

**Health Care Authority  
Office of Hospital Finance**

**DISPROPORTIONATE SHARE HOSPITAL (DSH)  
DSH Reporting Data File (DRDF process)**

**Disproportionate Share Hospital (DSH) Program Background:**

- Medicaid Disproportionate Share Hospital (DSH): Under the Medicaid DSH program, the federal government provides a grant that allows states to make supplemental Medicaid payments to hospitals that provide uncompensated care to Washington residents.
- Medicare Disproportionate Share Hospital (DSH): Medicare's DSH program operates with similar objectives, offering Medicare payment adjustments to compensate hospitals that treat a greater proportion of low-income persons, who tend to be sicker and more costly to treat than other Medicare patients.

The Medicaid DSH payment amount is calculated by a formula set forth in WAC 182-550-4900 through 182-550-5400 that computes the number of Medicaid patient days divided by total hospital patient days. The Medicare DSH formula set forth in CFR §412.106 is computed by Medicare fiscal intermediaries and involves the calculation of a disproportionate share adjustment factor that is multiplied by the amount of federal DRG payments. The number of Medicaid days is critical to the DSH formula calculation.

**DSH Certification Process:**

Hospitals are required to submit an electronic data file, in a timely manner, to the Washington State Health Care Authority Office of Hospital Finance (HCA/OHF) for certification of Medicaid days. This certification process supports both the Medicaid and Medicare Disproportionate share reimbursement calculation process. Per federal law, HCA calculations are based solely on client eligibility rather than paid claims.

HCA/OHF's process of verifying client eligibility and hospital days for the DSH program utilizes the Medicaid Management Information System (MMIS) Recipient Eligibility File as the official source of client eligibility information. Hospitals submit electronic data files containing client identifying information to HCA. There are numerous client identifiers provided by a hospital and numerous client data combinations are run through an automated process that matches against MMIS eligibility files. The output record consists of the 56-byte input record plus (when a match is found) 24 additional bytes that contain the MMIS original Recipient ID, First Date of Service and Last Date of Service. This output data is returned to the hospitals, who have the opportunity to review and resubmit data for verification if discrepancies are noted. Hospitals may submit data a total of three times. Following the last provider submittal, at the

hospital's request, HCA prepares a final letter that becomes the official certification of DSH patient days for both Medicaid DSH and Medicare DSH.

### **DSH Algorithm and Process Review:**

Since early 2003, HCA/OHF has had numerous requests to rerun DSH certification data for the hospitals to support Medicare DSH payments. Requests for data reruns sometime go back ten years or more, and have at times resulted in calculations that are quite different from the original match results. HCA has had increasing requests for a line-by-line review of these discrepancies. In addition, the Medicare fiscal intermediary has been repeatedly asked to accept supplemental documentation from providers or consultants.

The purpose of this document is to present overall results of an extensive review and analysis of the algorithm and methodology use in the matching process. Documentation submitted by one of Washington's DSH consultants has been reviewed and sample client eligibility has been verified. This document presents findings from that review and supports the conclusion that the process has accurately identified Medicaid eligibility. While actual eligibility counts vary according to the point in time when the data is run, substantive errors in the match process and the methodology have not been discovered.

### **DSH "Medicaid Days" Defined:**

Eligible days for DSH calculations are defined in 42 CFR §412.106. In addition, 42 CFR §412.106(b)(4)(iii) states that "the hospital has the burden of furnishing data adequate to prove eligibility for each Medicaid patient day claimed under this paragraph, and of verifying with the State that a patient was eligible for Medicaid during each claimed patient hospital day." Thus, the State is responsible for eligibility determination and reporting; this provision may be interpreted to mean that days not included in the HCA DSH Certification letter cannot be included, regardless of whether or not the hospital provider believes that supplemental documentation supports the addition of client days. HCFA Ruling 97-2 concluded that days of patient eligibility that cannot be verified by State records to have fallen within a period wherein the patient was eligible for Medicaid cannot be counted.

The term "Medicaid days" is defined as days on which a client is *eligible* for medical assistance benefits under an approved Title XIX program, whether or not the hospital received payment for those inpatient hospital services. Following the verification of Title XIX eligibility, HCA determines whether any of the days are dual entitlement days and, to the extent that they are, subtracts them from the other days in the calculation. The DSH calculation excludes clients eligible for State-only programs.

### **Overall Analysis Findings:**

- *Provider Data Submission:* It should be noted that hospitals often experience difficulty in the submission of data files for the DSH Reporting Data File (DRDF) match process. While

HCA makes every effort to assist hospitals in the accurate verification of data, data submitted with errors in the client identifying information or in an incorrect format will not result in a match for Title XIX eligibility. Regardless of any changes to the existing process, reliable matches will only occur to the extent that providers send accurate data in the requested format and in a timely manner.

- *Purging of Recipient Eligibility File:* Recipient eligibility files can be purged in the MMIS either online or through the monthly process that purges any recipient with an eligibility segment end date over three years old. This purging process accounts for many of the differences in data re-submitted for certification after a period of several years. HCA's analysis verified that the primary reason for the difference in counts between provider submissions was eligibility change or inactivity.
- *Medicare eligibility:* Medicare eligibility is carried in the MMIS and can be determined by the combination of Program, Match, and Medical Code. Clients meeting certain eligibility requirements are recorded as eligible for that program, with Medicare eligibility also noted. Medicare eligibility is entered at the time a client applies for Medicaid benefits. Continuous Medicare eligibility data matches also identify a client in the MMIS as Medicare eligible.

