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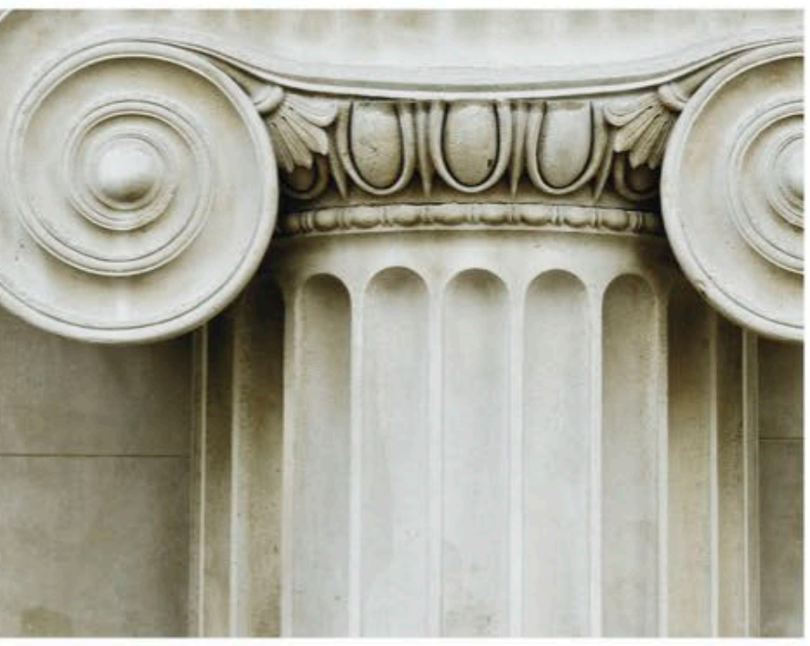
DISPROPORTIONATE SHARE HOSPITAL (DSH) 2026 PAYMENT LIMIT CALCULATION/2022 EXAMINATION UPDATE

DEDICATED TO GOVERNMENT HEALTH PROGRAMS



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OVERVIEW

- DHS Communications
- DSH Examination Policy
- DSH Payment Limit Calculation Overview
- DSH Examination/Payment Limit Timeline
- Paid Claims Data Review
- Review of DSH Surveys and Exhibits
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- Recap of Prior Year Procedures (2021)
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DHS COMMUNICATIONS

- DSH Recoupment Process
- DSH Waiver Process Clarification
- SFY25 DSH Q3 and Q4 Payments
- SFY25 DSH Calculation Report

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RELEVANT DSH POLICY

- DSH Implemented under Section 1923 of the Social Security Act (42 U.S. Code, Section 1396r-4)
- Audit/Reporting implemented in FR Vol. 73, No. 245, Friday, Dec. 19, 2008, Final Rule
  - Medicaid Reporting Requirements
    42 CFR 447.299 (c)
  - Independent Certified Audit of State DSH Payment Adjustments
    42 CFR 455.300 Purpose
    42 CFR 455.301 Definitions
    42 CFR 455.304 Conditions for FFP
- February, 2010 CMS FAQ titled, "*Additional Information on the DSH Reporting and Audit Requirements*"

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RELEVANT DSH POLICY (CONT.)

- Allotment Reductions and Additional Reporting Requirements implemented in FR Vol. 78, No. 181, September 18, 2013, Final Rule
- CMCS Informational Bulletin Dated December 27, 2013 delaying implementation of Medicaid DSH Allotment reductions 2 years.
- April 1, 2014 – P.L. 113-93 (Protecting Access to Medicare Act) delays implementation of Medicaid DSH Allotment reductions 1 additional year.
- *Additional Information of the DSH Reporting and Audit Requirements – Part 2*, clarification published April 7, 2014.
- Audit/Reporting implemented in FR Vol. 79, No. 232, Wednesday, Dec. 03, 2014, Final Rule

RELEVANT DSH POLICY (CONT.)

- "Medicare Access and CHIP Reauthorization Act" - Public Law, April 16, 2015, Sec. 412 Delay of Reduction to Medicaid DSH Allotments; delayed DSH reductions until FY 2018
- State DSH Hospital Allotment Reductions, July 28, 2017 FR Vol. 82, No. 144, Proposed Rule
- Bi-partisan Budget Act of 2018, enacted on February 9, 2018 delayed DSH reductions until FY 2020
- CARES Act§3813 delayed until December 1, 2020
- Consolidated Appropriations Act for 2021 delayed DSH reductions until FY 2024 and then amended to FY 2025
- Medicaid DSH Third Party Payor Rule resulting from the Consolidated Appropriations Act (CAA) in FR Vol. 89, No. 37, Friday, Feb. 23, 2024, Final Rule

DSH YEAR 2022 EXAMINATION IMPACT

- **Per 42 CFR 455.304,** findings of state reports and audits for Medicaid state plan years 2005-2010 will not be given weight except to the extent that the findings draw into question the reasonableness of the state's uncompensated care cost estimates used for calculating prospective DSH payments for Medicaid state plan year 2011 and thereafter.
- The current DSH year 2022 examination report is a recoupment year.

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DSH PAYMENT LIMIT CALCULATION OVERVIEW

- Purpose
- Waiver Process
- Documentation Requirements
  - Schedule of Information and Records of Data Needed for DSH Examination

SCHEDULE OF INFORMATION AND RECORDS OF DATA NEEDED FOR DSH EXAMINATION

- The form will be used to identify the documentation that will need to be retained and submitted for the DSH audit.
- Listed documentation is not only required but may also be beneficial to the hospital/state.
- This applies to all hospitals that receive a DSH payment.
- The form will be sent out by DHS and will need to be signed and returned to DHS by May 30, 2025.

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Schedule of Information and Records of Data Needed for DSH Examination

The following is the list of data items that need to be retained for the annual DSH examination.

For Medicaid State Plan (MSP) Year 2026 (July 1, 2025 - June 30, 2026):

1 If the hospital provided non-emergency obstetric services, names of two obstetricians with staff privileges and their Unique Physician Identification Number (UPIN) numbers. If the hospital is classified as a rural hospital, two names and UPIN numbers of physicians of any specialty may be provided as long as the physician has staff privileges.

2 Documentation on Supplemental/Enhanced Medicaid payments made by the state. (Supplemental/Enhanced Medicaid payments include Upper Payment Limit payments, cost report settlements (tentative and /or final), additional payments for graduate medical education, and all Medicaid additional payments made for inpatient and outpatient services covered by DSH.)

3 Documentation on Supplemental/Enhanced Medicaid payments and DSH Payments that are received from Medicaid managed care organizations. (Supplemental/Enhanced Medicaid payments include Upper Payment Limit payments, cost report settlements (tentative and/or final), additional payments for graduate medical education, and all Medicaid additional payments made for inpatient and outpatient services covered by DSH.)

4 Documentation on Supplemental/Enhanced Medicaid payments and DSH Payments that are received from Out-of-State Medicaid Agencies. (Supplemental/Enhanced Medicaid payments include Upper Payment Limit payments, cost report settlements (tentative and /or final), additional payments for graduate medical education, and all additional Medicaid payments made for inpatient and outpatient services covered by DSH.)

5 Documentation on non-claims based Payments that are received from Medicare. These payments can include: Medicare cost report settlements, bad debt reimbursement payments, Direct GME Payments, IME payments, Medicare DSH adjustments, inpatient capital payments, organ acquisition payments, intern and resident payments, pass-through cost payments, and transitional corridor payments.

6 Documentation from your records detailing payment of intergovernmental transfers, if applicable.

7 Documentation from your records detailing the recording of payments received for all DSH payments received from the State.

8 Documentation supporting any out-of-state DSH payments received (i.e., remittances, detailed general ledgers, or add-on rates).

For each cost report period that overlaps Medicaid State Plan (MSP) Year 2026 (July 1, 2025 - June 30, 2026):

9 Uninsured: Detail listings of inpatient and outpatient charges by uninsured patient. Uninsured patient is a patient without creditable coverage as defined in 45 CFR 146.113. http://edocket.access.gpo.gov/cfr_2007/octqtr/pdf/45cfr146.113.pdf
Please note - CMS issued a final rule in the December 3, 2014 Federal Register that allows for hospitals to report 'exhausted' or 'insurance non-covered' services as uninsured, as long as they are a Medicaid covered hospital service.
Include a description of the logic used to compile this listing (for example, financial classes or payor codes included or excluded).
Upon receipt of this information, a random sample of claims may be selected for further testing. Therefore, we may request further documentation regarding these claims.

10 Detail listing of self-pay payments (for all payor types) received during the fiscal year(s) under review, regardless of date of service. Include a description of the logic used to compile the listing. The listing is to include the following details:

* Account Number
* Patient Name
* Financial Class
* Payment Date
* Payment Amount
* Date of Admit
* Date of Discharge

11 Documentation related to inpatient and outpatient services from Medicaid managed care organizations which can either be:

*
A detailed log by revenue code for each patient with charges, days and payments (include a description of the logic used to compile the log) or
* Reports from the various Medicaid managed care organizations detailing days, charges by revenue code, and payments (e.g. PS&Rs or remittance advice summaries).

12 Documentation related to inpatient and outpatient services from Out-of-State Medicaid State Agencies which can either be:

*
A detailed log by revenue code for each patient with charges, days and payments (include a description of the logic used to compile the log) or
* Reports from the various Medicaid State Agencies detailing days, charges by revenue code, and payments (e.g. PS&Rs or remittance advice summaries).

13
A detailed patient specific log of all dual eligible individuals (Medicare and Medicaid Eligible) that were seen as inpatients or outpatients, which includes days, charges by revenue code and total payments made by Medicare and/or Medicaid. Include a description of the logic used to compile the log.

14 Documentation related to inpatient and outpatient services for any other Medicaid eligible (but not billed to Medicaid or included in #8 through 12 above) patients. Documentation should be a detailed log by revenue code for each patient with days, charges and payments. Include a description of the logic used to compile the log.

15 If applicable, listing of Federal Section 1011 payments (federal payments for treatment of eligible undocumented aliens) detailing payments received during the year(s) under review. Documentation should be detailed by patient with account numbers.

16 A detailed working trial balance used to prepare each cost report (including revenues).

17 Audited (if Available) Financial Statements. Consolidated Financial Statements are acceptable if separated financial statements for the hospital under review are included.

18 Revenue code crosswalk used to prepare the cost report.

19 If the hospital is a transplant facility provide all transplants (Medicaid, uninsured, Medicare, and others) by organ, and note if reimbursed through Medicaid Fee for Service (FFS), Medicaid Managed Care, out of state, uninsured, etc.

20 Payer Code Listing (Listing of payer code mnemonics used in the facility system).

21 A detailed revenue working trial balance by payor / contract. The schedule should show charges, contractual adjustments, and revenues by payor plan and contract (e.g., Medicare, each Medicaid agency payor, each Medicaid Managed Care contract).

22 The audited electronic cost report from Medicare. If you do not have the electronic version, then a scanned copy along with the adjustment report from Medicare and a copy of the NPR letter that accompanies the audited cost report. If you do not have audited cost reports, then please provide the ECR files that were provided to Medicare.

The following information should be retained for items 9 and 11 - 14:

* Claim Type
* Primary Payer
* Secondary Payer
* Medicaid Provider #
* Account Number
* Medical Record Number
* Patient Identification Number
* Patient Name
* Admit Date
* Discharge Date
* Service Indicator (IP/OP)
* Revenue Code
* Hospital Charges
* Professional Charges
* Routine Days
* Primary Payer Payments
* Secondary Payer Payments
* Patient Payments

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To:
State of Wisconsin
Department of Health Services
Division of Medicaid Services

I certify that I have read the Schedule of Information and Records of Data Needed for DSH Examination:

Receipt and acceptance of DSH funds ("Big" / "Little" DSH), regardless of funding pools or size of payment, will require a hospital to participate in the Independent Audit Process.

I acknowledge that all information listed in the Schedule of Information and Records of Data Needed will be retained and available for the DSH Examination performed for SFY ending June 30, 2026.

Signature	Date	Phone Number
Print Name	Title or Position	E-mail Address
Facility Name		

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DSH YEAR EXAMINATION/PAYMENT LIMIT TIMELINE

- Survey files, supplemental/enhanced payments, and templates were uploaded to the web portal on November 4, 2024.
- State FFS, HMO, Crossover, and Medicaid Secondary MMIS data were uploaded to the web portal on February 12, 2025.
- Complete 2026 payment limit calculation surveys and patient level detail due by April 4, 2025.
- We are already in possession of the 2022 examination surveys provided in the prior year for the 2025 payment limit calculation.
- Draft 2022 examination report to the state by July 31, 2025.
- Final examination report and 2026 payment limit deliverable to the state by September 30, 2025.

Hospital A Timeline Example

Hospital's Cost Report Year End is 6/30

During…	Hospital Submits Data for Examination or Payment Limit:	Using Cost Report Period:	Myers and Stauffer Uses the Submitted Data in DSH Payment Limit Calculation for SFY:	Myers and Stauffer Conducts DSH Examination on Hospital's Cost Report Year Data:
CY 2022	Examination	6/30/2019	N/A*	6/30/2019
CY 2023	Examination	6/30/2020	N/A*	6/30/2020
CY 2023	Payment Limit	6/30/2021	6/30/2024	N/A
CY 2024	**Payment Limit**	**6/30/2022**	**6/30/2025**	**6/30/2021****
CY 2025	Payment Limit	6/30/2023	6/30/2026	6/30/2022**
CY 2026	Payment Limit	6/30/2024	6/30/2027	6/30/2023**

*Note: DHS calculated DSH payment limits for these SFYs, therefore Myers and Stauffer will still request DSH examination data for these cost report periods.

**Note: Myers and Stauffer will use cost report period data submitted for DSH Payment Limit for DSH examination review. Additional information may be requested for DSH examinations if:

1) Your hospital has not submitted DSH payment data to Myers and Stauffer for the cost report period(s) overlapping the SFY;
2) Your hospital submitted data for the DSH payment to Myers and Stauffer, but the data did not meet DSH examination requirements (example - patient detail was not submitted in Exhibit A - C format); or
3) Your hospital submitted data for the DSH payment to Myers and Stauffer, but upon review, additional information is needed in order for DSH examination procedures to be sufficiently completed.

Hospital B Timeline Example

Hospital's Cost Report Year End is 12/31

During…	Hospital Submits Data for Examination and/or Payment Limit	Using Cost Report Period:	Myers and Stauffer Uses the Submitted Data in DSH Payment Limit Calculation for SFY:	Myers and Stauffer Conducts DSH Examination on Hospital's Cost Report Year Data:
CY 2022	Examination	12/31/2019*	N/A**	6/30/2019
CY 2023	Examination	12/31/2020	N/A**	6/30/2020
CY 2023	Payment Limit	12/31/2021	6/30/2024	N/A
CY 2024	**Payment Limit**	**12/31/2022**	**6/30/2025**	**6/30/2021*** **
CY 2025	Payment Limit	12/31/2023	6/30/2027	6/30/2022***
CY 2026	Payment Limit	12/31/2024	6/30/2028	6/30/2023***

*Note: Assumes hospital participated in prior year examination and MSLC is already in receipt of cost report information for period ending 12/31/2019.
**Note: DHS calculated DSH payment limits for these SFYs, therefore Myers and Stauffer will still request DSH examination data for these cost report periods.
***Note: Myers and Stauffer will use cost report period data submitted for DSH Payment Limit for DSH examination review. Additional information may be requested for DSH examinations if:

1) Your hospital has not submitted DSH payment data to Myers and Stauffer for the cost report period(s) overlapping the SFY;
2) Your hospital submitted data for the DSH payment to Myers and Stauffer, but the data did not meet DSH examination requirements (example - patient detail was not submitted in Exhibit A - C format); or
3) Your hospital submitted data for the DSH payment to Myers and Stauffer, but upon review, additional information is needed in order for DSH examination procedures to be sufficiently completed.

