# DEPARTMENT OF HEALTH AND SOCIAL SERVICES

## DIVISION OF MEDICAID AND MEDICAL ASSISTANCE

Statutory Authority: 31 Delaware Code, Section 512 (31 **Del.C.** §512)

## PROPOSED

### PUBLIC NOTICE

### Medicaid State Plan Governing Payments for Disproportionate Share Hospital

In compliance with the State's Administrative Procedures Act (APA - Title 29, Chapter 101 of the Delaware Code) and under the authority of Title 31 of the **Delaware Code,** Chapter 5, Section 512 and with 42 CFR §447.205, Delaware Health and Social Services (DHSS) / Division of Medicaid and Medical Assistance (DMMA) is proposing to amend the Title XIX Medicaid State Plan regarding the reimbursement methodology for *Disproportionate Share Hospital*.

Any person who wishes to make written suggestions, compilations of data, testimony, briefs or other written materials concerning the proposed new regulations must submit same to Sharon L. Summers, Planning & Policy Development Unit, Division of Medicaid and Medical Assistance, 1901 North DuPont Highway, P.O. Box 906, New Castle, Delaware 19720-0906 or by fax to 302-255-4425 by March 31, 2012.

The action concerning the determination of whether to adopt the proposed regulation will be based upon the results of Department and Division staff analysis and the consideration of the comments and written materials filed by other interested persons.

### SUMMARY OF PROPOSAL

Pursuant to the public notice requirements of Social Security Act §1902(a)(13)(A) and 42 CFR §447.205, the Division of Medicaid and Medical Assistance (DMMA) provides notice to the public that the agency intends to amend the Title XIX Medicaid State Plan related to hospital payments under the *Disproportionate Share Hospital* program.

**Statutory Authority**

- Social Security Act §1923(j), *Annual Reports and Other Requirements Regarding Payment Adjustments;*
- Social Security Act §1902(a)(13)(A), *Public process for determination of rates of payment;*
- 42 CFR §447.205, *Public Notice of Changes in Statewide Methods and Standards for Setting Payment Rates*;
- 42 CFR §447, *Payments for Services*; and,
- 42 CFR §455, Subpart D, *Independent Certified Audit of State Disproportionate Share Hospital Payment Adjustments*

**Background**

Federal law requires that state Medicaid programs make Disproportionate Share Hospital (DSH) payments to qualifying hospitals that serve a large number of Medicaid and uninsured individuals.

Federal law establishes an annual DSH allotment for each state that limits Federal Financial Participation (FFP) for total statewide DSH payments made to hospitals. Federal law also limits FFP for DSH through the hospital-specific DSH limit.

Under the hospital-specific DSH limit, FFP is not available for state DSH payments that are more than the hospital's eligible uncompensated care cost, which is the cost of providing inpatient hospital and outpatient hospital services to Medicaid patients and the uninsured, minus payments received by the hospital on or on the behalf of those patients.

*DSH Audit and Reporting Requirements*

For states to receive FFP for DSH payments, federal law requires states to submit an independent certified audit and an annual report to the Secretary describing DSH payments made to each DSH hospital.

The report must identify each disproportionate share hospital that got a DSH payment adjustment, and provide any other information the Secretary needs to ensure the appropriateness of the payment amount. The annual certified independent audit includes specific verifications to make sure all DSH payments are appropriate.

**Summary of Proposal**

The Disproportionate Share Hospital (DSH) program was created by Congress to enable qualifying hospitals which serve a "disproportionate share" of low income individuals, such as people with Medicaid and who are uninsured, to receive supplemental payments to address uncompensated care. The Medicaid State Plan must include a description of the criteria used to designate hospitals as DSH hospitals and a definition of the formulas used to calculate the DSH payments.

Under the existing disproportionate share criteria in the Delaware Medicaid State Plan, only the Delaware Psychiatric Center (DPC) has qualified for Medicaid DSH payments. Although hospitals in the private sector could potentially qualify for

DSH payments under the current rules, no private hospital has met the criteria thus far. Under the proposed amendment, the new policy will increase the likelihood that additional private hospitals in Delaware may qualify for DSH payments. The new policy also sets forth a process and a timeline for hospitals to apply and be determined eligible for DSH payments. The policy further establishes a methodology for calculating the amount of DSH payments a hospital can receive. DSH payments are funded from a combination of Federal and State funds.