Under Medicare cost sharing programs, HCA may pay the Medicare premium for certain aged, blind and disabled clients. These eligibility categories are also carried in the Recipient Eligibility File in the MMIS.

- *Qualified Medicare Beneficiary (QMB):* A client must be entitled to Medicare Part A. Under certain income limits, HCA pays for Medicare Part B premiums, deductibles and co-payments;
  - *Special Low-Income Medicare Beneficiary (SLMB):* A client must have applied for or be enrolled in Medicare Part A. Under certain income limits, HCA pays the client's Medicare Part B premium only;
  - *Qualified Individual (QI):* A client must have applied for or be enrolled in Medicare Part A and not be eligible for any other Medicaid coverage. Under certain income limits, clients receive assistance with the cost of their Medicare premium;
  - *Qualified Disabled Working Individual(QDWI):* A client must have applied for or be enrolled in Medicare Part A as a working disabled person who has exhausted Premium-free Part A and whose SSA disability benefits ended because the clients earnings exceeded SSA's gainful activity limits. HCA pays the client's Medicare Part A premium only.
- *Remittance Advice as Documentation of DSH days:* According to governing rules cited above, DSH payments are based on client eligibility regardless of whether or not the hospital received payment for those inpatient hospital services. When claim payment is made, the state sends a Remittance Advice with payment that details the claims/client accounts for which payment has been made. HCA/OHF asserts that a Remittance Advice does not constitute evidence to validate Medicaid eligibility.

Providers have requested that Remittance Advice documentation be considered a valid source of Title XIX eligibility. HCA's analysis sampled twelve (12) Remittance Advices submitted for that purpose, and found that 7 of 12 sample claims had been reversed/recouped following payment, 2 of the 12 were paid for clients eligible under State-Funded Children Undocumented and thus not counted as Title XIX eligible, 1 was for a client whose eligibility ended prior to the hospital stay (claim was paid and not recouped, but eligible days were not counted), the remaining 2 of the 12 appear to have been Title XIX eligible and would have been verified if the data was submitted in proper format. In those instances, an error in the data submission from the provider resulted in the absence of the client eligibility match.

One of the primary reasons for ICN reversal is related to Third Party Insurance and/or Medicare recoupment activity. While the MMIS contains eligibility information regarding primary insurance, that information may not be known at the time of claim submission. HCA's immediate knowledge of primary insurance and issues such as retroactive Medicare eligibility leaves HCA with responsibility for identification, research and recovery of funds where Medicare or any third party insurer is liable for payment.

- *Claims for Newborns:* Newborns are automatically eligible for Categorically Needy coverage for 12 months if their mother was eligible at the time of the child's birth (no income limits apply). Claims for newborns can be billed in one of two ways; 1) newborns are often billed on the mother's Provider One # or 2) once a baby has his/her own Provider One #, a claim may be billed using the baby's Provider One #. Billed in either way, the days would be accurately counted in the DSH DRDF matching process if the data is submitted in the proper format.
- *Accuracy of Healthy Options Counts:* Providers have questioned accounts asserted to be paid by Healthy Options Plans, but which failed to be counted as Title XIX days. While OHF/HCA cannot confirm or refute payment by a HO plan, client eligibility records were reviewed and failed to identify any of the clients as Title XIX/HO eligible during the time span in question.
- *Complete Count of Patient Days:* HCA reviewed a sample of claims for which providers questioned the counting of only a portion of the inpatient hospital days. HCA noted instances where eligibility categories changed over the course of the hospital stay, resulting in some days being counted as Title XIX eligible days, while some were State Only program days. In one instance, the hospital stay spanned a time period outside of the fiscal period review, resulting in some days not being counted.
- *Out-of-State Clients:* Provider requests for review often cites Out of State Medicaid payments as eligible for inclusion in the DSH day count. Since the MMIS contains no record of out-of-state Medicaid clients, HCA/OHF is unable to verify or respond to that request.
- *Count of MI/GAU Hospital as Title XIX days:* HCA's review included an analysis of the identification of Medically Indigent (MI) and General Assistance (GAU) clients. HCA has

been asked whether or not inpatient hospital days for these clients should be included in Title XIX eligible day counts. An \* on a Remittance Advice identifies a MI/GAU client. While some federal matching funds were at one time provided to states for MI/GAU client hospital services, these funds came in the form of a grant for uncompensated care, but did not make a client Title XIX eligible. MI/GAU clients are not included in the count of Title XIX eligible days, except during the time frame January 1, 2011 through December 31, 2013.

### **Conclusion:**

It should be understood that the DRDF match process and methodology results in a count at a particular point in time. Title XIX eligibility changes occur frequently and individual records are sometimes difficult to reconstruct over time. When HCA is asked to rerun DSH Certification data after extended periods of time, records will not match the original run due to eligibility files being updated or purged.

The accuracy of the process has been evaluated using a variety of criteria noted above, and numerous questions regarding the accuracy of the data have been researched and answered. The results of HCA's analysis consistently show that HCA's process and methodology are materially accurate. HCA review has found no substantive errors in either the match process or the methodology for counting Medicaid eligible days and has concluded that the results should be considered valid.

HCA is committed to continuous analysis and process improvement where appropriate. In keeping with that commitment, the DSH Process will be examined for ongoing opportunities to simplify processes and increase efficiencies.



