers Submitting Information Regarding Medicare Beneficiaries Entitled to Medicare Advantage (MA) for Fiscal Year (FY) 2006 for the Medicare/Supplemental Security Income (SSI) Fraction

I. SUMMARY OF CHANGES: The Medicare beneficiary days should include Medicare Advantage days. Hospitals must submit data on their Fiscal Year 2006 MA days so that these days may be included in the MedPAR file and be counted in the Medicare fraction of the DSH calculation.

New / Revised Material
Effective Date: Discharges on or after October 1, 2005 through September 30, 2006
Implementation Date: July 6, 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. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

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
R	3/140.2.4.3/Low-Income Patient (LIP) Adjustment: The Supplemental Security Income (SSI)/Medicare Beneficiary Data for Inpatient Rehabilitation Facilities (IRFs) Paid Under the Prospective Payment System (PPS)

III. 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.

IV. ATTACHMENTS:

Business Requirements

Manual Instruction

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

Attachment - Business Requirements

Pub. 100-04	Transmittal: 1695	Date: March 6, 2009	Change Request: 6329

SUBJECT: Providers Submitting Information Regarding Medicare Beneficiaries Entitled to Medicare Advantage (MA) for Fiscal Year (FY) 2006 for the Medicare/Supplemental Security Income (SSI) Fraction

Effective Date: Discharges on or after October 1, 2005 through September 30, 2006

Implementation Date: July 6, 2009

I. GENERAL INFORMATION

A. Background: Part of the calculation used to determine whether or not a hospital is eligible for Medicare Disproportionate Share Hospital (DSH) add-on payments is based on the percentage of days for which the beneficiary was entitled to Medicare Part A and received Supplemental Security Income (SSI) payments from the Social Security Administration (SSA). SSA provides the SSI information to CMS and it is uploaded into the Medicare Provider Analysis and Review (MedPAR) file. CMS then pulls all of the Medicare days for patients entitled to SSI for each eligible hospital and determines the hospital's percentage of total Medicare days for which the Medicare beneficiaries were simultaneously entitled to both SSI and Medicare. By statute, Medicare beneficiary days include days for which a beneficiary is enrolled in Medicare Advantage (MA) since such patients by definition are entitled to Medicare Part A. Hospitals must submit data on their MA days so that these days are included in the MedPAR file and accurately counted in the Medicare fraction of the DSH calculation. The IPPS regulations on Medicare DSH are located in 42 CFR 412.106. The Inpatient Rehabilitation Facility (IRF) PPS regulations on Low-Income Patients (LIP) are located in 42 CFR 412.624(e)(2).

B. Policy: As of the implementation date of this CR, non-teaching IPPS and IRF hospitals are required to submit informational only bills to their Medicare contractor for the MA beneficiaries they treated, in order to ensure these days are accurately reflected in the DSH (or LIP for IRF) calculations for FY 2006. Non-teaching IPPS hospitals and all IRF hospital claims are to be submitted as covered informational only claims with Condition Code 04. Teaching IPPS hospitals are not covered under this instruction as they previously submitted their MA claims with Condition Codes 04 and 69 in order to be reimbursed for their Indirect Medical Education (IME) payment. Therefore, teaching IPPS hospitals shall not re-submit MA claims. Non-teaching IPPS hospitals that did not qualify for DSH payments and IRFs that did not qualify for LIP payments in FY 2006 may submit FY 2006 MA claims, but are not required to do so.

Non-teaching IPPS hospitals that received Medicare DSH payments in FY 2006 and all IRFs that received LIP payments in FY 2006 must submit claims for MA patients with discharge dates on or after October 1, 2005 through September 30, 2006 (FY 2006), in order to ensure that Medicare DSH calculations for FY 2006 accurately reflect MA inpatient days. These claims may be submitted as of the implementation date of this change request through November 30, 2009.

