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DISPROPORTIONATE SHARE HOSPITAL ADJUSTMENT: BACKGROUND AND CURRENT ISSUES

Prepared By
Powers Pyles Sutter & Verville, P.C.

May 2006

DSH Adjustment Percentage and 340B Eligibility

Acute care hospitals are eligible for the 340B drug discount program if the hospital: (1) is owned or operated by a unit of state or local government, is a public or private non-profit hospital which has formally been granted government powers, or a private non-profit hospital under contract with a state or local government to provide indigent care; (2) has a Medicare disproportionate share hospital ("DSH") adjustment percentage of greater than 11.75 percent; and (3) has certified that it will not obtain covered outpatient drugs through a group purchasing organization or other group purchasing arrangement.

The amount of the DSH adjustment percentage, therefore, determines whether a hospital qualifies for the 340B program, assuming other program requirements are met. The DSH adjustment percentage also has a significant effect on a hospital's Medicare reimbursement and has been the subject of considerable litigation for this reason. The following provides general background information on the DSH adjustment and a description of some recent litigation and other unresolved issues that may affect a hospital's ability to meet the 11.75 percent DSH adjustment threshold necessary to qualify for 340B program.

What Is DSH?

The DSH adjustment is an add-on to the DRG-based payments of the inpatient acute care hospital prospective payment system ("PPS"). Under PPS, hospitals in the same geographic area generally receive the same payment amount for providing care to a patient with a given diagnosis. The DSH adjustment is a percentage add-on to this PPS payment that is available to hospitals that serve a disproportionate number of indigent patients. The basis for this add-on is the recognition that indigent patients are often sicker and more costly to treat. The determination of whether a hospital serves a disproportionate number of indigent patients is based on a methodology prescribed by Congress, as implemented by the Centers for Medicare and Medicaid Services ("CMS").

Disproportionate Patient Percentage

A hospital's disproportionate patient percentage ("DPP") determines three issues of significance for hospitals. First, it determines whether a hospital qualifies for a DSH payment adjustment. Generally, a hospital must have a DPP of at least 15 percent to qualify for a DSH payment adjustment.[1] Second, it determines the DSH payment adjustment percentage, which is used to calculate the amount of a hospital's total DSH payment. Third, because it determines the DSH payment adjustment percentage, and whether that percentage is above 11.75 percent, it also impacts qualification for the 340B program.[2]

The DPP is the sum of two fractions, commonly known as the Medicare/SSI fraction and the Medicaid fraction. The calculation of DPP is as follows:

$$\text{DPP} = \frac{\text{Patient Days of Medicare Part A } \underline{\text{and}} \text{ SSI Entitlement}}{\text{Patient Days of Medicare Part A Entitlement}} + \frac{\text{Patient Days of Medicaid Eligibility } \underline{\text{but not}} \text{ Medicare Part A Entitlement}}{\text{Total Hospital Patient Days}}$$

(Medicare/SSI Fraction) (Medicaid Fraction)

The numerator of the Medicare/SSI fraction is patient days attributable to patients who are entitled to both Medicare Part A and supplemental security income ("SSI") benefits. The SSI program is administered by

[1] An urban hospital with 100 or more beds can also qualify for a DSH adjustment if more than 30 percent of its net inpatient care revenues are derived from State and local government payments for care furnished to indigent patients. These hospitals receive a DSH payment adjustment of 35 percent and are commonly known as "Pickle" hospitals in reference to the Congressman who sponsored the statutory amendment to create this category of DSH hospital.

[2] Some states also use the Medicare DPP to determine payment for Medicaid DSH.

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the Social Security Administration ("SSA") and provides benefits to indigent individuals who have a disability. CMS works with SSA to match Medicare and SSI records in order to determine the number of a hospital's Medicare patients who are also entitled to SSI benefits. The denominator of the Medicare fraction is the total number of patient days attributable to patients who are entitled to Medicare Part A benefits. Therefore, the Medicare fraction serves as a proxy, based on the SSI program, for the percentage of a hospital's Medicare patients that are indigent.

The numerator of the Medicaid fraction is the number of patient days attributable to patients who are eligible for assistance under the Medicaid State plan, but who are not entitled to Medicare Part A benefits. It is worth noting that the numerator includes patient days attributable to patients who are eligible for Medicaid even if the hospital did not receive payments from Medicaid for those days (because, for example, the patient's stay exceeded a Medicaid coverage limitation, or a third party insurer paid for those days). The denominator of the fraction is total patient days. Therefore, this fraction uses the Medicaid program as a proxy for determining the percentage of a hospital's total patients that are indigent and not entitled to Medicare.