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PAID CLAIMS DATA UPDATE

- Medicaid fee-for-service primary paid claims data
  - Uploaded to web portal.
  - Reported based on cost report year (using discharge date).
  - Same format as last year.
  - At revenue code level (including days).
  - Detailed data is available upon request.
  - Will exclude non-Title 19 services (such as CHIP).

PAID CLAIMS DATA UPDATE

- Medicaid managed care (HMO) primary paid claims data
  - Uploaded to web portal.
  - Reported based on cost report year (using discharge date).
  - At revenue code level (including days).
  - Detailed data is available upon request.

PAID CLAIMS DATA UPDATE

- Medicare/Medicaid crossover paid claims data
  - Uploaded to web portal.
  - Reported based on cost report year (using discharge date).
  - Same format as last year.
  - At revenue code level (including days).
  - Detailed data is available upon request.
  - Hospital is responsible for ensuring all Medicare payments are included in the final survey even if the payments are not reflected on the state's paid claim totals.

PAID CLAIMS DATA UPDATE

- Medicaid secondary paid claims data
  - Identifies Medicaid claims with TPL payments (dual-eligible) members.
  - Uploaded to web portal.
  - Reported based on cost report year (using discharge date).
  - At revenue code level (including days).
  - Detailed data is available upon request.

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Charges/payments for non-covered Medicaid services

State-Only charges and payments

Total payments to transfer to survey

Non-Crossovers IP								
Hospital ABC								
123456789								
	CR Period 1							
Period	1/1/2016							12/31/2016
Claims								200
	Paid Days	State Only Days	N/C Rev Days	Allowed Days	Total	Non-Covered	State-Only	Allowed
Days	1,500	50	-	1,450				
Charges					$ 900,000.00	$ 10,000.00	$ 5,000.00	$ 885,000.00
Medicaid FFS Paid					$ 100,000.00	$ -	$ 1,000.00	$ 99,000.00
Medicaid HMO Paid					$ -	$ -	$ -	$ -
Medicare Paid					$ -	$ -	$ -	$ -
Coins					$ -	$ -	$ -	$ -
TPL					$ -	$ -	$ -	$ -
CoPay					$ 100.00	$ -	$ -	$ 100.00
SpendDown					$ -	$ -	$ -	$ -
Deductible					$ -	$ -	$ -	$ -

Days summarized by revenue code

Revenue Code	Paid Days	State Only Days	N/C Rev Days	Allowed Days	Charges	Non-Covered Charges	State-Only Charges	Allowed Charges
109	-	-	-	-	$ -	$ -	$ -	$ -
110	-	-	-	-	$ -	$ -	$ -	$ -
111	40	1	-	39	$ 60,000.00	$ -	$ 1,000.00	$ 59,000.00
112	10	-	-	10	$ 20,000.00	$ -	$ -	$ 20,000.00
113	-	-	-	-	$ -	$ -	$ -	$ -
114	-	-	-	-	$ -	$ -	$ -	$ -
115	-	-	-	-	$ -	$ -	$ -	$ -
116	-	-	-	-	$ -	$ -	$ -	$ -
117	-	-	-	-	$ -	$ -	$ -	$ -
118	-	-	-	-	$ -	$ -	$ -	$ -
119	-	-	-	-	$ -	$ -	$ -	$ -
120	-	-	-	-	$ -	$ -	$ -	$ -
121	-	-	-	-	$ -	$ -	$ -	$ -
122	-	-	-	-	$ -	$ -	$ -	$ -
123	-	-	-	-	$ -	$ -	$ -	$ -
124	95	-	-	95	$ 180,000.00	$ -	$ -	$ 180,000.00
125	-	-	-	-	$ -	$ -	$ -	$ -

Charges summarized by revenue code

PAID CLAIMS DATA UPDATE

- "Other" Medicaid Eligibles
  - **Definition:** Medicaid-eligible patient services where Medicaid did not receive the claim or have any cost-sharing and, as a result, may not be included in the state's data.
  - The hospital must submit these eligible services on Exhibit C for them to be eligible for inclusion in the DSH uncompensated care cost (UCC).
  - Must EXCLUDE CHIP and other non-Title 19 services.
  - Should be reported based on cost report year (using discharge date).

PAID CLAIMS DATA UPDATE

- "Other" Medicaid Eligibles (cont.)
  - 2008 DSH Rule requires that ***all*** Medicaid eligibles are reported on the DSH survey and included in the UCC calculation.
  - Exhibit C should be submitted for this population. If no "other" Medicaid eligibles are submitted, we will contact you to request that they be submitted. If we still do not receive the requested Exhibit C or a signed statement verifying there are none to report, we may have to list the hospital as non-compliant in the DSH examination report.
  - Ensure that you ***separately report*** Medicaid, Medicaid HMO, Medicare, Medicare HMO, private insurance, and self-pay payments in Exhibit C.
  - Allowed days, charges, and payments from the Medicaid Secondary Summary file should be combined with your hospitals OME totals when completing the OME portion in Section H of Survey II.

PAID CLAIMS DATA UPDATE

Additional Clarification on Crossover and Other Medicaid Eligible Claims:

In-State Medicare FFS Crossover Column	In-State Other Medicaid Eligible Column
Medicare FFS primary with Medicaid FFS secondary	Private Insurance primary with Medicaid FFS secondary
Medicare FFS primary with Medicaid HMO secondary	Private Insurance primary with Medicaid HMO secondary
Medicare HMO primary with Medicaid FFS secondary	Medicaid FFS no-pays (as long as service provided is a Medicaid covered hospital service and there is additional coverage on the claim)
Medicare HMO primary with Medicaid HMO secondary	

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PAID CLAIMS DATA UPDATE

- Uninsured Services
    - Uninsured charges/days will be reported on Exhibit A and patient payments will be reported on Exhibit B.
    - Exhibit A charges/days should be reported based on cost report year (using discharge date).
    - Exhibit B patient payments will be reported based on cash basis (received during the cost report year).

PAID CLAIMS DATA UPDATE

- Out-of-State Medicaid paid claims data should be obtained from the state making the payment
    - If the hospital cannot obtain a paid claims listing from the state, the hospital should send in a detailed listing in Exhibit C format.
    - Must EXCLUDE CHIP and other non-Title 19 services.
    - Should be reported based on cost report year (using discharge date).
    - In future years, request out-of-state paid claims listing at the time of your cost report filing.

FILES EACH HOSPITAL RECEIVED

- For 2026 DSH Payment Limit Calculation
- <u>DSH data request documents:</u>
  - Notice of the DSH Procedures
  - DSH Survey Part I – DSH year data
  - DSH Survey Part II – Cost Report Year Data
  - Exhibit A-C Hospital Provided Claims Data Template
  - DSH Survey – Revenue Code Crosswalk Template

FILES EACH HOSPITAL RECEIVED

- Data received from the State provided to the hospitals:
  - Traditional FFS MMIS data (includes state-only program data)
  - HMO MMIS data (includes state-only program data)
  - Crossover MMIS data
  - Medicaid Secondary MMIS data (Medicaid with TPL)
  - Supplemental/Enhanced payments

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DSH SURVEYS

General Instruction – Survey Files

- The survey is split into 2 separate Excel files:
  - DSH Survey Part I – DSH Year Data.
    - DSH year-specific information.
    - Always complete one copy.
    - Hospitals have the option to waive their DSH payment.
  - DSH Survey Part II – Cost Report Year Data.
    - Cost report year-specific information.
    - Complete a separate copy for each cost report year needed to cover the DSH year.
    - Hospitals with year end changes or that are new to DSH may have to complete 2 or 3 year ends.

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DSH SURVEYS

General Instruction – Survey Files

- Do not complete a DSH Part II survey for a cost report year already submitted in a previous DSH exam year.
  - Example: Hospital A provided a survey for their year ending 12/31/21 with the DSH examination of SFY 2021 in the prior year. In the DSH year 2022 exam, Hospital A would only need to submit a survey for their year ending 12/31/22.
- Both surveys have an Instructions tab that has been updated. Please refer to those tabs if you are unsure of what to enter in a section. If it still isn't clear, please contact Myers and Stauffer.

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DSH SURVEYS

General Instruction – HCRIS Data

- Myers and Stauffer will pre-load certain sections of Part II of the survey using the Healthcare Cost Report Information System (HCRIS) data from CMS. However, the hospital is responsible for reviewing the data to ensure it is correct and reflects the best available cost report (audited if available).

- Hospitals that did not have a Medicare cost report on file with CMS will not see any data pre-loaded and will need to complete all lines as instructed.

DSH SURVEY PART I – DSH YEAR DATA

DSH Waiver & MIUR Data tab

- DSH Year and hospital information should already be completed.
- Answer DSH payment waiver question (question #5).
- If waiving DSH payment, answer all remaining questions (#6-20) and have CEO or CFO sign certification.
- If not waiving DSH payment, no further action is needed on this survey section.

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DSH Waiver & MIUR Data Form

General Information & DSH Waiver

1. Hospital Name	SELECT HOSPITAL NAME			
2. Medicaid Provider Number:	M'Caid #			
3. Medicare Provider Number:	M'care #			
4. DSH Payment Year:	From:	07/01/2025	To:	06/30/2026

Based on the hospital's projections, the above named hospital does not anticipate having uncompensated cost of care for Medicaid and the uninsured eligible for an interim DSH payment for SFY 2026. Therefore, this hospital elects not to receive an interim DSH payment for SFY 2026.

5. **Waive interim DSH payment for SFY 2026?**

Must answer DSH payment question.

Required Federal Reporting of MIUR Data - Hospital Patient Days

Note: If you selected "No" above, you do not need to fill out the days or certification block below.
If you selected "Yes" above, you must fill out the days below. CMS requires that the Department submit the MIUR for each hospital in the state that receives a Medicaid payment. This information is necessary for the accurate reporting of the MIUR and may affect future federal funding.

	Cost Report Year (01/00/00 - 01/00/00)
6. Total Paid Medicaid FFS Days	
7. Total Paid Medicaid Managed Care Days	
8. Total Medicaid FFS Crossover Days	
9. Other Medicaid Eligible Days (No Medicaid Payment)	
10. Out-of-State Paid Medicaid Days (Include FFS, Medicaid Managed Care, FFS Crossover, and Other Eligible)	
11. Total Hospital Days Per Cost Report Excluding Swing-Bed (C/R, W/S S-3, Pt. I, Col. 8, Sum of Lns. 14, 16, 17, 18.xx less lines 5 & 6)	
12. Total Medicaid Hospital Days Per Cost Report Excluding Swing Bed (W/S S-3, Pt. I, Col. 7, Sum of Lns. 2-4, 14, 16, 17, 18.xx less lines 5 & 6)	
13. Unreconciled Medicaid Hospital Days (Primary Medicaid Days including Out-of-State less Cost Report Total) (please include explanation with submission)	-

If answering "No" in prior section above, these boxes will change to be "blacked out" as no additional information is needed.

Medicaid Inpatient Utilization Rate (MIUR) Calculation

14. Total Medicaid Eligible Days	Sum of Line 6 thru Line 10	-
15. Total Hospital Days (excludes swing-bed)	Line 11	-
16. MIUR	Line 14 divided by Line 15	0.00%

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DSH Qualifying Information

Note If you selected "No" above, you do not need to fill out the OB responses or certification block below. Please complete the OB responses on "Sec. A-C DSH Year Data". Questions 17-19, below, should be answered in the accordance with Sec. 1923(d) of the Social Security Act.

	"Interim DSH Payment Year (07/01/25 -
During the Interim DSH Payment Year:	
17. Does the hospital have at least two obstetricians who have staff privileges at the hospital who have agreed to provide obstetric services to Medicaid-eligible individuals during the DSH year? (In the case of a hospital located in a rural area, the term "obstetrician" includes any physician with staff privileges at the hospital to perform nonemergency obstetric procedures.)	
List the Names of the two Obstetricians (or case of rural hospital, Physicians) who have agreed to perform OB services:	
18. Is the hospital exempt from the requirement listed under #1 above because the hospital's inpatients are predominantly under 18 years of age?	
19. Is the hospital exempt from the requirement listed under #1 above because it did not offer non-emergency obstetric services to the general population when federal Medicaid DSH regulations were enacted on December 22, 1987?	
19a. Was the hospital open as of December 22, 1987?	
19b. What date did the hospital open?	

If answering "No" in prior section above, the boxes in these sections will change to black as no additional information is needed.

Visconsin DSH Qualification Criteria

Supplemental DSH Qualification

	Answer (Yes/No)
In order to qualify for a SFY 2026 DSH payment under the Supplemental DSH Program, please verify that your facility meets the criteria below, as outlined in §9230 of the approved state plan:	
20. The hospital provides a wide array of services, including services provided through an emergency department recognized by DQA.	

Must complete if waiving DSH payment.

Certification

The information provided above is true and accurate to the best of our ability, and supported by the financial and other records of the hospital. I understand that a hospital that does not receive an interim DSH payment for a SFY will not be included in the independent DSH examination related to that SFY and will not be eligible for final DSH examination payment adjustments related to that SFY.

Signature of CEO or Other Authorized Person

Date

Print Name

Title

DSH SURVEY PART I – DSH YEAR DATA

Section A

- DSH Year should already be filled in.
- Hospital name should already be selected.
- Verify the cost report year end dates (should only include those that weren't previously submitted).
    - If these are incorrect, please call Myers and Stauffer and request a new copy.

Section B

- Answer all DSH Qualifying questions using drop-down boxes.

DSH SURVEY PART I – DSH YEAR DATA

Section C

- Item 1: Report any Medicaid supplemental payments, including UPL and Non-Claim Specific payments, for the state fiscal year. Do NOT include DSH payments.
- Item 2: Report any Medicaid Managed Care supplemental payments, including all Non-Claim Specific payments for hospital services such as lump sum payments for full Medicaid pricing (FMP), supplementals, quality payments, bonus payments, capitation payments received by the hospital (not by the MCO), or other incentive payments.
    - Hospital portion of supplemental payments reported on DSH Survey Part II, Section E, Question 14 should be reported here if paid on SFY basis.

Certification

- Answer the “Retain DSH” question but please note that IGTs are not a basis for answering the question “No”.
- Enter contact information.
- Have CEO or CFO sign this section after completion of Part II of the survey.

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A. General DSH Year Information

	Begin	End
1. DSH Year:	07/01/2022	06/30/2023

2. Select Your Facility from the Drop-Down Menu Provided: SELECT HOSPITAL NAME

Hospital name should already be selected.

Identification of cost reports needed to cover the DSH Year:

	Cost Report Begin Date(s)	Cost Report End Date(s)
3. Cost Report Year 1		
4. Cost Report Year 2 (if applicable)		
5. Cost Report Year 3 (if applicable)		

Only cost report years to be submitted will show here. You will need to prepare a separate Part II DSH Survey Excel file for each cost report year listed here.

	Data
6. Medicaid Provider Number:	M'Caid #
7. Medicaid Subprovider Number 1 (Psychiatric or Rehab):	M'caid Sub 1 #
8. Medicaid Subprovider Number 2 (Psychiatric or Rehab):	M'caid Sub 2 #
9. Medicare Provider Number:	M'care #

B. DSH Qualifying Information

Questions 1-3, below, should be answered in the accordance with Sec. 1923(d) of the Social Security Act.

