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 Medicare Disproportionate Share Hospitals (DSH):

- Background;
- Methods to qualify for the Medicare DSH adjustment;
- Affordable Care Act provision that impacts Medicare DSHs;
- Medicare Prescription Drug, Improvement, and Modernization Act (MMA) provisions that impact Medicare DSHs;
- Number of beds in hospital determination;
- Medicare DSH payment adjustment formulas;
- Resources; and
- Lists of helpful websites and Regional Office Rural Health Coordinators.
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) and the percentage of total patient days attributable to patients eligible for Medicaid but not eligible for Medicare Part A (including patient days not covered under Part A and patient days in which Part A benefits are exhausted). The chart below provides the Medicare DPP.

<table>
<thead>
<tr>
<th>Disproportionate Patient Percentage</th>
<th>Medicare/Supplemental Security Income Days</th>
<th>Medicaid, Non-Medicare Days</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Medicare Days</td>
<td></td>
<td>Total Patient Days</td>
</tr>
</tbody>
</table>

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.
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 that are uninsured. Each Medicare DSH receives an uncompensated care payment based on its share of insured low income days (the sum of Medicaid days and Medicare SSI days) reported by Medicare DSHs.

MMA PROVISIONS THAT IMPACT MEDICARE DSHs

Section 402 of the MMA further 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.

NUMBER OF BEDS IN HOSPITAL DETERMINATION

Under the “Code of Federal Regulations” (CFR) at 42 CFR 412.106(a)(1)(i) located at http://www.gpo.gov/fdsys/search/home.action on the United States Government Printing Office website, the number of beds in a hospital is determined, in accordance with 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.
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 Inpatient Prospective Payment System (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.

Effective October 1, 2012, beds used for inpatient ancillary labor/delivery services are included in the bed count available for IPPS-level acute care hospital services.

**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 are not applicable to Pickle hospitals. A PPS hospital is eligible for a Medicare DSH payment under the primary qualifying method when its DPP meets or exceeds 15 percent. The chart below shows Medicare DSH payment adjustment formulas for hospitals qualifying under the primary method.

### Medicare DSH Payment Adjustment Formulas – Primary Qualifying Method

<table>
<thead>
<tr>
<th>Status/Location</th>
<th>Number Of Beds</th>
<th>Threshold</th>
<th>Adjustment Formula</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>URBAN HOSPITALS</strong></td>
<td>0 - 99 Beds</td>
<td>≥15%, ≤20.2%</td>
<td>2.5% + [0.65 x (DPP – 15%)] Not to Exceed 12%</td>
</tr>
<tr>
<td></td>
<td>0 - 99 Beds</td>
<td>≥20.2%</td>
<td>5.88% + [0.825 x (DPP – 20.2%)] Not to Exceed 12%</td>
</tr>
<tr>
<td><strong>URBAN HOSPITALS</strong></td>
<td>100 or More Beds</td>
<td>≥15%, ≤20.2%</td>
<td>2.5% + [0.65 x (DPP – 15%)] No Cap</td>
</tr>
<tr>
<td><strong>URBAN HOSPITALS</strong></td>
<td>100 or More Beds</td>
<td>≥20.2%</td>
<td>5.88% + [0.825 x (DPP – 20.2%)] No Cap</td>
</tr>
<tr>
<td><strong>RURAL REFERRAL CENTERS</strong></td>
<td>N/A</td>
<td>≥15%, ≤20.2%</td>
<td>2.5% + [0.65 x (DPP – 15%)] No Cap</td>
</tr>
<tr>
<td><strong>RURAL REFERRAL CENTERS</strong></td>
<td>N/A</td>
<td>≥20.2%</td>
<td>5.88% + [0.825 x (DPP – 20.2%)] No Cap</td>
</tr>
<tr>
<td><strong>OTHER RURAL HOSPITALS</strong></td>
<td>0 - 499 Beds</td>
<td>≥15%, ≤20.2%</td>
<td>2.5% + [0.65 x (DPP – 15%)] Not to Exceed 12%</td>
</tr>
<tr>
<td><strong>OTHER RURAL HOSPITALS</strong></td>
<td>0 - 499 Beds</td>
<td>≥20.2%</td>
<td>5.88% + [0.825 x (DPP – 20.2%)] Not to Exceed 12%</td>
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<td>500 or More Beds</td>
<td>≥20.2%</td>
<td>5.88% + [0.825 x (DPP – 20.2%)] No Cap</td>
</tr>
</tbody>
</table>
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.