Calculating the DSH Adjustment Percentage

Hospitals use one of the following two formulas to determine DSH adjustment percentages (the formulas differ based on a hospital's DPP):

If DPP is between 15% and 20.2%, then:	DSH = 2.5 + (0.65)(DPP - 15)
If DPP is equal to or greater than 20.2%, then:	DSH = 5.88 + (0.825)(DPP - 20.2)

Notwithstanding these formulas, certain hospitals have a 12 percent cap on their DSH adjustment percentage. Hospitals that are exempt from the cap are: urban hospitals with more than 100 acute care beds, rural hospitals with more than 500 acute care beds, rural referral centers, and, effective for discharges occurring on or after October 1, 2006, Medicare-dependent hospitals.[3] All other DSH hospitals are subject to the 12 percent cap.

The Minimum DPP for 340B Eligibility

Hospitals must have a DPP of greater than 27.32 percent in order to satisfy the 11.75 percent threshold for participation in the 340B program. This is because, pursuant to the equations detailed above:

$$11.75 = 5.88 + (0.825)(\mathbf{27.32} - 20.2)$$

For all 340B hospitals, therefore, the first formula described above is inapplicable because it is used only for hospitals with a DPP of between 15 and 20.2 percent. Another category of DSH hospitals – often referred to as "Pickle" hospitals – receive a DSH payment adjustment of 35 percent and therefore all qualify for 340B.[4]

Data Used In DPP

The Office of Pharmacy Affairs ("OPA"), a department of the Health Resources and Services Administration, makes the determination as to whether a hospital's DSH adjustment percentage is above 11.75

[3] A Medicare-dependent hospital is one that is located in a rural area, has less than 100 beds, a high percentage of Medicare discharges and meets certain other criteria. These hospitals are subject to special payment provisions under Medicare.
[4] See footnote 1 for a description of "Pickle" hospitals.

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percent based on information provided by CMS. CMS obtains this information from each hospital's provider-specific file or PSF, which is a file containing hospital payment data that fiscal intermediaries should update quarterly. Generally, the Medicaid fraction of the DPP is based on a hospital's most recent "tentatively" settled cost report and remains the same for one year, until the hospital's next cost report is tentatively settled. (A tentatively settled cost report is one which the intermediary has reviewed preliminarily and is generally issued shortly after the cost report is filed.) The Medicare/SSI fraction of the DPP is generated by CMS and is generally updated by October 1 of each year.

Many 340B hospitals have reported that the DPP data on their PSF is inaccurate, normally because the intermediary did not update the PSF or used a reduced DPP to lower interim DSH payments. If the inaccurate data results in a DSH payment adjustment percentage of 11.75 percent or lower, the hospital can be dropped from the 340B program. Fortunately, to address concerns raised by the Public Hospital Pharmacy Coalition ("PHPC") and by individual hospitals and their representatives, OPA has agreed to accept letters from fiscal intermediaries and/or other documentation demonstrating that a hospital's DSH payment adjustment percentage remains above 11.75 percent and that, as a result, the hospital still qualifies for the 340B program. Please contact PHPC if you need more information about how to preserve your hospital's 340B eligibility when its DSH adjustment percentage, as reported by CMS to OPA, appears to be based on inaccurate data.

Current Issues Involving the DSH Adjustment

Hospitals have an obvious incentive to maximize their DSH adjustment percentage and therefore their Medicare DSH reimbursement.[5] For a 340B hospital, it is imperative that its DSH payment adjustment percentage remain above 11.75 percent to continue to participate in the program. Hospitals that are seeking to determine whether their DSH adjustment percentage is accurate should be aware of the following issues.

Issue One: Accuracy of the Medicare/SSI Fraction – The Provider Reimbursement Review Board ("PRRB") recently held that the Medicare/SSI fraction has serious flaws and ordered that the computer programs that are used to calculate this fraction be corrected to address the deficiencies.[6] The major problems that the PRRB found with the Medicare/SSI fraction relate to the match between CMS's patient days data and the SSA's entitlement data, and the completeness of SSA's SSI entitlement data. It is likely that this case will be appealed; therefore, this decision may not be the final word on the issue. Hospitals should be aware, however, that the Medicare/SSI fraction may not be accurate, and opportunities may be available to correct it.