Answer all DSH Examination OB questions

	DSH Examination Year (07/01/22 - 06/30/23)
During the DSH Examination Year:	
1. Did the hospital have at least two obstetricians who had staff privileges at the hospital that agreed to provide obstetric services to Medicaid-eligible individuals during the DSH year? (In the case of a hospital located in a rural area, the term "obstetrician" includes any physician with staff privileges at the hospital to perform nonemergency obstetric procedures.)	
2. Was the hospital exempt from the requirement listed under #1 above because the hospital's inpatients are predominantly under 18 years of age?	
3. Was the hospital exempt from the requirement listed under #1 above because it did not offer non-emergency obstetric services to the general population when federal Medicaid DSH regulations were enacted on December 22, 1987?	
3a. Was the hospital open as of December 22, 1987?	
3b. What date did the hospital open?	

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Questions 4-6, below, should be answered in the accordance with Sec. 1923(d) of the Social Security Act.

	DSH Payment Year (07/01/25 - 06/30/26)
During the Interim DSH Payment Year:	

Answer all Payment Year DSH Qualifying questions.

4. Does the hospital have at least two obstetricians who have staff privileges at the hospital who have agreed to provide obstetric services to Medicaid-eligible individuals during the DSH year? (In the case of a hospital located in a rural area, the term "obstetrician" includes any physician with staff privileges at the hospital to perform nonemergency obstetric procedures.)

   List the Names of the two Obstetricians (or case of rural hospital, Physicians) who have agreed to perform OB services:

5. Is the hospital exempt from the requirement listed under #1 above because the hospital's inpatients are predominantly under 18 years of age?
6. Is the hospital exempt from the requirement listed under #1 above because it did not offer non-emergency obstetric services to the general population when federal Medicaid DSH regulations were enacted on December 22, 1987?
7. Does the hospital provide a wide array of services, including services provided through an emergency department recognized by DQA as outlined in §9230 of the approved state plan?

C. Disclosure of Other Medicaid Payments Received:

1. **Medicaid Supplemental Payments for Hospital Services DSH Year 07/01/2022 - 06/30/2023**
   (Should include UPL and non-claim specific payments paid based on the state fiscal year. However, DSH payments should NOT be included.)

2. **Medicaid Managed Care Supplemental Payments for hospital services for DSH Year 07/01/2022 - 06/30/2023**
   (Should include all non-claim specific payments for hospital services such as lump sum payments for full Medicaid pricing (FMP), supplementals, quality payments, bonus payments, capitation payments received by the hospital (not by the MCO), or other incentive payments.
   NOTE: Hospital portion of supplemental payments reported on DSH Survey Part II, Section E, Question 14 should be reported here if paid on a SFY basis.

3. **Total Medicaid and Medicaid Managed Care Non-Claims Payments for Hospital Services07/01/2022 - 06/30/2023** $ -

Input all Medicaid supplemental payments for the DSH year. Should agree to the state's report.

Input all Medicaid Managed Care payments for the DSH year (HMO Access per state's report, etc.) Please provider support for any additional payments reported here.

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Certification:

Answer

Must answer the retain DSH question.

1. **Was your hospital allowed to retain 100% of the DSH payment it received for this DSH year? Matching the federal share with an IGT/CPE is not a basis for answering this question "no". If your hospital was not allowed to retain 100% of its DSH payments, please explain what circumstances were present that prevented the hospital from retaining its payments.**

   Explanation for "No" answers:

_____

_____

_____

The following certification is to be completed by the hospital's CEO or CFO:

I hereby certify that the information in Sections A, B, C, D, E, F, G, H, I, J, K and L of the DSH Survey files are true and accurate to the best of our ability, and supported by the financial and other records of the hospital. All Medicaid eligible patients, including those who have private insurance coverage, have been reported on the DSH survey regardless of whether the hospital received payment on the claim. I understand that this information will be used to determine the Medicaid program's compliance with federal Disproportionate Share Hospital (DSH) eligibility and payments provisions. Detailed support exists for all amounts reported in the survey. These records will be retained for a period of not less than 5 years following the due date of the survey, and will be made available for inspection when requested.

Complete certification and contact information.

Hospital CEO or CFO Signature	Title	Date
Hospital CEO or CFO Printed Name	Hospital CEO or CFO Telephone Number	Hospital CEO or CFO E-Mail

Contact Information for individuals authorized to respond to inquiries related to this survey:

Hospital Contact:	
Name	
Title	
Telephone Number	
E-Mail Address	
Mailing Street Address	
Mailing City, State, Zip	

Outside Preparer:	
Name	
Title	
Firm Name	
Telephone Number	
E-Mail Address	

DSH YEAR SURVEY PART II
SECTION D – GENERAL INFORMATION

Submit one copy of the part II survey for each cost report year not previously submitted.

- **Question #2 – An "X" should be shown in the column of the cost report year survey you are preparing.**
  - If you have multiple years listed, you will need to prepare multiple surveys.
  - If there is an error in the year ends, contact Myers and Stauffer to send out a new copy.

- **Question #3 – This question may be already answered based on pre-loaded HCRIS data. If your hospital is going to update the cost report data to a more recent version of the cost report, select the status of the cost report you are using with this drop-down box.**

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D. General Cost Report Year Information 7/1/2022 - 6/30/2023

The following information is provided based on the information we received from the state. Please review this information for items 4 through 8 and select "Yes" or "No" to either agree or disagree with the accuracy of the information. If you disagree with one of these items, please provide the correct information along with supporting documentation when you submit your survey.

1. Select Your Facility from the Drop-Down Menu Provided:	Hospital ABC			
	7/1/2022 through 6/30/2023			
2. Select Cost Report Year Covered by this Survey (enter "X"):	X			
3. Status of Cost Report Used for this Survey (Should be audited if available):				
3a. Date CMS processed the HCRIS file into the HCRIS database:				

	Data	Correct?	If Incorrect, Proper Information
4. Hospital Name:	Hospital ABC		
5. Medicaid Provider Number:	XXXXXXXXXX		
6. Medicaid Subprovider Number 1 (Psychiatric or Rehab):	0		
7. Medicaid Subprovider Number 2 (Psychiatric or Rehab):	0		
8. Medicare Provider Number:	XXXXXX		

Out-of-State Medicaid Provider Number. List all states where you had a Medicaid provider agreement during the cost report year.

	State Name	Provider No.
9. State Name & Number		
10. State Name & Number		
11. State Name & Number		
12. State Name & Number		
13. State Name & Number		
14. State Name & Number		
15. State Name & Number		

(List additional states on a separate attachment)

Should have an "X" for the cost report year you are reporting on. Should have a separate Excel file for each year listed here.

Please indicate the status of the cost report used to complete the survey (e.g., as-filed, audited, reopened).

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DSH YEAR SURVEY PART II SECTION E, MISC. PAYMENT INFO.

- 1011 Payments - You must report your Section 1011 payments included in payments on Exhibit B (posted at the patient level), and payments received but not included in Exhibit B (not posted at the patient level), and separate the 1011 payments between hospital services and non-hospital services (non-hospital services include physician services).
- If your facility received DSH payments from another state (other than your home state) these payments must be reported on this section of the survey (calculate amount for the cost report period).
- Enter in total cash basis patient payment totals from Exhibit B as instructed. These are check totals to compare to the supporting Exhibit B.

DSH YEAR SURVEY PART II SECTION E, MISC. PAYMENT INFO.

- If your facility received Medicaid Managed Care payments not paid at the claim level, answer “Yes” and provide the breakout of the payments applicable to hospital and non-hospital services.
- If no such payments were received during the year, answer “No”.

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E. Disclosure of Medicaid / Uninsured Payments Received: (07/01/2022 - 06/30/2023)

1. Section 1011 Payment Related to Hospital Services Included in Exhibits B & B-1 (See Note 1)	
2. Section 1011 Payment Related to Inpatient Hospital Services NOT Included in Exhibits B & B-1 (See Note 1)	
3. Section 1011 Payment Related to Outpatient Hospital Services NOT Included in Exhibits B & B-1 (See Note 1)	
4. **Total Section 1011 Payments Related to Hospital Services (See Note 1)**	$-
5. Section 1011 Payment Related to Non-Hospital Services Included in Exhibits B & B-1 (See Note 1)	
6. Section 1011 Payment Related to Non-Hospital Services NOT Included in Exhibits B & B-1 (See Note 1)	
7. **Total Section 1011 Payments Related to Non-Hospital Services (See Note 1)**	$-
8. **Out-of-State DSH Payments (See Note 2)**	

Section 1011 undocumented alien payments reconciliation.

Out-of-state DSH payments

	Inpatient	Outpatient	Total
9. Total Cash Basis Patient Payments from Uninsured (On Exhibit B)			$-
10. Total Cash Basis Patient Payments from All Other Patients (On Exhibit B)			$-
11. Total Cash Basis Patient Payments Reported on Exhibit B (Agrees to Column (N) on Exhibit B, less physician and non-hospital portion of payments)	$-	$-	$-
12. Uninsured Cash Basis Patient Payments as a Percentage of Total Cash Basis Patient Payments:	0.00%	0.00%	0.00%

Insured and uninsured patient payments reconciliation (from Exhibit B).

13. **Did your hospital receive any Medicaid managed care payments not paid at the claim level?** *Should include all non-claim-specific payments such as lump sum payments for full Medicaid pricing, supplementals, quality payments, bonus payments, capitation payments received by the hospital (not by the MCO), or other incentive payments.*	
14. Total Medicaid managed care non-claims payments (see question 13 above) received applicable to hospital services	
15. Total Medicaid managed care non-claims payments (see question 13 above) received applicable to non-hospital services	
16. Total Medicaid managed care non-claims payments (see question 13 above) received	$-

Note 1: Subtitle B - Miscellaneous Provision, Section 1011 of the Medicare Prescription Drug Improvement and Modernization Act of 2003 provides federal reimbursement for emergency health services furnished to undocumented aliens. If your hospital received these funds during any cost report year covered by the survey, they must be reported here. If you can document that a portion of the payment received is related to non-hospital services (physician or ambulance services), report that amount in the section titled "Section 1011 Payments Related to Non-Hospital Services." Otherwise report 100 percent of the funds you received in the section related to hospital services.

Note 2: Report any DSH payments your hospital received from a state Medicaid program (other than your home state). In-state DSH payments will be reported directly from the Medicaid program and should not be included in this section of the survey.

Report any lump sum payment (payments not paid at the claim level) received from MCOs in this section.
Examples include payments for full Medicaid pricing, supplementals, quality payments, bonus payments, capitation payments received by the hospital (not by the MCO), or other incentive payments.

DSH YEAR SURVEY PART II
SECTION F MIUR/LIUR

- The state must report your actual MIUR and LIUR for the DSH year - data is needed to calculate the MIUR/LIUR.
- Section F-1: Total hospital days from cost report. Myers and Stauffer will pre-load CMS HCRIS cost report data into this section, **if available at the time of survey creation**. If it is incorrect or doesn't agree to a more recently audited version of the cost report, please correct as needed and update question #3 in Section D.
- Section F-2: If cash subsidies are specified for I/P or O/P services, record them as such, otherwise record entire amount as unspecified. If any subsidies are directed toward non-hospital services, record the subsidies in the non-hospital cell.
- Section F-2: Report charity care charges based on your own hospital financials or the definition used for your state DSH payment (support must be submitted).

DSH YEAR SURVEY PART II SECTION F, MIUR/LIUR

Section F-3: Report hospital revenues and contractual adjustments.

- Myers and Stauffer will pre-load CMS HCRIS cost report data into this section, **if available at the time of survey creation**. If it is incorrect or doesn't agree to a more recently audited version of the cost report, please correct as needed and update question #3 in Section D.

- Totals should agree with the cost report worksheets G-2 and G-3. If not, provide an explanation with the survey.

- Contractuals by service center are set-up to calculate based on total revenues and the total contractuals from G-3. If you have contractuals by service center or the calculation does not reasonably state the contractual split between hospital and non-hospital, overwrite the formulas as needed and submit the necessary support.

DSH YEAR SURVEY PART II
SECTION F, MIUR/LIUR

Section F-3: Reconciling Items Necessary for Proper Calculation of LIUR

- Bad debt and charity care write-offs not included on G-3, line 2 should be entered on lines 30 and 31 so they can be properly excluded in calculating net patient service revenue utilized in the LIUR.
- Medicaid DSH payments and state and local patient care cash subsidies included on G-3, line 2 should be entered on line 32 and 33 so they can be properly excluded in calculating net patient service revenue also.
- Medicaid Provider Tax included on G-3, line 2 should be entered on line 34 so it can be properly excluded in calculating net patient service revenue.

F. MIUR / LIUR Qualifying Data from the Cost Report (07/01/2022 – 06/30/2023)

F-1. Total Hospital Days Used in Medicaid Inpatient Utilization Ratio (MIUR)

1.	Total Hospital Days Per Cost Report Excluding Swing-Bed (C/R, W/S S-3, Pt. I, Col. 8, Sum of Lns. 14, 16, 17, 18.00-18.03, 30, 31 less line 5 & 6)	-

(See Note in Section F-3, below)

Days per cost report

F-2. Cash Subsidies for Patient Services Received from State or Local Governments and Charity Care Charges (Used in Low-Income Utilization Ratio (LIUR)

2.	Inpatient Hospital Subsidies	
3.	Outpatient Hospital Subsidies	
4.	Unspecified I/P and O/P Hospital Subsidies	
5.	Non-Hospital Subsidies	
6.	Total Hospital Subsidies	$ -
7.	Inpatient Hospital Charity Care Charges	
8.	Outpatient Hospital Charity Care Charges	
9.	Non-Hospital Charity Care Charges	
10.	Total Charity Care Charges	$ -

State or local Govt. subsidies.

Charity care charges (only used in LIUR

F-3. Calculation of Net Hospital Revenue from Patient Services (Used for LIUR) (W/S G-2 and G-3 of Cert

NOTE: All data in this section must be verified by the hospital. If data is already present in this section, it was completed using CMS HCRIS cost report data. If the hospital has a more recent version of the cost report, the data should be updated to the hospital's version of the cost report. Formulas can be overwritten as needed with actual data.

		Total Patient Revenues (Charges)			Contractual Adjustments (formulas below can be overwritten if amounts are known)			
		Inpatient Hospital	Outpatient Hospital	Non-Hospital	Inpatient Hospital	Outpatient Hospital	Non-Hospital	Net Hospital Revenue
11.	Hospital	$ -			$ -	$ -	$ -	$ -
12.	Subprovider I (Psych or Rehab)	$ -			$ -	$ -	$ -	$ -
13.	Subprovider II (Psych or Rehab)	$ -			$ -	$ -	$ -	$ -
14.	Swing Bed - SNF			$ -			$ -	
15.	Swing Bed - NF			$ -			$ -	
16.	Skilled Nursing Facility			$ -			$ -	
17.	Nursing Facility			$ -			$ -	
18.	Other Long-Term Care			$ -			$ -	
19.	Ancillary Services	$ -	$ -		$ -	$ -	$ -	$ -
20.	Outpatient Services		$ -			$ -	$ -	$ -
21.	Home Health Agency			$ -			$ -	
22.	Ambulance			$ -			$ -	
23.	Outpatient Rehab Providers			$ -	$ -	$ -	$ -	$ -
24.	ASC	$ -	$ -		$ -	$ -	$ -	$ -
25.	Hospice			$ -			$ -	
26.	Other	$ -	$ -	$ -	$ -	$ -	$ -	$ -
27.	Total	$ -	$ -	$ -	$ -	$ -	$ -	$ -
28.	Total Hospital and Non Hospital		Total from Above	$ -		Total from Above	$ -	

Overwrite contractual formulas if unreasonable or hospital has actual numbers by service center.