The proposed amendment will become effective May 1, 2012.

The provisions of this state plan amendment are subject to approval by the Centers for Medicare and Medicaid Services (CMS).

**Fiscal Impact Statement**

Funds have been appropriated in the FY12 state budget to make payments to hospitals that meet the new criteria. The Governor's Recommended Budget for FY13 includes ongoing funding to make DSH payments under the new regulations.

| | **Fiscal Year 2012** | **Fiscal Year 2013** |
|---|---|---|
| General (State) funds | $4.0 million | $4.0 million |
| Federal funds | $4.5 million | $4.9 million |

**DMMA PROPOSED REGULATION #12-06**
**REVISION:**

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DISPROPORTIONATE SHARE HOSPITAL

~~In accordance with the provisions of Section 1923(b)(1)(A)(B) of the Social Security Act, the Delaware Medicaid Program will determine whether a hospital qualifies as "serving a disproportionate share of the poor".~~

~~Medicaid defines uncompensated care as the cost of services to Medicaid patients, less the amount paid by the State under the non-disproportionate share hospital payment provisions of the State Plan. The cost of services to uninsured patients (those who have no health insurance or source of third party payments) less the amount of payments made by these patients is included in the definition of uncompensated care. Any hospital meeting the definition of a disproportionate share hospital will receive payments in accordance with Section 1923 (c)(3). Hospitals meeting the standard are entitled to receive payments of ninety percent (90%) of its uncompensated care amount.~~

~~Medicaid requires that the 1923(d)(3) provision of the Act be met, which states that any disproportionate share hospital have a Medicaid utilization rate of a least one percent (1%).~~

~~With the exceptions noted in 1923(d)(2)(A), Medicaid also requires that the 1923(d) provision of the Act be met, which states that any disproportionate share hospital have at least two (2) obstetricians who have staff privileges at the hospital and who have agreed to provide obstetric services to individuals who are entitled to medical assistance for such services under the State Plan.~~

~~Medicaid requires that the payment adjustments received by all disproportionate share hospitals not exceed, in the aggregate, the established limits each Federal fiscal year as expressed in Section 1923(f) of the Act as published annually in the HCFA Federal Register. Medicaid also requires that the payment adjustments made to individual hospitals not exceed one hundred percent (100%) of their established limits for the State fiscal year as expressed in Section 1923(g) of the Act.~~

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**Disproportionate Share Hospital (DSH) Payments**

Delaware hospitals participating in the Delaware Medical Assistance (Medicaid) program that serve a disproportionate share of Medicaid and low income patients may be eligible for reimbursement from the Delaware Hospital DSH Fund. DHSS, DMMA has established criteria regarding the hospital qualifications and the maximum amount of reimbursement for hospitals that apply. For purposes of the DSH program, hospitals that have multiple geographic locations providing inpatient services will be treated as a single hospital when the hospital submits a consolidated Medicare cost report for its locations.

DSH Definitions

Note: The terms "costs", "charges" and "revenue/payment", as defined below, do not include the costs, charges and revenue/payment related to serving inmates of public institutions for which Medicaid funds are not available.

- Delaware Hospital DSH Fund – the total annual amount of funds available for distribution to DSH qualified hospitals. The amount is computed each year by the Medicaid agency based on the availability of state matching funds, the FMAP up to the maximum of Delaware's annual Federal DSH allotment.
- Hospital Specific DSH Limit – the maximum annual DSH payment amount a hospital can receive in accordance with section 42 CFR 447.299 (c) (16).
- Low Income Utilization Rate (per section 1923 (b) (3) of the Social Security Act) - In general, for an annual period, the Low Income Utilization Rate is the sum of the percentages computed by dividing:
  - Medicaid payments for inpatient and outpatient care by total hospital inpatient and outpatient payments received from all sources, plus
  - Inpatient charity care charges by total inpatient charges.
- Medicaid Inpatient Utilization Rate (per section 1923 (b) (2) of the Social Security Act) - In general, for an annual period, the Medicaid Inpatient Utilization Rate is the percentage computed by dividing inpatient days attributable to patients who were eligible for Medicaid by total inpatient hospital bed days.
- Revenue – as used in connection with the DSH program means payments received from any source.



