DEPARTMENT OF HEALTH & HUMAN SERVICES Centers for Medicare & Medicaid Services

6325 Security Boulevard
Baltimore, MD 21207

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Dear State Medicaid Director:

Attached for your information is a summary of the provisions of section 13621 of the 1993 Omnibus Reconciliation Act. These provisions, effective for most States in the State fiscal year beginning on or after July 1, 1994, place new limits on the facilities which may qualify as disproportionate share hospitals (DSH), and the maximum payment adjustment such facilities may receive under the Medicaid program.

The Health Care Financing Administration is planning regulations to codify these new requirements in the Code of Federal Regulations. Until these regulations are published, this summary represents HCFA's interpretation of the new DSH requirements.

Comments or questions on this material may be directed to Bernard Truffer, Director of the Division of Payment Policy. Mr. Truffer may be reached at 410 - 966 - 1357.

/s/

Sally K. Richardson

Enclosure

Cc:
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Summary of OBRA 93 DSH Limit Requirements

INTRODUCTION

Section 13621 of the Omnibus Budget Reconciliation Act of 1993 (OBRA 93) contains provisions which affect qualification of, and payment to, disproportionate share hospitals (DSH) under the Medicaid program. This document is to provide the States with HCFA's interpretation of the key provisions of the new law.

DSH QUALIFICATION

Under prior law, States had considerable flexibility to define hospitals as DSH under sections 1923(a) and (b) of the Social Security Act. These new provisions required States to include in their plans a definition of DSH. The law also required States to include in their definitions all hospitals which met either a minimum Medicaid or low-income utilization threshold. Beyond these minimums, States were permitted to include any other hospitals in their definitions.

The new law adds a new provision (§1923(d)(3)) to the Social Security Act which limits States' flexibility to define hospitals as DSH. Effective for the State fiscal year that begins in 1994, (except for certain States that do not have a regular State legislative session in 1994), States may not qualify any facility as a DSH, unless the hospital has, at a minimum, a Medicaid utilization rate (MUR) of one percent. This provision applies to all States, including those eligible for exceptions to the DSH requirements under section 1923(e) of the Act.

The Medicaid utilization rate (MUR) formula is specified in §1923(b)(2) of the Social Security Act. This formula is generally computed as follows:

$$MUR\ \% = 100 \times M/T$$

M = Hospital's number of inpatient days attributable to patients who for these days were eligible for Medical Assistance under the State Plan.

T = Hospital's total inpatient days

In calculating the Medicaid inpatient utilization rate, the Statute requires States to include newborn days, days in specialized wards, and administratively necessary days. States, in computing the Medicaid utilization rate for a particular hospital, are also to account for days attributable to individuals eligible for Medicaid in another State.

It is important to note that the numerator of the MUR formula does not include days attributable to Medicaid patients between 21 and 65 years of age in Institutions for Mental Disease (IMDs). These patients are not eligible for Medical Assistance under the State plan for the days in which they are inpatients of IMD's and may not be counted as Medicaid days in computing the Medicaid utilization rate.

The new limitation on qualification does not require that DSH facilities meet the one percent threshold in the payment year. Rather, they must meet the one percent limit in the period for which the State's Medicaid plan determines DSH qualification. For example, if the State plan determines DSH eligibility for the payment year beginning in 1995, based on data from 1993, as long as a hospital met the one percent threshold in 1993, it may continue to be eligible in 1995.

LIMIT ON DSH PAYMENT ADJUSTMENT

Section 13621 of the OBRA 93 also establishes facility specific limits on the amount of the payment adjustments that States may make to DSHs. Under prior law, while State DSH spending was constrained in the aggregate, the payment adjustment to a particular DSH was not limited.

The new provision, which is effective on different dates for public and private hospitals, establishes a limit on the amount of the payment adjustment that may be made to any DSH during the State fiscal year. The annual DSH payment adjustment to each DSH may not exceed the limit for that hospital.

STATE FISCAL YEARS BEGINNING BEFORE JANUARY 1, 1995. -- For those State fiscal years beginning between July 1, 1994, and January 1, 1995, the new limit applies only to public hospitals. The law defines public hospital as a hospital "owned" or operated by the State, or by an instrumentality or a unit of government within a State.

STATE FISCAL YEARS BEGINNING ON OR AFTER JANUARY 1, 1995. – For State fiscal years beginning on or after January 1, 1995, the limit provisions apply to all DSHs in the State.

EXCEPTION FOR CERTAIN STATES. **- -** For those States which do not have regular legislative sessions scheduled in 1994, the DSH limit provision applies to fiscal years beginning after January 1, 1995. For these States, the limit will apply to all DSHs in the State.