29.	Total Per Cost Report	Total Patient Revenues (G-3 Line 1)	-	Total Contractual Adj. (G-3 Line 2)	-
30.	Increase worksheet G-3, Line 2 for Bad Debts NOT INCLUDED on worksheet G-3, Line 2 (impact is a decrease in net patient revenue)				
31.	Increase worksheet G-3, Line 2 for Charity Care Write-Offs NOT INCLUDED on worksheet G-3, Line 2 (impact is a decrease in net patient revenue)				
32.	Increase worksheet G-3, Line 2 to reverse offset of Medicaid DSH Revenue INCLUDED on worksheet G-3, Line 2 (impact is a decrease in net patient revenue)				
33.	Increase worksheet G-3, Line 2 to reverse offset of State and Local Patient Care Cash Subsidies INCLUDED on worksheet G-3, Line 2 (impact is a decrease in net patient revenue)				
34.	Decrease worksheet G-3, Line 2 to remove Medicaid Provider Taxes INCLUDED on worksheet G-3, Line 2 (impact is an increase in net patient revenue)				
35.	Blank Recon Line OR "Decrease worksheet G-3, Line 2 to remove Charity Care Charges related to insured patients INCLUDED on worksheet G-3, Line 2 (impact is an increase in net patient revenue)"				
36.	Adjusted Contractual Adjustments				-
37.	Unreconciled Difference	Unreconciled Difference (Should be $0)	$ -	Unreconciled Difference (Should be $0)	$ -

Reconciling lines utilized to ensure that only true contractuals are included in the calculation of the LIUR.

DSH YEAR SURVEY PART II SECTION G, COST REPORT DATA

- Utilized to compute the per diems and cost-to-charge ratios used to calculate uncompensated care costs.
  - Pre-populated with hospital-specific HCRIS data, **if available at the time of survey creation**.
- Hospital should update the pre-populated HCRIS costs coming from B Part I to agree with the Medicare version of the cost report. RCE adjustments may need to be updated also.
- All other pre-populated HCRIS data should be verified to Medicare version of the cost report by the hospital.
- NF, SNF, and Swing Bed Cost for Medicaid, Medicare, and Other payers will be excluded from Total Hospital Cost.

DSH YEAR SURVEY PART II SECTION G, COST REPORT DATA

- Calculation of Routine Cost Per Diems
  - Days
  - Cost
- Calculation of Ancillary Cost-to-Charge Ratios
  - Charges
  - Cost
- NF, SNF, and Swing Bed Cost for Medicaid, Medicare, and Other Payors

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Routine charges are populated here

Routine cost per diems – calculated based on cost report data entered below

G. Cost Report - Cost / Days / Charges

Cost Report Year (07/01/2022-06/30/2023) | Hospital ABC

NOTE: All data in this section must be verified by the hospital. If data is already present in this section, it was completed using CMS HCRIS cost report data. If the hospital has a more recent version of the cost report, the data should be updated to the hospital's version of the cost report. Formulas can be overwritten as needed with actual data.

Line #		Cost Center Description	Total Allowable Cost	Intern & Resident Costs Removed on Cost Report *	RCE and Therapy Add-Back (If Applicable		Provider Tax Assessment	Total Cost	I/P Days and I/P Ancillary Charges	I/P Routine Charges and O/P Ancillary Charges	Total Charges	Medicaid Per Diem / Cost or Other Ratios
			Cost Report Worksheet B, Part I, Col. 26	*Cost Report Worksheet B, Part I, Col. 25 (Intern & Resident Offset ONLY*	*Cost Report Worksheet C, Part I, Col.2 and Col. 4*	*Swing-Bed Carve Out - Cost Report Worksheet D-1, Part I, Line 26*	*Allocation of Provider Tax from Section L of the Survey Based on Total Cost*	*Calculated*	*Days - Cost Report W/S D-1, Pt. I, Line 2 for Adults & Peds; W/S D-1, Pt. 2, Lines 42-47 for others*	*Inpatient Routine Charges - Cost Report Worksheet C, Pt. I, Col. 6 (Informational only unless used in Section L charges allocation)*		*Calculated Per Diem*
		Routine Cost Centers (list below):										
1	03000	ADULTS & PEDIATRICS	$ -	$ -	$ -	$ -	$ -	$ -	-	$ -		$ -
2	03100	INTENSIVE CARE UNIT	$ -	$ -	$ -		$ -	$ -	-	$ -		$ -
3	03200	CORONARY CARE UNIT	$ -	$ -	$ -		$ -	$ -	-	$ -		$ -
4	03300	BURN INTENSIVE CARE UNIT	$ -	$ -	$ -		$ -	$ -	-	$ -		$ -
5	03400	SURGICAL INTENSIVE CARE UNIT	$ -	$ -	$ -		$ -	$ -	-	$ -		$ -
6	03500	OTHER SPECIAL CARE UNIT	$ -	$ -	$ -		$ -	$ -	-	$ -		$ -
7	04000	SUBPROVIDER I	$ -	$ -	$ -		$ -	$ -	-	$ -		$ -
8	04100	SUBPROVIDER II	$ -	$ -	$ -		$ -	$ -	-	$ -		$ -
9	04200	OTHER SUBPROVIDER	$ -	$ -	$ -		$ -	$ -	-	$ -		$ -
10	04300	NURSERY	$ -	$ -	$ -		$ -	$ -	-	$ -		$ -
11			$ -	$ -	$ -		$ -	$ -	-	$ -		$ -
12			$ -	$ -	$ -		$ -	$ -	-	$ -		$ -
13			$ -	$ -	$ -		$ -	$ -	-	$ -		$ -
14			$ -	$ -	$ -		$ -	$ -	-	$ -		$ -
15			$ -	$ -	$ -		$ -	$ -	-	$ -		$ -
16			$ -	$ -	$ -		$ -	$ -	-	$ -		$ -
17			$ -	$ -	$ -		$ -	$ -	-	$ -		$ -
18		Total Routine	$ -	$ -	$ -	$ -	$ -	$ -	-	$ -		
19		Weighted Average										$ -

Line #		Observation Data (Non-Distinct)	*Hospital Observation Days - Cost Report W/S S-3, Pt. I, Line 28, Col. 8*	*Subprovider I Observation Days - Cost Report W/S S-3, Pt. I, Line 28.01, Col. 8*	*Subprovider II Observation Days - Cost Report W/S S-3, Pt. I, Line 28.02, Col. 8*		*Calculated (Per Diems Above Multiplied by Days)*	*Inpatient Charges - Cost Report Worksheet C, Pt. I, Col. 6*	*Outpatient Charges - Cost Report Worksheet C, Pt. I, Col. 7*	*Total Charges - Cost Report Worksheet C, Pt. I, Col. 8*	*Medicaid Calculated Cost-to-Charge Ratio*
20	09200	Observation (Non-Distinct)	-	-	-		$ -	$ -	$ -	$ -	-

Calculation of observation CCR. Uses per diems calculated in first section to carve out and calculate observation cost.

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G. Cost Report - Cost / Days / Charges

Cost Report Year (07/01/2022-06/30/2023)

Line #	Cost Center Description	Total Allowable Cost	Intern & Resident Costs Removed on Cost Report *	RCE and Therapy Add-Back (If Applicable		Provider Tax Assessment	Total Cost	I/P Days and I/P Ancillary Charges	I/P Routine Charges and O/P Ancillary Charges	Total Charges	Medicaid Per Diem / Cost or Other Ratios
		Cost Report Worksheet B, Part I, Col. 26	*Cost Report Worksheet B, Part I, Col. 25 (Intern & Resident Offset ONLY*	*Cost Report Worksheet C, Part I, Col.2 and Col. 4*		*Allocation of Provider Tax from Section L of the Survey Based on Total Cost*	*Calculated*	*Inpatient Charges - Cost Report Worksheet C, Pt. I, Col. 6*	*Outpatient Charges - Cost Report Worksheet C, Pt. I, Col. 7*	*Total Charges - Cost Report Worksheet C, Pt. I, Col. 8*	*Medicaid Calculated Cost-to-Charge Ratio*
	Ancillary Cost Centers (from W/S C excluding Observation) (list below):										
21		$ -	$ -	$ -		$ -	$ -	$ -	$ -	$ -	-
22		$ -	$ -	$ -		$ -	$ -	$ -	$ -	$ -	-
23		$ -	$ -	$ -		$ -	$ -	$ -	$ -	$ -	-
24		$ -	$ -	$ -		$ -	$ -	$ -	$ -	$ -	-
25		$ -	$ -	$ -		$ -	$ -	$ -	$ -	$ -	-
26		$ -	$ -	$ -		$ -	$ -	$ -	$ -	$ -	-
27		$ -	$ -	$ -		$ -	$ -	$ -	$ -	$ -	-
28		$ -	$ -	$ -		$ -	$ -	$ -	$ -	$ -	-
29		$ -	$ -	$ -		$ -	$ -	$ -	$ -	$ -	-
30		$ -	$ -	$ -		$ -	$ -	$ -	$ -	$ -	-
31		$ -	$ -	$ -		$ -	$ -	$ -	$ -	$ -	-
32		$ -	$ -	$ -		$ -	$ -	$ -	$ -	$ -	-
33		$ -	$ -	$ -		$ -	$ -	$ -	$ -	$ -	-
34		$ -	$ -	$ -		$ -	$ -	$ -	$ -	$ -	-
35		$ -	$ -	$ -		$ -	$ -	$ -	$ -	$ -	-
36		$ -	$ -	$ -		$ -	$ -	$ -	$ -	$ -	-
126	**Total Ancillary**	$ -	$ -	$ -		$ -	$ -	$ -	$ -	$ -	
127	**Weighted Average**										-
128	**Sub Totals**	$ -	$ -	$ -		$ -	$ -	$ -	$ -	$ -	
129	NF, SNF, and Swing Bed Cost for Medicaid *(Sum of applicable Cost Report Worksheet D-3, Title 19, Column 3, Line 200 and Worksheet D, Part V, Title 19, Column 5-7, Line 200)*						$ -				
130	NF, SNF, and Swing Bed Cost for Medicare *(Sum of applicable Cost Report Worksheet D-3, Title 18, Column 3, Line 200 and Worksheet D, Part V, Title 18, Column 5-7, Line 200)*						$ -				
131	NF, SNF, and Swing Bed Cost for Other Payers *(Hospital must calculate. Submit support for calculation of cost.)*										
131.01	Other Cost Adjustments (support must be submitted)										
132	**Grand Total**						$ -				
133	Total Intern/Resident Cost as a Percent of Other Allowable Cost						0.00%				

* Note A - Final cost-to-charge ratios should include teaching cost. Only enter Intern & Resident costs if it was removed in Column 25 of Worksheet B, Pt. I of the cost report you are using.

All cost report data. Calculation of ancillary cost-to-charge ratios.

Enter NF, SNF, and Swing bed costs for Medicaid and Medicare per cost report. Enter data for other payors per hospital internal records.

DSH SURVEY PART II
SECTION H, IN-STATE MEDICAID

- Enter inpatient (routine) days, I/P and O/P charges, and payments. The form will calculate cost and shortfall / long-fall for:
  - In-State FFS Medicaid Primary *(Traditional Medicaid) from state's paid claims summaries.*
  - In-State Medicaid Managed Care Primary *(Medicaid HMO) from state's paid claims summaries.*
  - In-State Medicare Crossovers *(Traditional/HMO Medicare with Traditional/HMO Medicaid Secondary) from state's paid claims summaries.*
  - In-State Other Medicaid Eligibles *(Medicaid Secondary) from state's paid claims summaries. Also includes Medicaid with other coverage(s) not included elsewhere submitted on Exhibit C.*
  - *Medicaid FFS & MCO Exhausted and Non-Covered (Not to be included elsewhere).*

DSH SURVEY PART II SECTION H, IN-STATE MEDICAID UPDATE FOR 2022

- Medicaid FFS & MCO Exhausted and Non-Covered
  - Medicaid-eligible patients where payment was denied, due to exhausted benefits prior to obtaining service or patient belonging to limited Medicaid benefit plan that does not cover an otherwise Medicaid-covered service, for the specific hospital service provided.
  - Includes both in-state and out-of-state claims.
  - Medicaid eligibility must be supported by exhibit C and include the patient's Medicaid ID number.

All Medicaid categories.

H. In-State Medicaid and All Uninsured Inpatient and Outpatient Hospital Data:

New columns

Cost Report Year (07/01/2022-06/30/2023) #N/A

Line #	Cost Center Description	Medicaid Per Diem Cost for Routine Cost Centers	Medicaid Cost to Charge Ratio for Ancillary Cost Centers	In-State Medicaid FFS Primary		In-State Medicaid Managed Care Primary		In-State Medicare Cross-Overs (with Medicaid Secondary)		In-State Other Medicaid Eligibles (Not Included Elsewhere & with Medicaid Secondary - Exclude Medicaid Exhausted and Non-Covered)		Medicaid FFS & MCO Exhausted and Non-Covered (Not to be Included Elsewhere)	
				Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient
		From Section G	*From Section G*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*
	Routine Cost Centers (from Section G):												
1	03000 ADULTS & PEDIATRICS	$ -		Days		Days		Days		Days		Days	
2	03100 INTENSIVE CARE UNIT	$ -											
3	03200 CORONARY CARE UNIT	$ -											
4	03300 BURN INTENSIVE CARE UNIT	$ -											
5	03400 SURGICAL INTENSIVE CARE UNIT	$ -											
6	03500 OTHER SPECIAL CARE UNIT	$ -											
7	04000 SUBPROVIDER I	$ -											
8	04100 SUBPROVIDER II	$ -											
9	04200 OTHER SUBPROVIDER	$ -											
10	04300 NURSERY	$ -											
11		$ -											
18			Total Days	-		-		-		-		-	
19	Total Days per PS&R or Exhibit Detail			-		-		-		-		-	
20	Unreconciled Days (Explain Variance)			-		-		-		-		-	
21	Routine Charges			Routine Charges		Routine Charges		Routine Charges		Routine Charges		Routine Charges	
21.01	Calculated Routine Charge Per Diem			$ -		$ -		$ -		$ -		$ -	

Enter in Medicaid days and total routine charges. Per diem cost amounts carry over from Section G cost report data.

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H. In-State Medicaid and All Uninsured Inpatient and Outpatient Hospital Data:

Cost Report Year (07/01/2022-06/30/2023) #N/A

New columns

	Line #	Cost Center Description	Medicaid Per Diem Cost for Routine Cost Centers	Medicaid Cost to Charge Ratio for Ancillary Cost Centers	In-State Medicaid FFS Primary		In-State Medicaid Managed Care Primary		In-State Medicare Cross-Overs (with Medicaid Secondary)		In-State Other Medicaid Eligibles (Not Included Elsewhere & with Medicaid Secondary - Exclude Medicaid Exhausted and Non-Covered)		Medicaid FFS & MCO Exhausted and Non-Covered (Not to be Included Elsewhere)	
					Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient
	Ancillary Cost Centers (from W/S C) (from Section G):				Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges
22	09200	Observation (Non-Distinct)		-										
23				-										
24				-										
25				-										
26				-										
27				-										
28				-										
29				-										
30				-										
31				-										
32				-										
33				-										
34				-										
35				-										
36				-										
37				-										
38				-										
39				-										
40				-										
41				-										
42				-										
43				-										
44				-										

Enter in all Medicaid ancillary charges. Cost-to-charges ratios carry over from Section G cost report data.