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**Disproportionate Share Hospital (DSH) Payments (cont'd)**

- Uncompensated Care – as used in connection with the DSH program means the sum of the differences between:
  - The annual COST of inpatient and outpatient services to Medicaid eligible patients minus the inpatient and outpatient REVENUE (payments) received for Medicaid eligible patients (including both fee-for-service payments and payments made by Medicaid managed care organizations); plus
  - The annual COST of inpatient and outpatient hospital services provided to uninsured patients (excluding the cost of providing physician services to the uninsured) minus any payments received from or on behalf of the uninsured (including any Federal section 1011 payments for eligible aliens)
- Uninsured – as used in connection with the DSH program means a person who has no source of third party coverage (creditable coverage as defined in Federal regulations at 45 CFR 144 and 146). However, if adopted in final form, the term uninsured shall be defined in accordance with 42 CFR 447.295

(a) Minimum Criteria:

No hospital shall receive disproportionate share hospital payments unless it meets the criteria in this section (a) and other criteria as specified in sections (b) or (c) or (d):

1) The hospital has a Medicaid Inpatient Utilization rate of at least 1%, and

2) The hospital has at least two obstetricians (or in the case of a rural hospital, two physicians) with staff privileges at the hospital who have agreed to provide obstetric services to individuals who are entitled to Medicaid as per section 1923(d)(1) and (2) of the Social Security Act. This requirement does not apply to a hospital which did not offer non-emergency obstetric services to the general population as of December 21, 1987 or to a hospital that predominantly serves individuals under 18 years of age, and

3) The hospital's inpatient facility is physically located within the geographic boundaries of the State of Delaware, and

4) The hospital must agree to comply and cooperate with the DSH audit requirements, and

5) The hospital must submit a timely application with accurate data in accordance with section (f) below unless a waiver is granted by DMMA.

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**Disproportionate Share Hospital (DSH) Payments (cont'd)**

Hospitals that meet the criteria in this section (a) must also meet the criteria identified in either section (b) or (c) or (d) below in order to qualify for the Delaware DSH program.

(b) Additional Federal Criteria

If a hospital meets the criteria specified in section (a) above, the following subparagraphs 1 and 2 describe additional criteria that a hospital must meet to qualify as a disproportionate share hospital unless the hospital qualifies under sections (c) or (d):

1) The hospital's Medicaid inpatient utilization rate is at least one standard deviation above the mean Medicaid inpatient utilization rate for hospitals receiving Medicaid payment in the State; OR

2) The hospital's low income utilization rate exceeds 25%.

(c) Delaware-Specific DSH Criteria for Acute Care General Hospitals

If a hospital meets the criteria specified in section (a) above, a hospital may qualify to receive disproportionate share hospital payments under this section if it meets all of the following criteria:

1) It is a not-for-profit hospital and is categorized under Delaware Medicaid criteria as an acute care general hospital and is not categorized as an Institution for Mental Diseases (IMD), and

2) The hospital has an inpatient facility located within an incorporated city in Delaware with a population greater than 50,000 and provides obstetric services at that facility to the general population including both fee-for-service and managed care Medicaid/CHIP recipients, and

3) During the consecutive twenty four (24) month period immediately prior to the month of issuance of the DSH payment, the hospital has been an enrolled provider with all participating Delaware Medicaid/CHIP managed care organizations and the Delaware Medicaid/CHIP fee-for-service program for all inpatient and outpatient services offered by the hospital, and

4) The hospital's low income utilization rate exceeds 15%.

(d) Delaware Specific DSH Criteria for Psychiatric Hospitals (Institutions of Mental Disease - IMD):



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**Disproportionate Share Hospital (DSH) Payments (cont'd)**

If a hospital meets the criteria specified in section (a) above, a psychiatric hospital (IMD) may qualify as a disproportionate share hospital under this section if it meets all of the following criteria:

1) It must be a public psychiatric hospital (owned or operated by an agency of Delaware State government), and

2) It must serve a disproportionate share of low-income patients. For the purpose of this section (d), the term "disproportionate share" shall be defined as follows: sixty percent (60%) or more of the service revenue is attributable to a combination of the following:

- Public funds
- Bad debts
- Free care

(e) Payments to DSH Qualified Hospitals Under Delaware's Disproportionate Share Program:

1) DSH Payment Limits – All Delaware DSH Qualified Hospitals

A) The state share of payments made to all DSH qualified hospitals cannot exceed the State's maximum annual Delaware Hospital DSH Fund.