<table>
<thead>
<tr>
<th>Medicare DPP</th>
<th>300 Medicare/Supplemental Security Income Days</th>
<th>1,000 Medicaid, Non-Medicare Days</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>_______________________ + ________________________ = .35</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2,000 Total Medicare Days</td>
<td>5,000 Total Patient Days</td>
</tr>
</tbody>
</table>

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:

- \[ 5.88\% + \left(\frac{0.825 \times (DPP - 20.2\%)\}}{100}\right) \]
- \[ 5.88\% + \left(\frac{0.825 \times (35\% - 20.2\%)\}}{100}\right) \]
- \[ 5.88\% + 12.21\% = 18.09\% \]

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**

<table>
<thead>
<tr>
<th>For More Information About…</th>
<th>Resource</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare DSH Information</td>
<td><a href="http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/dsh.html">http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/dsh.html</a> on the Centers for Medicare &amp; Medicaid Services (CMS) website</td>
</tr>
<tr>
<td>Medicare Information for Patients</td>
<td><a href="http://www.medicare.gov">http://www.medicare.gov</a> on the CMS website</td>
</tr>
</tbody>
</table>
HELPFUL WEBSITES

American Hospital Association Rural Health Care
http://www.aha.org/advocacy-issues/rural

Critical Access Hospitals Center
http://www.cms.gov/Center/Provider-Type/Critical-Access-Hospitals-Center.html

Disproportionate Share Hospital
http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/dsh.html

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

Health Resources and Services Administration
http://www.hrsa.gov

Hospital Center
http://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

Physician Bonuses
http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HPSAPSAPhysicianBonuses

Rural Assistance Center
http://www.raconline.org

Rural Health Clinics Center
http://www.cms.gov/Center/Provider-Type/Rural-Health-Clinics-Center.html

Swing Bed Providers
http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/SwingBed.html

Telehealth
http://www.cms.gov/Medicare/Medicare-General-Information/Telehealth

U.S. Census Bureau
http://www.census.gov

REGIONAL OFFICE RURAL HEALTH COORDINATORS

Below is a list of contact information for CMS Regional Office Rural Health Coordinators who provide technical, policy, and operational assistance on rural health issues.

Region I – Boston
Rick Hoover
E-mail: rick.hoover@cms.hhs.gov
Telephone: (617) 565-1258
States: Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont

Region II – New York
Miechal Lefkowitz
E-mail: miechal.lefkowitz@cms.hhs.gov
Telephone: (212) 616-2517
States: New Jersey, New York, Puerto Rico, and Virgin Islands

Region III – Philadelphia
Patrick Hamilton
E-mail: patrick.hamilton@cms.hhs.gov
Telephone: (215) 661-4097
States: Delaware, Maryland, Pennsylvania, Virginia, West Virginia, and the District of Columbia

Region IV – Atlanta
Lana Dennis
E-mail: lana.dennis@cms.hhs.gov
Telephone: (404) 562-7379
States: Alabama, Florida, Georgia, Kentucky, Mississippi, North Carolina, South Carolina, and Tennessee

Region V – Chicago
Nicole Jacobson
E-mail: nicole.jacobson@cms.hhs.gov
Telephone: (312) 353-5737
States: Illinois, Indiana, Michigan, Minnesota, Ohio, and Wisconsin

Region VI – Dallas
Kaleigh Emerson
E-mail: kaleigh.emerson@cms.hhs.gov
Telephone: (214) 767-6444
States: Arkansas, Louisiana, New Mexico, Oklahoma, and Texas

Region VII – Kansas City
Claudia Odgers
E-mail: claudia.odgers@cms.hhs.gov
Telephone: (816) 426-6524
States: Iowa, Kansas, Missouri, and Nebraska

Region VIII – Denver
Lyla Nichols
E-mail: lyla.nichols@cms.hhs.gov
Telephone: (303) 844-6218
States: Colorado, Montana, North Dakota, South Dakota, Utah, and Wyoming

Region IX – San Francisco
Neal Logue
E-mail: neal.logue@cms.hhs.gov
Telephone: (415) 744-3551
States: Arizona, California, Hawaii, Nevada, Guam, Commonwealth of the Northern Mariana Islands, and American Samoa

Region X – Seattle
Teresa Cumpton
E-mail: teresa.cumpton@cms.hhs.gov
Telephone: (206) 615-2391
States: Alaska, Idaho, Oregon, and Washington

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