DSH SURVEY PART II
SECTION H, IN-STATE MEDICAID

- Medicaid Payments Include:
  - Claim payments.
    - Payments should be broken out between payor sources
- Medicaid cost report settlements.
- Medicare bad debt payments (crossovers).
- Medicare cost report settlement payments (crossovers).
- Other third party payments (TPL).
- Medicaid Managed Care Quality Incentive Payments, or other lump sum payments received from Medicaid Managed Care organizations paid on a cost reporting period

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H. In-State Medicaid and All Uninsured Inpatient and Outpatient Hospital Data:

Cost Report Year (07/01/2022-06/30/2023) #N/A

Line #	Cost Center Description	Medicaid Per Diem Cost for Routine Cost Centers	Medicaid Cost to Charge Ratio for Ancillary Cost Centers	In-State Medicaid FFS Primary		In-State Medicaid Managed Care Primary		In-State Medicare Cross-Overs (with Medicaid Secondary)		In-State Other Medicaid Eligibles (Not Included Elsewhere & with Medicaid Secondary - Exclude Medicaid Exhausted and Non-Covered)		Medicaid FFS & MCO Exhausted and Non-Covered (Not to be Included Elsewhere)	
				Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient
	Totals / Payments												
128	**Total Charges** *(includes organ acquisition from Section J)*			$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
129	Total Charges per PS&R or Exhibit Detail			$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
130	Unreconciled Charges (Explain Variance)			-	-	-	-	-	-	-	-	-	-
131	**Total Calculated Cost (includes organ acquisition from Section J)**			$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)												
133	Total Medicaid (or State-Only) Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down) (See Note E)												
134	Private Insurance (including primary and third party liability)												
135	Self-Pay (including Co-Pay and Spend-Down)												
136	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)			$ -	$ -	$ -	$ -						
137	Medicaid Cost Settlement Payments (See Note B)												
138	Other Medicaid Payments Reported on Cost Report Year (See Note C)												
139	Medicare Traditional (non-HMO) Paid Amount (excludes coinsurance/deductibles) (See Note G)												
140	Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)												
141	Medicare Cross-Over Bad Debt Payments												
142	Other Medicare Cross-Over Payments (See Note D)												
143	Payment from Hospital Uninsured During Cost Report Year (Cash Basis)												
144	Section 1011 Payment Related to Inpatient Hospital Services NOT Included in Exhibits B & B-1 (from Section E)												
145	**Calculated Payment Shortfall / (Longfall) (PRIOR TO SUPPLEMENTAL PAYMENTS AND DSH)**			$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
146	**Calculated Payments as a Percentage of Cost**			0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
147	**Total Medicare Days from W/S S-3 of the Cost Report Excluding Swing-Bed (C/R, W/S S-3, Pt. I, Col. 6, Sum of Lns. 2, 3, 4, 14, 16, 17, 18 less lines 5 & 6)**							-					
148	**Percent of cross-over days to total Medicare days from the cost report**							0%					

Enter in all Medicaid, Medicaid Managed Care, Medicare, Medicare Managed Care, Private Insurance, Self-Pay, Cost Settlements, and Crossover Bad Debt, and Other Medicare Crossover payments.

DSH SURVEY PART II
SECTION H, UNINSURED

- State-only Program data (*provided by the State summarized by revenue code. If applicable, incorporate this data in the State/Local-Only Indigent Care Program section*.)

- Report uninsured services, patient days (by routine cost center) and ancillary charges by cost center.

- Survey form Exhibit A shows the data elements that need to be collected and provided to Myers and Stauffer.

- For uninsured payments, enter the uninsured hospital patient payment totals from your Survey form Exhibit B. Do NOT pick up the non-hospital or insured patient payments in Section H even though they are reported in Exhibit B.

DSH SURVEY PART II SECTION H, UNINSURED

- State-only claims with no Medicare or private insurance liability can be included in Exhibit A.
    - Exception: State-only indigent care programs delivered by a private Managed Care Organization (MCO) should be submitted on Exhibit C to ensure proper reporting of payments received from the MCO. Cost and payments should still be included in uninsured columns of DSH Survey Part II.
- See Additional Information of the DSH Reporting and Audit Requirements – Part 2, clarification published April 7, 2014, item # 12.

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State-only claims days from MMIS data. (FFS & MCO data combined)

Uninsured days must agree to Exhibit A.

H. In-State Medicaid and All Uninsured Inpatient and Outpatient Hospital Data:

Cost Report Year (07/01/2022-06/30/2023) #N/A

Line #	Cost Center Description	Medicaid Per Diem Cost for Routine Cost Centers	Medicaid Cost to Charge Ratio for Ancillary Cost Centers	State/Local-Only Indigent Care Program		Uninsured	
				Inpatient	Outpatient	Inpatient (See Exhibit A)	Outpatient (See Exhibit A)
		From Section G	*From Section G*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From Hospital's Own Internal Analysis*	*From Hospital's Own Internal Analysis*
	Routine Cost Centers (from Section G):						
03000	ADULTS & PEDIATRICS	$ -					
03100	INTENSIVE CARE UNIT	$ -					
03200	CORONARY CARE UNIT	$ -					
03300	BURN INTENSIVE CARE UNIT	$ -					
03400	SURGICAL INTENSIVE CARE UNIT	$ -					
03500	OTHER SPECIAL CARE UNIT	$ -					
04000	SUBPROVIDER I	$ -					
04100	SUBPROVIDER II	$ -					
04200	OTHER SUBPROVIDER	$ -					
04300	NURSERY	$ -					
		$ -					
				Days		**Days**	
			Total Days	-		-	
	Total Days per PS&R or Exhibit Detail					-	
	Unreconciled Days (Explain Variance)			-		-	
				Routine Charges		**Routine Charges**	
	Routine Charges						
	Calculated Routine Charge Per Diem			$ -		$ -	

State-only Claims charges from the MMIS data. (FFS & MCO data combined)

Uninsured Charges must agree to Exhibit A.

H. In-State Medicaid and All Uninsured Inpatient and Outpatient Hospital Data:

Cost Report Year (07/01/2021-06/30/2022) #N/A

Line #	Cost Center Description	Medicaid Per Diem Cost for Routine Cost Centers	Medicaid Cost to Charge Ratio for Ancillary Cost Centers	State/Local-Only Indigent Care Program		Uninsured	
				Inpatient	Outpatient	Inpatient (See Exhibit A)	Outpatient (See Exhibit A)
		From Section G	*From Section G*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From Hospital's Own Internal Analysis*	*From Hospital's Own Internal Analysis*
	Ancillary Cost Centers (from W/S C) (from Section G):			Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges
22	09200 Observation (Non-Distinct)		-				
23			-				
24			-				
25			-				
26			-				
	Totals / Payments						
128	**Total Charges** *(includes organ acquisition from Section J)*			$ -	$ -	$ -	$ -
						(Agree to Exhibit A)	(Agree to Exhibit A)
129	Total Charges per PS&R or Exhibit Detail					$ -	$ -
130	Unreconciled Charges (Explain Variance)			-	-	-	-
131	**Total Calculated Cost (includes organ acquisition from Section J)**			$ -	$ -	$ -	$ -

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CERTIFIED PUBLIC ACCOUNTANTS

H. In-State Medicaid and All Uninsured Inpatient and Outpatient Hospital Data:

Cost Report Year (07/01/2021-06/30/2022) #N/A

Line #	Cost Center Description	Medicaid Per Diem Cost for Routine Cost Centers	Medicaid Cost to Charge Ratio for Ancillary Cost Centers	State/Local-Only Indigent Care Program: Inpatient	State/Local-Only Indigent Care Program: Outpatient	Uninsured: Inpatient (See Exhibit A)	Uninsured: Outpatient (See Exhibit A)
		From Section G	*From Section G*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From Hospital's Own Internal Analysis*	*From Hospital's Own Internal Analysis*
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)						
133	Total Medicaid (or State-Only) Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down) (See Note E)					(See Note F)	
134	Private Insurance (including primary and third party liability)						
135	Self-Pay (including Co-Pay and Spend-Down)					(See Note F)	
136	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)			$ -	$ -		
137	Medicaid Cost Settlement Payments (See Note B)						
138	Other Medicaid Payments Reported on Cost Report Year (See Note C)						
139	Medicare Traditional (non-HMO) Paid Amount (excludes coinsurance/deductibles)						
140	Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)						
141	Medicare Cross-Over Bad Debt Payments						
142	Other Medicare Cross-Over Payments (See Note D)					(Agree to Exhibit B and B-1)	(Agree to Exhibit B and B-1)
143	Payment from Hospital Uninsured During Cost Report Year (Cash Basis)						
144	Section 1011 Payment Related to Inpatient Hospital Services NOT Included in Exhibits B & B-1 (from Section E)					$ -	$ -
145	Calculated Payment Shortfall / (Overfall) (PRIOR TO SUPPLEMENTAL PAYMENTS AND DSH)			$ -	$ -	$ -	$ -
146	**Calculated Payments as a Percentage of Cost**			0%	0%	0%	0%

147 **Total Medicare Days from W/S S-3 of the Cost Report Excluding Swing-Bed (C/R, W/S S-3, Pt. I, Col. 6, Sum of Lns. 2, 3, 4, 14, 16, 17, 18 less lines 5 & 6)**

148 **Percent of cross-over days to total Medicare days from the cost report**

Note A - These amounts must agree to your inpatient and outpatient Medicaid paid claims summary. For Managed Care, Cross-Over data,
Note B - Medicaid cost settlement payments refer to payments made by Medicaid during a cost report settlement that are not reflected on t
Note C - Other Medicaid Payments such as Outliers and Non-Claim Specific payments. DSH payments should NOT be included. UPL payn
Note D - Should include other Medicare cross-over payments not included in the paid claims data reported above. This includes payments
Note E - Medicaid Managed Care payments should include *all* Medicaid Managed Care payments related to the services provided, including, but not limited to, incentive payments, bonus payments, capitation and sub-capitation payments.

Note F - Only include claims in this column that are NOT Medicaid eligible, but are covered under a state/local-only indigent care program. Payments received on these claims from the state/local-only indigent care program should be reported as subsidies in Section F-2. Do not report these state/local-only indigent care program payments in Section H unless the payments are from a private Managed Care Organization that is delivering the state/local-only indigent care program. Payments received from a private Managed Care Organization that is delivering the state/local-only indigent care program should be included on line 133. Payments received from patients related to these claims should be reported on line 135 if not already included in cash basis uninsured payments on line 143.

State-Only Claims payments from the MMIS data.

Uninsured cash-basis payments must agree to the Uninsured on Exhibit B.

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

DSH SURVEY PART II SECTION H, UNINSURED

- If BOTH of the following conditions are met, a hospital is NOT required to submit any uninsured data on the survey nor Exhibits A and B:

1. The hospital Medicaid shortfall is greater than the hospital's total Medicaid DSH payments for the year.
   - The shortfall is equal to all Medicaid (FFS, HMO, crossover, In-State, OME, Out-of-State) cost less all applicable payments in the survey and non-claim payments such as UPL, GME, outlier, and supplemental payments.
2. The hospital provides a certification that it incurred additional uncompensated care costs serving uninsured individuals.

DSH SURVEY PART II
SECTION H, UNINSURED

NOTE: It is important to remember that if you are not required to submit uninsured data that it may still be to the advantage of the hospital to submit it.

1. Your hospital's total UCC may be used to redistribute overpayments from other hospitals (to your hospital).

2. Your hospital's total UCC is utilized to establish future DSH payment limits.

3. CMS DSH allotment reductions may be partially based on states targeting DSH payments to hospitals with high uninsured and Medicaid populations.

DSH SURVEY PART II – SECTION H, IN-STATE MEDICAID AND UNINSURED

- Additional Edits
  - In the far right column, you will see an error message if your total charges or days by cost center exceed those reported from the cost report in Section G of the survey. Please clear these errors prior to filing the survey.
    - The errors occur when the cost report groupings differ from the grouping methodology used to complete the DSH survey.
- Calculated payments as a percentage of cost by payor (at bottom).
  - Review percentage for reasonableness.

DSH SURVEY PART II – SECTION H, IN-STATE MEDICAID AND UNINSURED

- Additional Errors
  - On Section H and I, in the crossover columns, there will be an error above the days section that will pop up if you enter more crossover days on the DSH survey than are included in Medicare days on W/S S-3 of the cost report per HCRIS data.
    - Please review your data if this occurs and correct the issue prior to filing the survey.

DSH SURVEY PART II – SECTION H, IN-STATE MEDICAID AND UNINSURED

- Additional Errors
  - On Section H, in column AY, there is a % Survey to Cost Report Totals column. The percentages listed in this column are calculating total in-state and out-of-state days and charges divided by total cost report days and charges by cost center, and in total.
  - Please review your data for reasonableness and correct any issues prior to filing the survey.

DSH SURVEY PART II
SECTION I, OUT OF STATE MEDICAID

- Report Out-of-State Medicaid days, charges and payments.
- Report in the same format as Section H. Days, charges and payments received must agree to the other state's PS&R (or similar) claim payment summary. If no summary is available, submit Exhibit C (hospital data) as support.
- If your hospital provided services to several other states, please consolidate your data and provide support for your survey responses.

DSH SURVEY PART II – SECTIONS J & K, ORGAN ACQUISITION

- Total organ acquisition cost and total useable organs will be pre-loaded from HCRIS data, **if available at the time of survey creation**. If it is incorrect or doesn't agree to a more recently audited version of the cost report, please correct as needed and update question #3 in Section D.
- These schedules should be used to calculate organ acquisition cost for Medicaid (in-state and out-of-state) and uninsured for transplants occurring at the hospital.
- Summary claims data (PS&R) or similar documents and provider records (organ counts) must be provided to support the charges and useable organ counts reported on the survey. The data for uninsured organ acquisitions should be reported separately from the Exhibit A.

DSH SURVEY PART II - SECTIONS J & K, ORGAN ACQUISITION

- All organ acquisition charges should be reported in Sections J & K of the survey and should be EXCLUDED from Section H & I of the survey. (Days should also be excluded from H & I)
- Medicaid and uninsured charges/days included in the cost report D-4 series as part of the total organ acquisition charges/days, must be excluded from Sections H & I of the survey as those costs are included in the cost per organ amount on Section J & K.

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In-State organ acquisitions.