Per section 1923(f)(2) of the Social Security Act, an annual maximum Federal DSH allotment is computed for each state each federal fiscal year. Federal DSH funds can only be spent up to the corresponding amount of state matching funds that are available. The amount of federal DSH funds, the amount of state matching funds and the Medicaid federal/state match rate (FMAP) could change every year. Therefore,

each year, the exact amount of the Delaware Hospital DSH Fund cannot be known in advance and will be computed by DMMA each year.

B) The amount of an annual DSH payment to an individual hospital must be the lesser of:

i) the Hospital-Specific DSH limit; or
ii) the amount determined in accordance with sections (e) (2), (e) (3) and (e) (4) below, or
iii) the amount determined in accordance with section (e) (1) (C) below.



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**Disproportionate Share Hospital (DSH) Payments (cont'd)**

C) In the event that the State's annual Delaware Hospital DSH Fund amount is not sufficient to make all of the payments described in sections (e) (2), (e) (3) and (e) (4) below, then payments will be made as follows:

i) from the available funds in the Delaware Hospital DSH Fund, the full amount of DSH payments or the total amount of the Delaware Hospital DSH Fund, whichever is less, will be made first to hospitals that qualify under section (d) above in accordance with section (e) (2) below. If the funds available are not sufficient to make the full payment amount to each hospital qualifying under section (e) (2), then the remaining funds will be allocated proportionately based on each hospital's percentage of the total payments due to all hospitals qualifying under section (e) (2).

ii) from the amount of any funds remaining in the Delaware Hospital DSH Fund after the payments described in section (e) (1) (C) (i) above, the full amount of DSH payments or the total amount remaining in the Delaware Hospital DSH Fund, whichever is less, will be made to hospitals that qualify under section (e) (3) below. If the funds remaining are not sufficient to make the full payment amount to each hospital qualifying under section (e) (3), then the remaining funds will be allocated proportionately based on each hospital's percentage of the total payments due to all hospitals qualifying under section (e) (3).

iii) from the amount of any funds remaining in the Delaware Hospital DSH Fund after the payments described in sections (e) (1) (C) (i) and (ii) above, payments will be made to other hospitals that qualify in accordance with section (e) (4) below. If the funds remaining are not sufficient to make the full payment amount to the other qualifying hospitals, then the remaining funds will be allocated proportionately based on each of the other qualifying hospital's percentage of the total payments due to all other qualifying hospitals in accordance with section (e) (4).

2) DSH Payments to Psychiatric Hospitals:

Per section 19239h)(2)(A) of the Social Security Act, no more than 33 percent of the annual Federal DSH allotment for Delaware will be used with the appropriate amount of State matching funds to make an annual DSH payment to psychiatric hospitals that meet the Delaware DSH Criteria in sections (b) and/or (d) above. These annual DSH payments will be made in a lump sum to each qualifying hospital. Unless the payment amount is restricted by other sections of this DSH policy, a psychiatric hospital that meets the criteria specified in section (b) but not section (d) above will receive a payment in accordance with section (e) (4) (A) or (C) below.



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**Disproportionate Share Hospital (DSH) Payments (cont'd)**

A psychiatric hospital that meets the criteria specified in section (d) above will receive a payment of 33 percent of the annual Federal DSH allotment for Delaware plus the appropriate amount of State matching funds minus the total amount of any payments made to other psychiatric hospitals

3) Payments to Hospitals that Meet the Delaware DSH Criteria in section (c) above

Unless the payment amount is restricted by other sections of this DSH policy, each hospital that meets the criteria specified in section (c) above shall receive an annual payment under Delaware's DSH program equal to the Hospital Specific DSH limit. DSH payments will be made in a lump sum each year.