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A / B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
							FISS	MCS	VMS	CWF	
6329.1	The Standard System shall accept covered informational only claims (Type of Bill (TOB) 11X, not 110) with Condition Code 04 from non-teaching IPPS hospitals and all IRF PPS hospitals for discharges on or after October 1, 2005 through September 30, 2006 for MA beneficiaries to ensure these days are captured in National Claims History and MedPAR for Fiscal Year (FY) 2006.						X				NCH / Med-PAR
6329.2	The Standard Systems shall not apply the inpatient deductible to any covered 11X TOBs when a Condition Code 04 is present from October 1, 2005 and beyond.									X	
6329.2.1	Contractors shall reprocess claims that had deductible applied when brought to their attention.	X		X							
6329.3	The Standard System shall accept CMG A9999 on IRF claims for discharges on or after October 1, 2005.						X				
6329.3.1	The Standard System shall load A9999 in the VSAM file back to October 1, 2005.						X				HIPPS File
6329.3.2	The Standard System shall install FY 2006 IRF Pricer in order to process A9999 claims.						X				IRF Pricer
6329.4	Contractors shall reject claims that contain Condition Code 04 and no GHOD file exists in CWF from October 1, 2005 and beyond with C5241.	X		X							
6329.5	The Standard System shall override timely filing for 11X TOBs when a condition code 04 is present on FY 2006 informational only claims.						X				
6329.6	The Standard System shall suppress the Medicare Summary Notice (MSN) on covered 11X TOBs when Condition Code 04 is present from October 1, 2005 and beyond.						X				
6329.7	The Standard Systems shall not subject these claims to any Medicare Secondary Payer editing, with the exception of MSP 1st claim development processing.						X			X	

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
							FISS	MCS	VMS	CWF	
6329.8	A provider education article related to this instruction will be available at http://www.cms.hhs.gov/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within one week of the availability of the provider education article. In addition, the provider education article shall be included in your next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.	X		X							

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements:
"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:
6329.1	Non-teaching IPPS hospitals and all IRF PPS hospitals should submit a COVERED 11X TOB (not 110), Medicare primary (Z in the primary payer field), condition code 04, with the Medicare Health Insurance Claim Account Number (HICAN), and all corresponding claim information (claim data elements are outlined in Pub. 100-04, Chapter 25, Section 75.1) needed to process the inpatient claim. Providers that are unaware of a patient's HICAN may obtain the HICAN from either the patient or the Medicare Advantage plan in which the patient was enrolled.

X-Ref Requirement Number	Recommendations or other supporting information:
	IRFs will also append Case-Mix Group (CMG) A9999 to the Revenue Code 0024 line and use the discharge date in the 'service date' field. The deadline for providers to submit their FY 2006 claims is November 30, 2009.

Section B: All other recommendations and supporting information:
V. CONTACTS

Pre-Implementation Contact(s): Policy- Tiffany Swygert at Tiffany.Swygert@cms.hhs.gov
Claims Processing -Sarah Shirey-Losso at Sarah.Shirey-Losso@cms.hhs.gov or Valeri Ritter at Valeri.Ritter@cms.hhs.gov

Post-Implementation Contact(s): Policy- Tiffany Swygert at Tiffany.Swygert@cms.hhs.gov
Claims Processing- Sarah Shirey-Losso at Sarah.Shirey-Losso@cms.hhs.gov or Valeri Ritter at Valeri.Ritter@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.1695, Issued: 03-06-09, Effective: 10-01-05 through 09-30-06, Implementation: 07-06-09)

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 *may not re*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 will 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 will 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 is responsible for reviewing 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. 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 must:

- 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.

140.2.4.3 – Low-Income Patient (LIP) Adjustment: The Supplemental Security Income (SSI)/Medicare Beneficiary Data for Inpatient Rehabilitation Facilities (IRFs) Paid Under the Prospective Payment System (PPS)

(Rev.1695, Issued: 03-06-09, Effective: 10-01-05 through 09-30-06, Implementation: 07-06-09)

The LIP adjustment accounts for differences in costs among IRFs associated with differences in the proportion of low-income patients treated. The LIP adjustment is calculated as (1 + disproportionate share hospital (DSH) patient percentage) raised to a power specified in the most recent IRF PPS final rule published in the Federal Register. To compute the DSH patient percentage the following formula is used:

$$\text{DSH} = \frac{\text{Medicare SSI Days}}{\text{Total Medicare Days}} + \frac{\text{Medicaid, Non-Medicare Days}}{\text{Total Days}}$$

This instruction provides the data for determining additional payment amounts for IRFs with low-income patients. An SSI data file below shows the latest available IRF-specific data to compute an IRF's SSI ratio for the associated specified fiscal year (FY). An IRF may use this ratio as part of the formula to estimate their LIP adjustment for a cost reporting period that begins subsequent to the FY specified by the data file. As appropriate a file will be updated annually (usually each October/November).

