Medicaid Disproportionate Share Hospital (DSH) Program
For Hospital Fiscal Year Ending in 2022
Information and Instructions for Completing the DMMA DSH Application (DMMA Form DSH 1)
November 2023

The Division of Medicaid and Medical Assistance (DMMA) is announcing the process and schedule for applying for a Disproportionate Share Hospital (DSH) payment, based on data for the hospital's fiscal year ending in calendar year 2022.

DSH Background

Federal regulations allow state Medicaid programs to make payments to hospitals that serve a disproportionate share of Medicaid and uninsured patients. The federal regulations specify certain qualifying criteria and, in addition, permit the establishment of state specific criteria. Limited Federal Medicaid funds are available to each state for this purpose and can only be utilized to the extent that state matching funds are available. To qualify, a hospital must submit a timely application to DMMA, provide the required information, and be determined by DMMA to meet the requirements of the DSH program.

Applying for a Medicaid DSH payment is optional and does not affect the hospital's participation in any other aspect of the Medicaid program.

DSH Application Due Dates

An acute care Delaware hospital wishing to apply for a Medicaid DSH payment for the hospital fiscal year ending in calendar year 2022 must submit an application (DMMA Form DSH 1) that is received by DMMA by 4:30 p.m. Eastern time on February 2, 2024. For psychiatric hospitals / institutes for mental disease (IMDs), the deadline is March 29, 2024, by 4:30 p.m. Eastern time.

DSH Payment Timeframe

DMMA expects to issue DSH payments to all qualifying hospitals on or before June 30, 2024.

DSH Payment and Audit Requirements

By receiving a DSH payment, a hospital agrees to comply and cooperate with all requirements of an independent audit. This audit will certify that information submitted by the hospital's organization on Form DSH 1 is accurate and will require the hospital to provide supporting documentation related to the fiscal year reflected in the application. To that end, the hospital also agrees to reimburse the state in the event the audit finds that inaccurate information provided by the hospital resulted in a higher DSH payment than should have been made.

A hospital will be required to demonstrate their meeting verifications required by *the Code of Federal Regulations (42 CFR, Parts 447 and 455) and the State of Delaware's Medicaid State Plan Section under 4.19A* (the "Requirements") for receiving a DSH payment, as follows:

1. If applicable, recipient facilities must have at least two obstetricians who have staff privileges at the facility and who have agreed to provide obstetric services to individuals who are entitled to medical assistance for such services under such State plan. In addition, a facility that is an Institute for Mental Disease must have a Medicaid inpatient utilization rate (as defined under Social Security Act Section 1923(b)) of not less than 1 percent.

2. The Disproportionate Share Hospital ("DSH") payments made to the facilities must comply with the hospital-specific DSH payment limit. Only uncompensated care costs of furnishing inpatient and outpatient hospital services to Medicaid eligible individuals, less the amount paid by the State under the non-disproportionate share hospital payment provisions of the State Plan, and individuals with no third party coverage, less the amount of payments made by these patients, may be included in the calculation of the hospital-specific disproportionate share payment limit, as described in Section 1923(g)(1)(A) of the Social Security Act.

3. For purposes of the hospital-specific limit calculation, any Medicaid payments (including regular Medicaid fee-for-service rate payments, supplemental/enhanced Medicaid payments, and Medicaid managed care organization payments) received by the facilities for furnishing inpatient hospital and outpatient hospital services to Medicaid eligible individuals, which are in excess of the Medicaid incurred costs for such services, must be applied against the uncompensated care costs ("UCC") of furnishing inpatient hospital and outpatient hospital services to individuals with no source of third party coverage for such services.

4. Any information and records for inpatient and outpatient hospital specific costs under the Medicaid program must be separately documented and maintained; this includes but is not limited to claimed expenditures under the Medicaid program, uninsured inpatient and outpatient hospital service costs in determining payment adjustments, and any payments made on behalf of the uninsured from payment adjustments.

5. The estimate of the hospital-specific DSH limit must be calculated in accordance with Section 1923(d)(5) of the Social Security Act.