Issue Two: Medicaid and Waiver Days – The federal district court for the District of Columbia recently ruled that Section 1115 waiver days must be included in calculating the Medicaid fraction of the DPP for periods prior to January 20, 2000.[7] The 9th Circuit Court of Appeals had already issued a similar ruling.[8] Section 1115 waivers, implemented in several states, allow states to furnish medical assistance to expanded eligibility populations that would not otherwise have been eligible for Medicaid. Although Medicare regulations include Section 1115 waiver days in the DSH calculation for patient discharges on or after January 20, 2000, CMS has taken the position that such days should not be counted prior to that date. The Cookeville and Portland Adventist courts rejected that position. After the Cookeville decision was issued, Congress passed the Deficit Reduction Act of 2005, which includes a provision that CMS contends ratifies its position regarding the exclusion of Section 1115 waiver days prior to January 20, 2000. The government

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[5] Many states also use the Medicare DSH formula to determine Medicaid DSH adjustments.

[6] Baystate Medical Center v. Mutual of Omaha, PRRB Dec. No. 2006-D20 (2006).

[7] Cookeville Regional Medical Center, et al. v. Thompson, Civil Action No. 04-1053 (D.D.C. Oct. 28, 2005), *appeal docketed,* No. 05-5495 (D.C. Cir. Jan. 5, 2006).

[8] Portland Adventist Medical Center v. Thompson, Medicare and Medicaid Guide (CCH) ¶ 301,592 (9th Cir. Mar. 2, 2005).

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has sought to have the Cookesville ruling altered in light of this provision. However, this prompted a protest by Congressmen from Tennessee (where the Cookeville hospitals are located), who have stated that they believed that the Cookeville decision would remain intact when they voted for the Deficit Reduction Act. There will undoubtedly be further litigation on this issue.

Issue Three: Medicare Managed Care Days – Whether or not a patient day is attributable to a patient who is a Medicare beneficiary impacts various components of the DPP. [9] The statute defines Medicare days as days related to patients "entitled to benefits under Part A" of the Medicare statute. Patients who are enrolled in a Medicare managed care plan receive their benefits under Part C, not Part A, of the Medicare statute, which has led to a controversy over how Medicare managed care days should be treated in the DPP. CMS has taken the position that Medicare managed care days should be included in the denominator of the Medicare/SSI fraction based on the reasoning that managed care beneficiaries are *entitled* to benefits under Part A even though they receive their benefits under Part C. (They would also be included in the numerator of the Medicare/SSI fraction if the patient were entitled to SSI.) Some hospitals argue that Medicare managed care days should be included in the numerator of the Medicaid fraction (if they are eligible for Medicaid) because managed care beneficiaries receive their benefits under Part C and therefore they are *not* "entitled to benefits under Part A." It appears that most hospitals would benefit by including these days in the Medicaid fraction rather than the Medicare/SSI fraction (because the denominator of the Medicare/SSI fraction generally increases proportionally more than the numerator when the managed care days are included) and there undoubtedly will be litigation on this issue.

Issue Four: Dual Eligibles Who Have Exhausted Their Medicare Coverage – Generally, days attributable to patients who are beneficiaries of both Medicare and Medicaid (known as "dual eligibles") are not included in the numerator of the Medicaid fraction because, as stated above, the numerator of the Medicaid fraction excludes patient days attributable to patients "entitled to benefits under Part A." In cases in which a dual eligible exhausts his or her Medicare coverage (because the number of Medicare covered patient days has been exceeded), there is a question as to how these days should be treated. For discharges occurring prior to October 1, 2004, CMS did not include these patient days in the DPP, but CMS adopted a policy of including these days in the Medicare/SSI fraction for discharges occurring on or after October 1, 2004. Some hospitals argue that these patient days should be included in the numerator of the Medicaid fraction, rather than in the SSI/Medicare fraction because, after the patient exhausts his or her Medicare coverage, the patient is no longer "entitled to benefits under Part A." This issue may also be the subject of litigation in the future.

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If you have any questions about DSH issues, feel free to contact Bill von Oehsen or Barbara Straub Williams at (202) 466-6550.

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[9] Days attributable to patients who are entitled to both Medicare Part A and SSI are included in the numerator of the Medicare/SSI fraction and total days attributable to patients who are entitled to Medicare Part A are included in the denominator of the Medicare/SSI fraction. The numerator of the Medicaid fraction includes patient days attributable to Medicaid eligible inpatients who are *not* entitled to Medicare Part A. *All* patient days are included in the denominator of the Medicaid fraction, regardless of the form of payment.

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