J. Transplant Facilities Only: Organ Acquisition Cost In-State Medicaid and Uninsured

Cost Report Year [07/01/2022-06/30/2023] | N/A

		Total Organ Acquisition Cost	Additional Add-In Interest/Residual Cost	Total Adjusted Organ Acquisition Cost	Revenue for Medicaid/ Cross-Over / Uninsured Organs Sold	Total Durable Organs (Count)	In-State Medicaid FFS Primary		In-State Medicaid Managed Care Primary		In-State Medicare Cross-Overs (with Medicaid Secondary)		In-State Other Medicaid Eligibles (Not Included Elsewhere (with Medicaid Secondary - Exclude Medicaid Exhausted and Non-Covered)		Medicaid FFS & MCO Exhausted and Non-Covered (Not to be Included Elsewhere)		State/Local-Only Indigent Care Program		Uninsured	
							Charges	Durable Organs (Count)	Charges	Durable Organs (Count)	Charges	Durable Organs (Count)	Charges	Durable Organs (Count)	Charges	Durable Organs (Count)	Charges	Durable Organs (Count)	Charges	Durable Organs (Count)
		Cost Report Worksheet D-6, Pt. III, Col. 5, Line 57	*Add-On Cost Factor on Section G, Line 355a Total Cost Report Organ Acquisition Cost*	*Sum of Cost Report Organ Acquisition Cost and the Add-On Cost*	*Similar to instructions from Cost Report W/S D-6 Pt. III, Col. 5, Line 56 (substitute Medicare with Medicaid/ Cross-Overs & uninsured). See*	*Cost Report Worksheet D-6, Pt. III, Line 57*	*From Paid Claims Data or Provider Logs (Note-A)*	*From Paid Claims Data or Provider Logs (Note-A)*	*From Paid Claims Data or Provider Logs (Note-A)*	*From Paid Claims Data or Provider Logs (Note-A)*	*From Paid Claims Data or Provider Logs (Note-A)*	*From Paid Claims Data or Provider Logs (Note-A)*	*From Paid Claims Data or Provider Logs (Note-A)*	*From Paid Claims Data or Provider Logs (Note-A)*	*From Paid Claims Data or Provider Logs (Note-A)*	*From Paid Claims Data or Provider Logs (Note-A)*	*From Paid Claims Data or Provider Logs (Note-A)*	*From Paid Claims Data or Provider Logs (Note-A)*	*From Hospital's Uncollected Receipts*	*From Hospital's Uncollected Receipts*
1	Lung Acquisition	$ -	$ -	$ -																
2	Kidney Acquisition	$ -	$ -	$ -																
3	Liver Acquisition	$ -	$ -	$ -																
4	Heart Acquisition	$ -	$ -	$ -																
5	Pancreas Acquisition	$ -	$ -	$ -																
6	Intestinal Acquisition	$ -	$ -	$ -																
7	Islet Acquisition	$ -	$ -	$ -																
8		$ -	$ -	$ -																
9	**Totals**	$ -	$ -	$ -	$ -		$ -		$ -		$ -		$ -		$ -		$ -		$ -	
10	**Total Cost**																			

Note A - These amounts must agree to your inpatient and outpatient Medicaid paid claims summary, if available [if not, use hospital's logs and submit with survey].
Note B: Enter Organ Acquisition Payments in Section H as part of your In-State Medicaid total payments.
Note C: Enter the total revenue applicable to organs furnished to other providers, to organ procurement organizations and others, and for organs transplanted into non-Medicaid / non-Uninsured patients [but where organs were included in the Medicaid and Uninsured organ counts above]. Such revenues must be determined under the accrual method of accounting. If organs are transplanted into non-Medicaid/non-Uninsured patients who are not liable for payment on a charge basis, and so such there is no revenue applicable to the related organ acquisitions, the amount entered must also include an amount representing the acquisition cost of the organs transplanted into such patients.

K. Transplant Facilities Only: Organ Acquisition Cost Out-of-State Medicaid

Cost Report Year [07/01/2022-06/30/2023] | N/A

Out-of-state organ acquisitions.

		Total Organ Acquisition Cost	Additional Add-In Interest/Residual Cost	Total Adjusted Organ Acquisition Cost	Revenue for Medicaid/ Cross-Over / Uninsured Organs Sold	Total Durable Organs (Count)	Out-of-State Medicaid FFS Primary		Out-of-State Medicaid Managed Care Primary		Out-of-State Medicare FFS Cross-Overs (with Medicaid Secondary)		Out-of-State Other Medicaid Eligibles (Not Included Elsewhere & with Medicaid Secondary)	
							Charges	Durable Organs (Count)	Charges	Durable Organs (Count)	Charges	Durable Organs (Count)	Charges	Durable Organs (Count)
		Cost Report Worksheet D-6, Pt. III, Col. 5, Line 57	*Add-On Cost Factor on Section G, Line 355a Total Cost Report Organ Acquisition Cost*	*Sum of Cost Report Organ Acquisition Cost and the Add-On Cost*	*Similar to instructions from Cost Report W/S D-6 Pt. III, Col. 5, Line 56 (substitute Medicare with Medicaid/ Cross-Overs & uninsured). See*	*Cost Report Worksheet D-6, Pt. III, Line 57*	*From Paid Claims Data or Provider Logs (Note-A)*	*From Paid Claims Data or Provider Logs (Note-A)*	*From Paid Claims Data or Provider Logs (Note-A)*	*From Paid Claims Data or Provider Logs (Note-A)*	*From Paid Claims Data or Provider Logs (Note-A)*	*From Paid Claims Data or Provider Logs (Note-A)*	*From Paid Claims Data or Provider Logs (Note-A)*	*From Paid Claims Data or Provider Logs (Note-A)*
11	Lung Acquisition	$ -	$ -	$ -	$ -									
12	Kidney Acquisition	$ -	$ -	$ -	$ -									
13	Liver Acquisition	$ -	$ -	$ -	$ -									
14	Heart Acquisition	$ -	$ -	$ -	$ -									
15	Pancreas Acquisition	$ -	$ -	$ -	$ -									
16	Intestinal Acquisition	$ -	$ -	$ -	$ -									
17	Islet Acquisition	$ -	$ -	$ -	$ -									
18		$ -	$ -	$ -	$ -									
19	**Totals**	$ -	$ -	$ -	$ -		$ -		$ -		$ -		$ -	
20	**Total Cost**													

Note A - These amounts must agree to your inpatient and outpatient Medicaid paid claims summary, if available [if not, use hospital's logs and submit with survey].
Note B: Enter Organ Acquisition Payments in Section I as part of your Out-of-State Medicaid total payments.

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DSH SURVEY PART II SECTION L, PROVIDER TAXES

- Due to Medicare cost report tax adjustments, an adjustment to cost may be necessary to properly reflect the Medicaid and uninsured share of the provider tax assessment for some hospitals.
- The Medicaid and uninsured share of the provider tax assessment is an allowable cost for Medicaid DSH even if Medicare offsets some of the tax.

DSH SURVEY PART II SECTION L, PROVIDER TAXES

- The Medicaid DSH audit rule clearly indicates that the portion of permissible provider taxes applicable to Medicaid and uninsured is an allowable cost for the Medicaid DSH UCC. (FR Vol. 73, No. 245, Friday, Dec. 19, 2008, page 77923)
- All permissible provider tax not included in allowable cost on the cost report will be added back and allocated to the Medicaid and uninsured UCC on a reasonable basis (e.g., costs).

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DSH SURVEY PART II SECTION L, PROVIDER TAXES

- If applicable, Section L should be used to assist in reconciling total provider tax expense reported in the cost report and the amount actually incurred by a hospital (paid to the state).
- Complete the section using cost report data and hospital's own general ledger.

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DSH SURVEY PART II
SECTION L, PROVIDER TAXES

- Include the Worksheet A line number the tax is included on or provide a reason for the variance between the tax per the general ledger and the amount included in the cost report.
- The tax expense should be reflected based on the cost reporting period rather than the DSH year.

DSH SURVEY PART II SECTION L, PROVIDER TAXES

- At a minimum the following should still be excluded from the final tax expense:
  - Additional payments paid into the association "pool" should NOT be included in the tax expense.
  - Association fees.
  - Non-hospital taxes (e.g., nursing home and pharmacy taxes).

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L. Provider Tax Assessment Reconciliation / Adjustment

An adjustment is necessary to properly reflect the Medicaid and uninsured share of the provider tax assessment for some hospitals. The Medicaid and uninsured share of the provider tax assessment collected is an allowable cost in determining hospital-specific DSH limits and, therefore, can be included in the DSH examination survey. However, depending on how your hospital reports it on the Medicare cost report, an adjustment may be necessary to ensure the cost is properly reflected in determining your hospital-specific DSH limit. For instance, if your hospital removed part or all of the provider tax assessment on the Medicare cost report, the full amount of the provider tax assessment would not have been apportioned to the various payers through the step down allocation process, resulting in the Medicaid and uninsured share being understated in determining the hospital-specific DSH limit. If your hospital needs to make an adjustment for the Medicaid and uninsured share of the provider tax assessment, please fill out the reconciliation below, and submit the supporting general ledger entries and other supporting documentation to Myers and Stauffer, LC along with your hospital's DSH examination surveys.

Cost Report Year (07/01/2022-06/30/2023) #N/A

Enter in G/L and cost report total tax amount

Worksheet A Provider Tax Assessment Reconciliation:

		Dollar Amount	W/S A Cost Center Line	
1	Hospital Gross Provider Tax Assessment (from general ledger)*			
1a	*Working Trial Balance Account Type and Account # that includes Gr*			*(WTB Account #)*
2	Hospital Gross Provider Tax Assessment Included in Expense on the C			*(Where is the cost included on w/s A?)*
3	Difference (Explain Here ---------->)	$ -		

Specify whether expense or C/A and WTB acct #

Tax reclassifications, if any, on W/S A-6

	Provider Tax Assessment Reclassifications (from w/s A-6 of the Medicare cost report)			
4	*Reclassification Code*			*(Reclassified to / (from))*
5	*Reclassification Code*			*(Reclassified to / (from))*
6	*Reclassification Code*			*(Reclassified to / (from))*
7	*Reclassification Code*			*(Reclassified to / (from))*
	DSH UCC ALLOWABLE - Provider Tax Assessment Adjustments (from w/s A-8 of the Medicare cost report)			
8	*Reason for adjustment*			*(Adjusted to / (from))*
9	*Reason for adjustment*			*(Adjusted to / (from))*
10	*Reason for adjustment*			*(Adjusted to / (from))*
11	*Reason for adjustment*			*(Adjusted to / (from))*
	DSH UCC NON-ALLOWABLE Provider Tax Assessment Adjustments (from w/s A-8 of the Medicare cost report)			
12	*Reason for adjustment*			
13	*Reason for adjustment*			
14	*Reason for adjustment*			
15	*Reason for adjustment*			
16	Total Net Provider Tax Assessment Expense Included in the Cost Report	$ -		

Enter in tax adjustments on W/S A-8 that are allowable for Medicaid DSH.

Enter in tax adjustments on W/S A-8 that are not allowable even for Medicaid DSH.

DSH UCC Provider Tax Assessment Adjustment:

17	Gross Allowable Assessment Not Included in the Cost Report	$ -

Tax allocation to UCC is estimated here but is subject to examination

EXHIBIT A – UNINSURED CHARGES/DAYS BY REVENUE CODE

- Survey form Exhibit A has been designed to assist hospitals in collecting and reporting all uninsured charges and routine days needed to cost out the uninsured services.
- Total hospital charges / routine days from Exhibit A must agree to the total entered in Section H of the survey.
- Must be for discharges in the cost report fiscal year.
- Line item data must be at patient date of service level with multiple lines showing revenue code level charges.

EXHIBIT A - UNINSURED

- Exhibit A:
  - Include *Primary Payor Plan*, *Secondary Payor Plan*, *Provider #, PCN, Birth Date, SSN*, *Gender, Name, Admit, Discharge, Service Indicator, Revenue Code, Total Charges, Days, Patient Payments, Private Insurance Payments, and Claim Status* fields.
  - A complete list (key) of payor plans is required to be submitted separately with the survey.

EXHIBIT A - UNINSURED

- Claim Status (Column R) is the same as the prior year – need to indicate if Exhausted / Non-Covered Insurance claims are being included under the December 3, 2014 final DSH rule.
  - If exhausted / non-covered insurance services are included on Exhibit A, then they must also be included on Exhibit B for patient payments.
- Submit Exhibit A in the format shown either in Excel or a CSV file using the tab or | (pipe symbol above the enter key).
- Data not submitted in the correct format may be returned to the hospital with a request for revisions to get the data into the prescribed Exhibit A format.

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Exhibit A - Uninsured Charges

Claim Type (A)	Primary Payor Plan (B)	Secondary Payor Plan (C)	Hospital's Medicaid Provider # (D)	Patient Identifier Number (PCN) (E)	Patient's Birth Date (F)	Patient's Social Security Number (G)	Patient's Gender (H)	Name (I)
Uninsured Charges	Charity	Self-Pay	12345	2222222	1/1/1960	999-99-999	Female	Doe, Jane
Uninsured Charges	Charity	Self-Pay	12345	2222222	1/1/1960	999-99-999	Female	Doe, Jane
Uninsured Charges	Charity	Self-Pay	12345	2222222	1/1/1960	999-99-999	Female	Doe, Jane
Uninsured Charges	Charity	Self-Pay	12345	2222222	1/1/1960	999-99-999	Female	Doe, Jane
Uninsured Charges	Charity	Self-Pay	12345	2222222	1/1/1960	999-99-999	Female	Doe, Jane
Uninsured Charges	Charity	Self-Pay	12345	2222222	1/1/1960	999-99-999	Female	Doe, Jane
Uninsured Charges	Medicare		12345	4444444	7/12/1985	999-99-999	Male	Jones, James
Uninsured Charges	Medicare		12345	4444444	7/12/1985	999-99-999	Male	Jones, James
Uninsured Charges	Blue Cross		12345	1111111	3/5/2000	999-99-999	Male	Smith, Mike

Admit Date (J)	Discharge Date (K)	Service Indicator (Inpatient / Outpatient) (L)	Revenue Code (M)	Total Charges for Services Provided (N)	Routine Days of Care (O)	Total Patient Payments for Services Provided (P)	Total Private Insurance Payments for Services Provided (Q)	Claim Status (Exhausted or Non-Covered Service, if applicable) (R)
3/1/2010	3/11/2010	Inpatient	110	$ 4,000.00	7			
3/1/2010	3/11/2010	Inpatient	200	$ 4,500.00	3			
3/1/2010	3/11/2010	Inpatient	250	$ 5,200.25				
3/1/2010	3/11/2010	Inpatient	300	$ 2,700.00				
3/1/2010	3/11/2010	Inpatient	360	$ 15,000.75				
3/1/2010	3/11/2010	Inpatient	450	$ 1,000.25				
6/15/2010	6/15/2010	Outpatient	250	$ 150.00		$ 500.00		Exhausted
6/15/2010	6/15/2010	Outpatient	450	$ 750.00		$ 500.00		Exhausted
8/10/2010	8/10/2010	Outpatient	450	$ 1,100.00			$ 100.00	Non-Covered Service

Exhibit A - Uninsured charges/days

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EXHIBIT B – ALL PATIENT PAYMENTS (SELF-PAY) ON A CASH BASIS

- Survey form Exhibit B has been designed to assist hospitals in collecting and reporting all patient payments received on a cash basis.
- Exhibit B should include all patient payments regardless of their insurance status.
- Total patient payments from this exhibit are entered in Section E of the survey.
- Insurance status should be noted on each patient payment so you can sub-total the uninsured hospital patient payments and enter them in Section H of the survey.

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EXHIBIT B – ALL PATIENT PAYMENTS (SELF-PAY) ON A CASH BASIS

- Patient payments received for uninsured services need to be reported on a cash basis.

- For example, a cash payment received during the 2022 cost report year that relates to a service provided in the 2012 cost report year, must be used to reduce uninsured cost for the 2022 cost report year.

EXHIBIT B – ALL PATIENT PAYMENTS (SELF-PAY) ON A CASH BASIS

- Exhibit B
    - Include *Primary Payor Plan*, *Secondary Payor Plan*, *Payment Transaction Code, Provider #, PCN, Birth Date, SSN*, and *Gender, Admit, Discharge, Date of Collection, Amount of Collection, 1011 Indicator, Service Indicator, Hospital Charges, Physician Charges, Non-Hospital Charges, Insurance Status, Claim Status and Calculated Collection* fields.
        - A separate “key” for all payment transaction codes should be submitted with the survey.
- Submit Exhibit B in the format shown using Excel or a CSV file using the tab or | (pipe symbol above the enter key).
- Data not submitted in the correct format may be returned to the hospital with a request for revisions to get the data into the prescribed Exhibit B format.