If an acute care hospital qualifies for a DSH payment based on the DSH 1 report submitted with 2022 fiscal year data, DMMA expects to audit those hospital reports on or before June 30, 2025.

A. General Instructions - DMMA Form DSH 1:

1. In completing Form DSH 1, note that there are 3 tabs in the Excel document. Complete all three tabs.

2. The data requested on this report is for the hospital's fiscal year that ended in calendar year 2022.

   For questions about these instructions for Form DSH 1, contact Joshua Aidala at 302-255-9552 or via e-mail: Joshua.Aidala@delaware.gov

3. The completed Form DSH 1 (including all three (3) tabs in the Excel workbook) must be returned via US mail, other delivery service, or hand delivered to:

   Division of Medicaid and Medical Assistance
   P O Box 906
   DHSS Holloway Campus – Lewis Building
   1901 N DuPont Hwy
   New Castle, DE 19720

   Attention: Mr. Joshua Aidala

   and

   Form DSH 1 must also be submitted electronically via e-mail as an Excel or PDF document to:

   Joshua.Aidala@delaware.gov

4. If the hospital offers inpatient hospital services at more than one geographical location and submits a consolidated Medicare cost report, the hospital must submit a single DMMA Form DSH 1 report. Otherwise, submit a separate DMMA Form DSH 1 for each inpatient hospital location.

5. Complete each line of the report only with the information requested for that line. For example, if inpatient information is requested, only provide inpatient information not combined inpatient and outpatient data. If charges are requested, only provide charges, not revenue (i.e., payment) or cost data. If the specific information is not available for a particular line on the report, then leave that line blank.

6. If a hospital is not able to provide the requested information for each line on the report, it may still be to the advantage of the hospital to complete as much information as possible and submit a timely report. Leave blank any information that the hospital does not have and provide the information that is available.

7. Do not enter the number 0 (zero) if data is unavailable for a particular line. Leave the line blank or enter "unknown" or "not available".

B. Line by Line Instructions – DMMA Form DSH 1:

Line #	Instructions
	Hospital Fiscal Year -- enter the fiscal year that this report pertains to.
	For Profit or Not for Profit or State Government -- delete the ones that do not apply.
	IMD or Acute Care or Other – delete the ones that do not apply.
1.	**Only Answer This Question If This Is A State Gov't Owned IMD Hospital.** During the fiscal year, did 60% or more of service revenue come from Public Funds? Answer "Yes" or "No".
2.	If the hospital offers **inpatient services** at more than one geographic location, answer "Yes" or else answer "No" (two or more buildings on the same campus is one geographic location)
3.	If the answer to #2 above is "No", answer "NA" (Not Applicable) to this question. If the answer to #2 above is "Yes", and if the hospital files a consolidated Medicare cost report, answer "Yes" to this question. Otherwise answer "No" to this question (and file a separate report for each inpatient facility).
4.	If the hospital's inpatient population is predominately individuals under age 18 year of age, answer "NA". Otherwise, answer "yes" or "no" if the hospital offers obstetric services to the general public.
5.	If the answer to #4 is "No" or "NA", answer "NA" to this question. Otherwise, answer "yes" or "no" if the hospital has at least two (2) obstetricians (or two physicians in the case of a rural hospital) with staff privileges who have agreed to provide obstetric services to individuals who are entitled to Medicaid. Note: if the answer on line #4 is "yes" and the answer on line #5 is "no", the hospital cannot qualify for DSH payments according to Federal regulations.
6.	If you answer "No" or "NA" to questions #3 or #4 or #5, leave this question blank. Otherwise, give the address of the inpatient facility(s) that provide full obstetrical care to the general public including Medicaid recipients.
7.	For certain hospitals, in order to qualify for DSH, the hospital must be continuously enrolled as a Medicaid provider for the 24-month period ending in the month that the DSH payments are expected to be made. This includes enrollment with the Medicaid fee-for-service program as well as with all Medicaid managed care organizations.
8.	Enter the number of total annual **inpatient** bed days for the hospital's fiscal year. This includes all Medicaid and non-Medicaid patients.
9.	Enter the number of total annual **inpatient** bed days for person's who were eligible for Medicaid during the hospital's fiscal year. This includes Medicaid individuals covered by the DMMA fee-for-service program as well as persons covered by the DMMA managed care program.
10.	Enter the total annual dollar amount of all **inpatient** hospital charges during the hospital's fiscal year.
11.	Enter the total annual dollar amount of all **inpatient** hospital **charity care** charges during the hospital's fiscal year.
12.	Enter the total annual dollar amount of the **cost** of **inpatient and outpatient** services for **Medicaid** patients including fee-for-service and those enrolled in managed care. Note: cost should be based on a ratio of cost to charges that covers all applicable hospital costs and charges relating to inpatient and outpatient care and does not distinguish among payer types such as Medicare, Medicaid, other insurers or private pay. This number should be copied from the DSH Supplement Form tab in the Excel workbook.
13.	Enter the total annual dollar amount of the **cost** of **inpatient and outpatient** services for