CALCULATION OF LIMIT

The limit applicable to DSH payment adjustments is composed of two parts. The first part of the limit is the Medicaid "shortfall". The "shortfall" is the cost of services furnished to Medicaid patients, less the amount paid under the non-DSH payment method under the State plan.

The second part of the formula is the cost of services provided to patients who have no health insurance or source of third party payment for services provided during the year, less the amount of payments made by these patients.

DSH LIMIT = M + U

M = Cost of Services to Medicaid patient, less the amount paid by the State under the non-DSH payment provisions of the State plan.

U = Cost of Services to Uninsured Patients, less any cash payments made by them.

COST OF SERVICES

There are several important considerations that must be made in determining the cost of services under the DSH limit, whether for Medicaid or uninsured individuals. First, the legislative history of this provision makes it clear that States may include both inpatient and outpatient costs in the calculation of the limit. Second, in defining "costs of services" under this provision, HCFA would permit the State to use the definition of allowable costs in its State plan, or any other definition, as long as the costs determined under such a definition do not exceed the amounts that would be allowable under the Medicare principles of cost reimbursement. The Medicare principles are the general upper payment limit under institutional payment under the Medicaid program. HCFA believes this interpretation of the term "costs incurred" is reasonable because it provides States with a great deal of flexibility up to a

maximum standard that is widely known and used in the determination of hospital costs.

Uninsured Patients

One of the key provisions in the limit is the determination of which of a hospital's patients "have no health insurance or source of third party payment for services provided". A number of States have asked about the meaning of this provision, and whether it includes, for example, individuals with indemnity policies, or individuals whose policies contain day limits that are exhausted.

HCFA believes it would be permissible for States to include in this definition individuals who do not possess health insurance which would apply to the service for which the individual sought treatment.

Special Provision for "High Disproportionate Share" Hospitals

The law provides special treatment for certain "High Disproportionate Share Hospitals", for the State fiscal year that begins before January 1, 1995. During this period, the limit on the DSH payment adjustment such a hospital could receive is 200 percent of the general limit.

To qualify as a "High Disproportionate Share Hospital", a hospital must:

1. be a public hospital, and
2. meet one of the following two categories:
    a. The hospital must have Medicaid utilization at least one standard deviation above the mean Medicaid utilization rate in the State; or
    b. The hospital must have the greatest number of Medicaid inpatient days of any hospital in the State, in the previous fiscal year.

Payment of DSH adjustments to a "High Disproportionate Share Hospital" above 100 percent of the limit can only be made if the Governor of the State certifies to the Secretary of HHS that the hospital's "applicable minimum amount" (AMA) is used for health services during the year. The AMA is the difference between the amount of the DSH adjustment and the amount of the basic limit (i.e. the Medicaid shortfall and the cost of services provided to individuals with no health insurance). In determining the cost of health services, against which the AMA is compared, the

statute provides that Medicare, Title V, Public Health Service funds and payments by third parties, not including Medicaid, are deducted.

An example of the application of the "AMA" provision is as follows:

Assume the State pays a DSH adjustment to a hospital of $1 million. The limit for the hospital is $500,000. The excess of the DSH adjustment over the limit ($500,000) can only be made if the Governor certifies that the excess was used for health care services during the year. The Governor's certification indicates that the State runs a number of public health clinics that cost, in the aggregate, $2 million. These clinics receive an aggregate of $1 million in payments from Medicare, Title V, other third parties and Public Health Service Grants. Since the balance ($1 million) is greater than the excess DSH payment ($500,000), the DSH payment is permissible.

While the calculation of the AMA must be done for each "High Disproportionate Share Hospital", it is permissible for the State to demonstrate in the aggregate that the AMAs for all High Disproportionate Share Hospitals are used for health services during the year. This would be done by demonstrating that the State has health services costs (excluding the Federal and other third party payments) in excess of the combined AMAs.

Implementation

In order to implement this provision, States should take the following actions by September 30, 1994:

1. Identify all disproportionate share hospitals, and indicate for each hospital the Medicaid utilization rate, and the estimated DSH adjustment each hospital will receive during the State Fiscal Year.

2. Identify all Disproportionate Share Hospitals which are public hospitals and subject to the limit during the transition period.

3. Identify all high disproportionate share hospitals which would be subject to the limit at 200 percent.

4. Provide an assurance that all DSH facilities will receive payment adjustments during the State Fiscal Year not greater than the limit.

5. Provide the basis for the assurance that the estimated DSH adjustment for each hospital will not exceed the limit. This explanation should include an estimate of the DSH adjustment, as well as an estimate of the limit, for each hospital.

6. If the DSH payment exceeds the limit, the State should also submit an amendment to its State plan designed to bring the payment adjustment in line with the limit.