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Exhibit B - Self-Pay Payments

Claim Type (A)	Primary Payor Plan (B)	Secondary Payor Plan (C)	Transaction Code (D)	Hospital's Medicaid Provider # (E)	Patient Identifier Number (PCN) (F)	Patient's Birth Date (G)	Patient's Social Security Number (H)	Patient's Gender (I)	Name (J)
Self Pay Payments	Medicare	Medicaid	500	12345	3333333	2/7/2025	999-99-999	Male	Jones, Anthony
Self Pay Payments	Medicare	Medicaid	500	12345	3333333	2/7/2025	999-99-999	Male	Jones, Anthony
Self Pay Payments	Medicare	Medicaid	500	12345	3333333	2/7/2025	999-99-999	Male	Jones, Anthony
Self Pay Payments	Medicare	Medicaid	500	12345	3333333	2/7/2025	999-99-999	Male	Jones, Anthony
Self Pay Payments	Blue Cross		150	12345	9999999	9/25/1979	999-99-999	Male	Smith, John
Self Pay Payments	Blue Cross		150	12345	9999999	9/25/1979	999-99-999	Male	Smith, John
Self Pay Payments	Blue Cross		150	12345	9999999	9/25/1979	999-99-999	Male	Smith, John
Self Pay Payments	Self-Pay		500	12345	7777777	7/9/2000	999-99-999	Male	Cliff, Heath
Self Pay Payments	Self-Pay		500	12345	7777777	7/9/2000	999-99-999	Male	Cliff, Heath
Self Pay Payments	United Healthcare		500	12345	5555555	2/15/1960	999-99-999	Male	Johnson, Joe

Admit Date (K)	Discharge Date (L)	Date of Cash Collection (M)	Amount of Cash Collections (N)	Indicate if Collection is a 1011 Payment (O)	Service Indicator (Inpatient / Outpatient) (P)	Total Hospital Charges for Services Provided (Q)	Total Physician Charges for Services Provided (R)	Total Other Non-Hospital Charges for Services Provided (S)	Insurance Status When Services Were Provided (Insured or Uninsured) (T)	Claim Status (Exhausted or Non-Covered Service, if applicable) (U)
7/12/1995	7/14/1995	1/1/2010	$ 50	No	Inpatient	$ 10,000	$ 900	$ -	Insured	
7/12/1995	7/14/1995	2/1/2010	$ 50	No	Inpatient	$ 10,000	$ 900	$ -	Insured	
7/12/1995	7/14/1995	3/1/2010	$ 50	No	Inpatient	$ 10,000	$ 900	$ -	Insured	
7/12/1995	7/14/1995	4/1/2010	$ 50	No	Inpatient	$ 10,000	$ 900	$ -	Insured	
9/21/2000	9/21/2000	9/30/2009	$ 150	No	Outpatient	$ 2,000	$ -	$ 50	Insured	Exhausted
9/21/2000	9/21/2000	10/31/2009	$ 150	No	Outpatient	$ 2,000	$ -	$ 50	Insured	Exhausted
9/21/2000	9/21/2000	11/30/2009	$ 150	No	Outpatient	$ 2,000	$ -	$ 50	Insured	Exhausted
12/31/2009	1/1/2010	5/15/2010	$ 90	No	Inpatient	$ 15,000	$ 1,000	$ -	Uninsured	
12/31/2009	1/1/2010	5/31/2010	$ 90	No	Inpatient	$ 15,000	$ 1,000	$ -	Uninsured	
9/1/2005	9/3/2005	11/12/2010	$ 130	No	Inpatient	$ 14,000	$ 400	$ 50	Insured	Non-Covered Service

Exhibit B - Cash Basis Patient Payments

EXHIBIT C – HOSPITAL-PROVIDED MEDICAID DATA

- Medicaid data reported on the survey must be supported by a third-party paid claims summary such as a PS&R, Managed Care Plan provided report, or state-run paid claims report.
- If not available, the hospital must submit the detail behind the reported survey data in the Exhibit C format. Otherwise, the data may not be allowed in the final UCC.

EXHIBIT C – HOSPITAL-PROVIDED MEDICAID DATA

- Types of data that require an Exhibit C are as follows:
  - Self-reported “Other” Medicaid eligibles (Section H).
  - Self-reported Medicaid FFS & MCO Exhausted and Non-Covered (Section H).
  - All self-reported Out-of-State Medicaid categories (Section I).
  - Additional or adjusted Medicaid FFS/HMO (crossover and non-crossover) claims noted during reconciliation of state and internal hospital data (Section H).

EXHIBIT C – HOSPITAL-PROVIDED MEDICAID DATA

- Exhibit C
  - Include *Primary Payor Plan*, *Secondary Payor Plan, Hospital MCD #, PCN, Patient's MCD Recipient #, DOB, Social, Gender, Name, Admit, Discharge, Service Indicator, Rev Code, Total Charges, Days, Medicare Traditional Payments,* ***Medicare Managed Care Payments****, Medicaid FFS Payments,* ***Medicaid Managed Care Payments****, Private Insurance Payments, Self-Pay Payments, and Sum All Payments* fields.
    - A complete list (key) of payor plans is required to be submitted separately with the survey.
- Submit Exhibit C in the format shown using Excel or a CSV file using the tab or | (pipe symbol above the enter key).

EXHIBIT C – HOSPITAL-PROVIDED MEDICAID DATA

- Exhibit C:
  - Data not submitted in the correct format may be returned to the hospital with a request for revisions to get the data into the prescribed Exhibit C format.
  - In particular, claims data submitted with days, charges, and/or payments in separate Excel files rather than combined into one Exhibit document as prescribed in Exhibit C may be sent back to the hospital to combine.
  - Note that payments being repeated on every line of an Exhibit C claim is acceptable and will be properly accounted for during the desk review.

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Claim Type (A)	Primary Payor Plan (B)	Secondary Payor Plan (C)	Hospital's Medicaid Provider # (D)	Patient Identifier Number (PCN) (E)	Patient's Medicaid Recipient # (F)	Patient's Birth Date (G)	Patient's Social Security Number (H)	Patient's Gender (I)	Name (J)	Admit Date (K)	Discharge Date (L)
Other Medicaid Eligible	Aetna		12345	2222222	123456	21916	999-99-999	Female	Doe, Jane	3/1/2010	3/11/2010
Other Medicaid Eligible	Aetna		12345	2222222	123456	21916	999-99-999	Female	Doe, Jane	3/1/2010	3/11/2010
Other Medicaid Eligible	Aetna		12345	2222222	123456	21916	999-99-999	Female	Doe, Jane	3/1/2010	3/11/2010
Other Medicaid Eligible	Aetna		12345	2222222	123456	21916	999-99-999	Female	Doe, Jane	3/1/2010	3/11/2010
Other Medicaid Eligible	Blue Cross		12345	2222222	123456	21916	999-99-999	Female	Doe, Jane	3/1/2010	3/11/2010
Other Medicaid Eligible	Blue Cross		12345	2222222	123456	21916	999-99-999	Female	Doe, Jane	3/1/2010	3/11/2010
Other Medicaid Eligible	Blue Cross		12345	4444444	98765	31240	999-99-999	Male	Jones, James	6/15/2010	6/15/2010
Other Medicaid Eligible	Blue Cross		12345	4444444	98765	31240	999-99-999	Male	Jones, James	6/15/2010	6/15/2010
Other Medicaid Eligible	Blue Cross		12345	1111111	65478	36590	999-99-999	Male	Smith, Mike	8/10/2010	8/10/2010

Service Indicator (Inpatient / Outpatient) (M)	Revenue Code (N)	Total Charges for Services Provided (O)	Routine Days of Care (P)	Total Medicare Traditional Payments for Services Provided (Q)	Total Medicare HMO Payments for Services Provided (R)	Total Medicaid Payments for Services Provided (S)	Total Medicaid MCO Payments for Services Provided (T)	Total Private Insurance Payments for Services Provided (U)	Self-Pay Payments (V)	Payments Received on Claim (Q)+(R)+(S)+(T)+(U)+(V)	Does claim have any coverage other than Medicaid FFS/Medicaid Managed Care? (Y/N)	Comments
Inpatient	110	$ 4,000	7	$ -	$ -	$ 50	$ -	$ 1,500	$ -	$ 1,550	Y	
Inpatient	200	$ 4,500	3	$ -	$ -	$ 50	$ -	$ 1,500	$ -	$ 1,550	Y	
Inpatient	250	$ 5,200		$ -	$ -	$ 50	$ -	$ 1,500	$ -	$ 1,550	Y	
Inpatient	300	$ 2,700		$ -	$ -	$ -	$ -	$ -	$ 75	$ 75	Y	
Inpatient	360	$ 15,001		$ -	$ -	$ -	$ -	$ -	$ 75	$ 75	Y	
Inpatient	450	$ 1,000		$ -	$ -	$ -	$ -	$ -	$ 75	$ 75	Y	
Outpatient	250	$ 150		$ -	$ -	$ -	$ -	$ -	$ 75	$ 75	Y	
Outpatient	450	$ 750		$ -	$ -	$ 100	$ -	$ 1,000	$ -	$ 1,100	Y	
Outpatient	450	$ 1,100		$ -	$ -	$ 100	$ -	$ 1,000	$ -	$ 1,100	Y	

DSH SURVEY PART I – DSH YEAR DATA

Checklist

- Separate tab in Part I of the survey.
- Should be completed after Part I and Part II surveys are prepared.
- Includes list of all supporting documentation that needs to be submitted with the survey for examination.
- Includes Myers and Stauffer address and phone numbers.

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DSH SURVEY PART I – DSH YEAR DATA

Submission Checklist

1. Electronic copy of the DSH Survey Part I – DSH Year Data.
2. Signed copy of the DSH Survey Part I. Please scan and submit it electronically.
3. Electronic copy of the DSH Survey Part II – Cost Report Year Data.

DSH SURVEY PART I – DSH YEAR DATA

Submission Checklist (cont.)

4. Electronic Copy of Exhibit A – Uninsured Charges/Days.
    - *Must be in Excel (.xls or .xlsx) or CSV (.csv) using either a TAB or | (pipe symbol above the ENTER key).*
5. Description of logic used to compile Exhibit A. Include a copy of all financial classes and payer plan codes utilized during the cost report period and a description of which codes were included or excluded if applicable.

DSH SURVEY PART I – DSH YEAR DATA

Submission Checklist (cont.)

6. Electronic Copy of Exhibit B – Self-Pay Payments.
   - *Must be in Excel (.xls or .xlsx) or CSV (.csv) using either a TAB or | (pipe symbol above the ENTER key).*
7. Description of logic used to compile Exhibit B. Include a copy of all transaction codes utilized to post payments during the cost reporting period and a description of which codes were included or excluded if applicable.

DSH SURVEY PART I – DSH YEAR DATA

Submission Checklist (cont.)

8. Electronic copy of Exhibit C for hospital-generated data (includes Medicaid eligibles, Medicare crossover*, Medicaid HMO*, or Out-Of-State Medicaid data that isn't supported by a state-provided or HMO-provided report).

   - *Must be in Excel (.xls or .xlsx) or CSV (.csv) using either a TAB or | (pipe symbol above the ENTER key).*

   - **If choosing to perform a reconciliation to State data and provide separate Exhibit C*

9. Description of logic used to compile each Exhibit C. Include a copy of all financial classes and payor plan codes utilized during the cost report period and a description of which codes were included or excluded if applicable.

DSH SURVEY PART I – DSH YEAR DATA

Submission Checklist (cont.)

10. Copies of all out-of-state Medicaid fee-for-service PS&Rs (Remittance Advice Summary or Paid Claims Summary including crossovers).

11. Copies of all out-of-state Medicaid managed care PS&Rs (Remittance Advice Summary or Paid Claims Summary including crossovers).

12. Copies of in-state Medicaid managed care PS&Rs (Remittance Advice Summary or Paid Claims Summary including crossovers).

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DSH SURVEY PART I – DSH YEAR DATA

Submission Checklist (cont.)

13. Support for Section 1011 (Undocumented Alien) payments if not applied at patient level in Exhibit B.

14. Documentation supporting out-of-state DSH payments received. Examples may include remittances, detailed general ledgers, or add-on rates.

15. Financial statements or other documentation to support total charity care charges and state / local govt. cash subsidies reported.

16. Revenue code cross-walk used to prepare cost report.

DSH SURVEY PART I – DSH YEAR DATA

Submission Checklist (cont.)

17. A detailed working trial balance used to prepare each cost report (including revenues).

18. A detailed revenue working trial balance by payor/contract. The schedule should show charges, contractual adjustments, and revenues by payor plan and contract (e.g., Medicare, each Medicaid agency payor, each Medicaid Managed care contract).

19. Electronic copy of all cost reports used to prepare each DSH Survey Part II.

20. A Worksheet A Mapping (reconciling expenses included on the detailed working trial balance to the expenses included on Worksheet A of the hospital's cost report).

21. Electronic copy of all cost reports used to prepare each DSH Survey Part II.

DSH SURVEY PART I – DSH YEAR DATA

Submission Checklist (cont.)

21. Documentation supporting cost report payments calculated for Medicaid/Medicare crossovers (dual eligibles).

22. Documentation supporting Medicaid Managed Care Quality Incentive Payments, or any other Managed Care lump sum payments.

UPDATES - MEDICAID DSH THIRD PARTY PAYOR RULE AND CAA

- Medicaid DSH Third Party Payor Rule resulting from Consolidated Appropriations Act (CAA)
  - Effective October 1, 2021 - Will impact WI starting with SFY 2023 DSH Examination
  - Allotment reductions delayed until SFY 2025 ($8B reduction per year)
  - The CAA calls for the exclusion of dual eligible cost and payments from the uncompensated care cost calculation (UCC), unless the hospital qualifies for the 97th percentile SSI exception.
  - Hospitals should continue to report all internal dual-eligible information as in previous years.

***Note: Due to CAA, it is <u>extremely</u> important that hospitals review query logic to ensure claim primary/secondary payors are <u>clearly and accurately</u> classified in submitted exhibits and claims are reported in the proper payor buckets on DSH surveys.**

UPDATES - MEDICAID DSH THIRD PARTY PAYOR RULE AND CAA

- Hospitals must indicate on all claims that there is no coverage other than Medicaid by inputting Yes or No in column X in Exhibit C.
- Column Y in Exhibit C is optional, but is provided for hospitals to include an explanation for why a claim should be considered Medicaid primary.

	J	K	L	M	N	O	P	Q	R	S	T	U	V	W	X	Y
1	Name (J)	Admit Date (K)	Discharge Date (L)	Service Indicator (Inpatient / Outpatient) (M)	Revenue Code (N)	Total Charges for Services Provided (O)	Routine Days of Care (P)	Total Medicare Traditional Payments for Services Provided (Q)	Total Medicare HMO Payments for Services Provided (R)	Total Medicaid Payments for Services Provided (S)	Total Medicaid MCO Payments for Services Provided (T)	Total Private Insurance Payments for Services Provided (U)	Self-Pay Payments (V)	Payments Received on Claim (Q)+(R)+(S)+(T)+(U)+(V)	Does claim have any coverage other than Medicaid FFS/Medicaid Managed Care? (Y/N)	Comments

UPDATES – MEDICAID DSH THIRD PARTY PAYOR RULE AND CAA

When reporting payor plans in columns B and C of Exhibit C, use the payor plan description rather than the payor plan code from your hospital's accounting system.