	uninsured patients. Note: cost should be based on a ratio of cost to charges that covers all applicable hospital costs and charges relating to inpatient and outpatient care and does not distinguish among payer types such as Medicare, Medicaid, other insurers, or private pay. This number should be copied from the DSH Supplement Form tab in the Excel workbook.
14.	Enter the total annual dollar amount of all **revenue (i.e., payments received**) for all **inpatient and outpatient** services during the hospital's fiscal year.
15.	Enter the total annual dollar amount of all **revenue (i.e., payments received)** for all **Medicaid** fee-for-service **inpatient and outpatient** services during the hospital's fiscal year.
16.	Enter the total annual dollar amount of all **revenue (i.e., payments received)** for all **Medicaid** patients enrolled in managed care **inpatient and outpatient** services during the hospital's fiscal year.
17.	Add the Medicaid revenue amounts on lines 15 and 16. This number should be copied from the DSH Supplement Form tab in the Excel workbook.
18.	Enter the Total Annual Federal Section 1011 Payments received by the hospital for eligible aliens (should also be included in the amount on line 14). This number should be copied from the DSH Supplement Form tab in the Excel workbook.
19.	Enter the total annual **inpatient and outpatient revenue/payments** received by the hospital during the year being reported by or on behalf of **uninsured** persons (should also be included in the amount on line 14). This number should be copied from the DSH Supplement Form tab in the Excel workbook.
20.	The amount on line 12 (**cost** of **inpatient and outpatient services for Medicaid)** minus the amount on line 17 (total **revenue** for **Medicaid inpatient and outpatient services**). This may be a negative number. This number should be copied from the DSH Supplement Form tab in the Excel workbook.
21.	From the amount on line 13 (**cost** of **inpatient and outpatient services for the uninsured)**, subtract the amounts on lines 18 and 19. This number should be copied from the DSH Supplement Form tab in the Excel workbook.
22.	Add the amounts from line 20 and line 21. This number should be copied from the DSH Supplement Form tab in the Excel workbook.
23.	Signature – the Form DSH 1 should be signed by the person completing the form. If the form is submitted electronically, the signature page can be scanned and submitted as a PDF file.

Definitions:

Term	Definitions for Form DMMA DSH 1
Cost	Cost should be based on a ratio of cost to charges that covers all applicable hospital costs and charges relating to inpatient and outpatient care for the year being reported and does not distinguish among payer types such as Medicare, Medicaid, other insurers or private pay. Costs (and charges) cannot include physician services provided to the uninsured. Perform the calculation on the DSH Supplement Form.
Inmates of public institutions for which Medicaid funds are not available	Means outpatient services provided to prisoners (inpatient services provided to prisoners are eligible for Medicaid funding) and persons in IMDs whose cost of care is not Medicaid reimbursable.

Inpatient hospital Charity Care Charges	The total amount of hospital charges for inpatient services attributable to charity care. These charges do not include bad debt charges, contractual allowances, or discounts given to legally liable third-party payers.
Revenue	Means payment received from any source.
Uninsured	Means a person who has no source of third-party coverage.