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 both Condition Code 04 and a default CMG code of A9999 *on the Revenue Code 0024 line*, to their Medicare contractor. This will ensure that these days are included in the IRF's SSI ratio for Fiscal Year 2007 and beyond. Teaching IRFs do not have to submit an additional bill with Condition Code 04. They already submit bills with Condition Codes 04 and 69 for Indirect Medical Education payments and CMS will use the information from these bills for the SSI ratio.

IRFs that received LIP payments during FY 2006 are also required to submit informational only bills for their Medicare Advantage patients.

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*
- *Revenue Code 0024 contains CMG A9999 and include the discharge date in the service date field*

- *All other required claim elements*

The SSI/Medicare beneficiary data for IRF PPS is available to fiscal intermediaries (FIs) electronically and contains the name of the facility, provider number, SSI days, covered Medicare days, and the ratio of Medicare Part A patient days attributable to SSI recipients. FIs will use this information to update their provider specific file. The files are located at the following CMS Web site address:

http://www.cms.hhs.gov/InpatientRehabFacPPS/05_SSIData.asp#TopOfPage

FIs use this data to determine an initial PPS payment amount, and if applicable, to determine a final outlier payment amount for IRFs whose discharges are during a specific cost reporting period. FIs make a determination of the amount of this percentage to compute the final LIP adjustment which allows the year-end settlement of a facility's cost report. When the FI settles a cost report for a specific fiscal year, that settled cost report will determine the final SSI ratio that is associated with that cost report. The FI uses the most recently settled SSI ratio to settle the current cost report. Once the final SSI ratio is determined for the actual fiscal year the cost report corresponds to, a retrospective adjustment may be made to account for the difference between the actual lip adjustment amount and the initial PPS lip adjustment payment amount.

A - Clarification of Allowable Medicaid Days in Calculating the Disproportionate Share Variable

Background

Under the IRF PPS, facilities receive additional payment amounts to account for the cost of furnishing care to low-income patients. This is done by making adjustments to the prospective payment rate. Under §1886(d)(5)(F) of the Act, the Medicare DSH percentage is made up of two computations. The results of these two computations are added together to determine the DSH percentage. First, the patient days of patients who, during a given month, were entitled to both Medicare Part A and SSI (excluding those patients who received only State supplementation), is divided by the number of covered patient days utilized by patients under Medicare Part A for that same period. Second, a determination is made regarding the patient days associated with beneficiaries who were eligible for medical assistance (Medicaid) under a State plan approved under Title XIX but who were not entitled to Medicare Part A (See 42 CFR 412.106(b)(4)) is determined. This number is divided by the total number of patient days for that same period. The SSI data is updated on an annual basis and these data are one of the components used to determine the DSH variable that is part of the appropriate LIP adjustment for each IRF.

Included 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 so 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. Second, 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. Third, the focus is on eligibility for medical assistance under 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.

Medicaid days, for purposes of the Medicare disproportionate share adjustment calculation, include 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 include, 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, we recognize in the calculation 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), 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, the FI 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.

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. See the chart below, which summarizes some, but not necessarily all, of the types of days to be excluded from (or included in) the Medicare DSH adjustment calculation.

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 so 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.

Types of Days Included/Excluded in the Medicare DSH Adjustment Calculation

Type of Day	Description	Eligible Title XIX Day
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	No
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	No
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.	No
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.	Yes
Medicaid Optional Targeted Low-Income Children (CHIP-	Days for patients who are Title XIX-eligible and who meet the definition of "optional targeted low-income children" under §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	Yes

Type of Day	Description	Eligible Title XIX Day
related) Days	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.	No.