4) Payments to Hospitals that Meet the Delaware DSH Criteria in section (b) above

Unless the payment amount is restricted by other sections of this DSH policy, each hospital that qualifies under the criteria specified in section (b), but does not meet the criteria specified in sections (c) and (d) above will receive a payment of:

A) $10,000 if the hospital is a psychiatric hospital that does not meet the criteria specified in section (d) above and has been an enrolled provider with all participating Delaware Medicaid/CHIP managed care organizations and the Delaware Medicaid/CHIP fee-for-service program for both inpatient and outpatient services offered by the hospital during the consecutive twenty four (24) month period immediately prior to the month of issuance of the DSH payment, or

B) $1,000,000 if the hospital is not a psychiatric hospital and has been an enrolled provider with all participating Delaware Medicaid/CHIP managed care organizations and the Delaware Medicaid/CHIP fee-for-service program for both inpatient and outpatient services offered by the hospital during the consecutive twenty four (24) month period immediately prior to the month of issuance of the DSH payment; or

C) $5,000 if the hospital has not been an enrolled provider with all Delaware Medicaid/CHIP managed care organizations and the Delaware Medicaid/CHIP fee-for-service program for both inpatient and outpatient services offered by the hospital during the consecutive twenty four (24) month period immediately prior to the month of issuance of the DSH payment.



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**Disproportionate Share Hospital (DSH) Payments (cont'd)**

(f) Application Process:

Each year after June 30, the Medicaid agency will compute the amount of funds available in the Delaware Hospital DSH Fund. After September 30 each year, the Medicaid agency will use the applications timely submitted by the hospitals to compile the data and perform any necessary calculations to determine the DSH payment amounts for each hospital. A hospital cannot qualify under section (b) (1) above unless a completed application is timely received from all hospitals in the state that receive Medicaid payments. The other qualifying criteria are hospital specific.

A hospital requesting Medicaid DSH payments must submit a completed application in a format approved by the Medicaid agency. The application must be received on or before September 30 of each year. The application will provide hospital specific inpatient and outpatient financial and other data for the hospital's fiscal year that ended in the prior calendar year.

On or before December 31 of each year, the Medicaid agency will send a written notice of action taken on each hospital's application. Each hospital that applied will be informed either that it does not qualify or that it qualifies and the amount of the hospital's DSH payment. Once a year, the Medicaid agency will issue the full DSH payment amount in a lump sum to hospitals that qualify for a payment.

In the initial year of the Delaware DSH program, the timing for submissions of applications for a hospital's fiscal year that ended in 2011 and the timing of payments to qualifying hospitals will be announced by the Medicaid agency after this DSH State Plan Amendment is approved.

(g) Audit Requirement:

Within one (1) year after receiving a DSH payment, the Medicaid agency will arrange for an independent audit of each hospital that receives a DSH payment in accordance with section 1923 (j) (2) of the Social Security Act. The auditor will take such steps as determined necessary to verify:

1) the extent to which the hospital reduced uncompensated care costs to reflect the total DSH payment received by the hospital; and

2) that the total amount of the DSH payment received by the hospital did not exceed the hospital-specific DSH payment limit; and

**Disproportionate Share Hospital (DSH) Payments (cont'd)**

3) that only the uncompensated care costs of providing inpatient and outpatient hospital services to Medicaid and uninsured individuals as described in section 1923 (g) (1) (A) of the Social Security Act were included in the calculation of the hospital specific limit; and

4) that the hospital included all Medicaid payments, including supplemental payments, in the calculation of the hospital-specific limits.

The audit must also verify that DMMA has documented and retained a record of costs, claimed expenditures, uninsured costs, payments made on behalf of the uninsured and other pertinent information related to DSH payments.

(h) Disposition of Overpayments or Underpayments:

If the data upon which a DSH payment is based is revised as a result of an audit or for any other reason and if, based on the revised data, it is determined that a hospital was paid more than it should have received according to the rules of the program, the hospital is required to reimburse the state the full amount of the overpayment within 60 days of notification of the overpayment. The Medicaid agency, including the Medicaid managed care companies, are authorized to recoup the full amount of the overpayment by withholding payments due to the hospital with the overpayment from claims being submitted to the program.

If the data upon which a DSH payment is based is revised as a result of an audit or for any other reason and if, based on the revised data, it is determined that a hospital was paid less than it should have received according to the rules of the program, no retroactive adjustments will be made by the Medicaid agency.

**15 DE Reg. 1265 (03/01/12) (Prop.)**