Example: "UHC Community Plan MCD" or "UHC Community Plan Medicaid" instead of "UHCCOMPL"

Provide a detailed payor plan crosswalk that clearly identifies Medicaid payor plans and non-Medicaid payor plans.

Ensure payments from commercial insurance are included in the Total Private Insurance Payments column (U) and that patient payments are included in Self-Pay Payments column (V).

PRIOR YEAR DSH

Significant Data Issues During Prior Year

- Incomplete DSH Survey Part II files.
- Days, charges, and payments reported in the DSH Survey Part II file(s) did not reconcile to the patient level detail reported in the Exhibit A-C Hospital Provider Claims data.
- Same days were applied to multiple revenue codes.
- No support or crosswalk did not accurately support the mapping of days and charges to cost centers in the DSH Survey Part II file, Section H & I.
- Provided templates (e.g., Exhibit A-C, crosswalk) not utilized for data submissions

PRIOR YEAR DSH

Common Issues Noted During Prior Year

- Hospitals had duplicate patient claims in the uninsured, other Medicaid eligible, and state's Medicaid FFS/HMO data.
- Patient payor classes that were not updated. (Example: a patient was listed as self-pay and it was determined that they later were Medicaid eligible and paid by Medicaid yet the patient was still claimed as uninsured).
- Incorrectly reporting elective (cosmetic surgeries) services and non-Medicaid untimely filings as uninsured patient claims.

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PRIOR YEAR DSH

Common Issues Noted During Prior Year

- Charges and days reported on survey exceeded total charges and days reported on the cost report (by cost center).
- Inclusion of patients in the uninsured charges listing (Exhibit A) that are concurrently listed as insured in the payments listing (Exhibit B).
- Patients listed as both insured and uninsured in Exhibit B for the same dates of service.

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PRIOR YEAR DSH

Common Issues Noted During Prior Year

- Under the December 3, 2014 final DSH rule, hospitals reported “Exhausted” / “Insurance Non-Covered” on Exhibit A (Uninsured) but did not report the payments on Exhibit B.
- “Exhausted” / “Insurance Non-Covered” reported in uninsured incorrectly included the following:
  - Services partially exhausted.
  - Denied due to timely filing.
  - Denied for medical necessity.
  - Denials for pre-certification.

PRIOR YEAR DSH

Common Issues Noted During Prior Year

- Exhibit B – Patient payments didn't always include all patient payments – some hospitals incorrectly limited their data to uninsured patient payments.
- Some hospitals didn't include their charity care patients in the uninsured even though they had no third party coverage.
- Only uninsured payments are to be on cash basis – all other payor payments must include all payments made for the dates of service as of the examination date.

PRIOR YEAR DSH

Common Issues Noted During Prior Year

- Liability insurance claims were incorrectly included in uninsured even when the insurance (e.g., auto policy) made a payment on the claim.
- Hospitals didn't report their charity care in the LIUR section of the survey or didn't include a break-down of inpatient and outpatient charity.
- Hospitals failing to include patients with Medicaid as secondary payer in the other Medicaid eligible category when a primary commercial payment was made.

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PRIOR YEAR DSH PAYMENT LIMIT CALCULATION (2025)

Common Issues Noted During 2025 Procedures

- Hospitals did not answer the DSH payment waiver question on the DSH Waiver & MIUR Data tab of the DSH Survey Part I.
- Hospitals that waived the DSH payment, did not complete the remaining questions on the DSH Waiver & MIUR Data tab.
- Hospitals that waived the DSH payment, submitted more documentation than required. If a hospital chooses to waive the DSH payment, the DSH Waiver & MIUR Data tab of the DSH Survey Part I is the only documentation that needs to be submitted.

WEB PORTAL

- Web Portal Activation
  - Click the “Activate Account” button in the “Welcome to your new Myers and Stauffer portal account” email
  - Click “Set up” button
  - Create a password and click the “Next” button
  - Add phone verification (optional)
  - Receive “Successful User Enrollment” message

WEB PORTAL

- First Time Log-In
  - Click the “Login” button
  - Click “Agree” on consent banner (This appears every login.)
  - Log-in using email/password
  - Follow instructions for second verification (if applicable)
  - Accept Terms of Use Agreement
  - View projects associated with account

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WEB PORTAL

- Ability to upload DSH submission
  - MSLC will review
    - Accept or reject
      - Once document is approved provider is no longer able to upload to that event.
        - Will need to notify MSLC of need to revise as-filed documents.
- Ability to include notes up to 1,000 characters

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DEDICATED TO GOVERNMENT HEALTH PROGRAMS

LOG OUT

Select a Project

Project
WI 2022 DSH Examination
WI 2026 DSH Payment

Select the appropriate project

Select correct provider name and cost report period

Select Cost Report Period

Provider: Select...

Fiscal Year: Begin Date | End Date

Legend of available actions

History

Legend											
Refresh	Upload	Download	Download PHI	Can't Download PHI	Review is Ok	Review is Not Ok	Needs Reviewed	Comparison	Show File Information	Mark as Not Applicable	Not Applicable

Event Date	Event	Expect Date	Response Date	UserID	Action
No Data For the selected Provider/Cost Report					

Example of Events in the Web Portal

Legend											
Refresh	Upload	Download	Download PHI	Can't Download PHI	Review is Ok	Review is Not Ok	Needs Reviewed	Comparison	Show File Information	Mark as Not Applicable	Not Applicable

To upload files

To indicate N/A

Event Date	Event	Expect Date	Response Date	UserID	Action
3/15/2018	DSH Survey Part I (Excel)	5/4/2018		JVIA	
3/15/2018	DSH Survey Part II (Excel) (1 copy each CR period)	5/4/2018		JVIA	
3/15/2018	Signed certification from DSH Survey Part I	5/4/2018		JVIA	
3/15/2018	Support for Section 1011 payments	5/4/2018		JVIA	
3/15/2018	Support for Out-of-State DSH payments	5/4/2018		JVIA	
3/15/2018	Description of logic used to compile Exhibit A	5/4/2018		JVIA	
3/15/2018	Description of logic used to compile Exhibit B	5/4/2018		JVIA	
3/15/2018	Description of logic used to compile Exhibit C(s)	5/4/2018		JVIA	
3/15/2018	Copy of all financial classes and payor plan codes	5/4/2018		JVIA	
3/15/2018	Copy of all transaction codes	5/4/2018		JVIA	
3/15/2018	Support for Subsidies reported	5/4/2018		JVIA	
3/15/2018	Financial statements or other charity care support	5/4/2018		JVIA	
3/15/2018	Revenue code crosswalk used to prepare cost report	5/4/2018		JVIA	

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WEB PORTAL

Website: https://dsh.mslc.com

- Contact WIDSH@mslc.com to request registration form or update contact information.

OTHER INFORMATION

Please use the DSH Part I Survey Submission Checklist when preparing to submit your surveys and supporting documentation.

Upload completed surveys, supporting claims detail, and other request data to the Web Portal.

Questions concerning the DSH Survey and Exhibits A-C can be directed to:

Brad Mehring: BMehring@mslc.com

Larissa Bazaldua: LBazaldua@mslc.com

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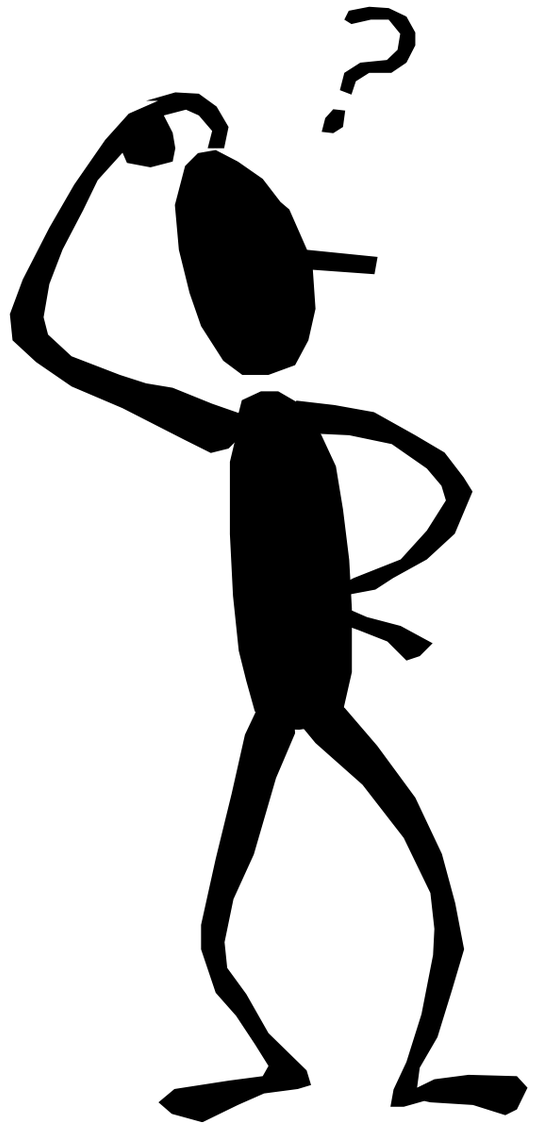

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FAQ

1. **What is the definition of uninsured for Medicaid DSH purposes?**

   Uninsured patients are individuals with no source of third party health care coverage (insurance) for the specific inpatient or outpatient hospital service provided. Prisoners must be excluded.

- On December 3, 2014, CMS finalized the proposed rule published on January 18, 2012 Federal Register to clarify the definition of uninsured and prisoners.
- Under this final DSH rule, the DSH examination looks at whether a patient is uninsured using a “service-specific” approach.
- Based on the 2014 final DSH rule, the survey allows for hospitals to report “fully exhausted” and “insurance non-covered” services as uninsured.

FAQ

1. **What is the definition of uninsured for Medicaid DSH purposes? (Continued from previous slide)**

   Excluded prisoners were defined in the 2014 final DSH rule as:

   - Individuals who are inmates in a public institution or are otherwise involuntarily held in secure custody as a result of criminal charges. These individuals are considered to have a source of third party coverage.
   - <u>Prisoner Exception</u>
     - If a person has been released from secure custody and is referred to the hospital by law enforcement or correction authorities, they can be included.
     - The individual must be admitted as a patient rather than an inmate to the hospital.
     - The individual cannot be in restraints or seclusion.

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FAQ

2. **What is meant by "Exhausted" and "Non-Covered" in the uninsured Exhibits A and B?**

   Under the December 3, 2014 final DSH rule, hospitals can report services if insurance is "fully exhausted" or if the service provided was "not covered" by insurance. The service must still be a hospital service that would normally be covered by Medicaid.

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FAQ

3. **What categories of services can be included in uninsured on the DSH survey?**

Services that are defined under the Medicaid state plan as a Medicaid inpatient or outpatient hospital service may be included in uninsured. *(Auditing & Reporting pg. 77907 & Reporting pg. 77913)*

- There has been some confusion with this issue. CMS attempts to clarify this in #24 of their FAQ titled "*Additional Information on the DSH Reporting and Audit Requirements*". It basically says if a service is a hospital service it can be included even if Medicaid only covered a specific group of individuals for that service.
  - EXAMPLE : A state Medicaid program covers speech therapy for beneficiaries under 18 at a hospital. However, a hospital provides speech therapy to an uninsured individual over the age of 18. Can they include it in uninsured? The answer is "Yes" since speech therapy is a Medicaid hospital service even though they wouldn't cover beneficiaries over 18.

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FAQ

4. **Can a service be included as uninsured, if insurance didn't pay due to improper billing, late billing, or lack of medical necessity?**

   No. Improper billing by a provider does not change the status of the individual as insured or otherwise covered. In no instance should costs associated with claims denied by a health insurance carrier for such a reason be included in the calculation of hospital-specific uncompensated care (would include denials due to medical necessity). *(Reporting pages 77911 & 77913)*

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FAQ

5. **Can unpaid co-pays or deductibles be considered uninsured?**

   No. The presence of a co-pay or deductible indicates the patient has insurance and none of the co-pay or deductible is allowable even under the 2014 final DSH rule. *(Reporting pg. 77911)*

6. **Can a hospital report their charity charges as uninsured?**

   Typically a hospital's charity care will meet the definition of uninsured but since charity care policies vary there may be exceptions. If charity includes unpaid co-pays or deductibles, those cannot be included. Each hospital will have to review their charity care policy and compare it to the DSH rules for uninsured.

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FAQ

7. **Can bad debts be considered uninsured?**

Bad debts cannot be considered uninsured if the patient has third party coverage. The exception would be if they qualify as uninsured under the 2014 final DSH rule as an exhausted or insurance non-covered service (but those must be separately identified).

FAQ

8. **How do IMDs (Institutes for Mental Disease) report patients between 22-64 that are not Medicaid-eligible due to their admission to the IMD?**

- Many states remove individuals between the ages of 22 and 64 from Medicaid eligibility rolls; if so these costs should be reported as uncompensated care for the uninsured. If these individuals are reported on the Medicaid eligibility rolls, they should be reported as uncompensated care for the Medicaid population. *(Reporting pg. 77929 and CMS Feb. 2010 FAQ #28 – Additional Information on the DSH Reporting and Audit Requirements)*

- Per CMS FAQ, if the state removes a patient from the Medicaid rolls and they have Medicare, they cannot be included in the DSH UCC.

  - Under the 2014 final DSH rule, these patients may be included in the DSH UCC if Medicare is exhausted.

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FAQ

9. Can a hospital report services covered under automobile polices as uninsured?

Not if the automobile policy pays for the service. We interpret the phrase "who have health insurance (or other third party coverage)" to broadly refer to individuals who have creditable coverage consistent with the definitions under 45 CFR Parts 144 and 146, as well as individuals who have coverage based upon a legally liable third party payer. The phrase would not include individuals who have insurance that provides only excepted benefits, such as those described in 42 CFR 146.145, unless that insurance actually provides coverage for the hospital services at issue (such as when an automobile liability insurance policy pays for a hospital stay). *(Reporting pages 77911 & 77916)*

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FAQ

10. How are patient payments to be reported on Exhibit B?

Cash-basis! Exhibit B should include patient payments collected during the cost report period (cash-basis). Under the DSH rules, uninsured cost must be offset by uninsured cash-basis payments.

11. Does Exhibit B include only uninsured patient payments or ALL patient payments?

ALL patient payments. Exhibit B includes all cash-basis patient payments so that testing can be done to ensure no payments were left off of the uninsured. The total patient payments on Exhibit B should reconcile to your total self-pay payments collected during the cost report year.

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FAQ

12. Should we include state and local government payments for indigent in uninsured on Exhibit B?

Uninsured payments do not include payments made by State-only or local only government programs for services provided to indigent patients (no Federal share or match). *(Reporting pg. 77914)*

13. Can physician services be included in the DSH survey?

Physician costs that are billed as physician professional services and reimbursed as such should not be considered in calculating the hospital-specific DSH limit. *(Reporting pg. 77924)*

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FAQ

14. Do dual eligibles (Medicare/Medicaid) have to be included in the Medicaid UCC?

Yes. CMS believes the costs attributable to dual eligible patients should be included in the calculation of the uncompensated care costs. *(Reporting pg. 77912)*

15. Does Medicaid HMO and Out-of-State Medicaid have to be included?

Yes. Under the statutory hospital-specific DSH limit, it is necessary to calculate the cost of furnishing services to the Medicaid populations, including those served by Managed Care Organizations (MCO), and offset those costs with payments received by the hospital for those services. *(Reporting pages 77920 & 77926)*

FAQ

16. Do Other Medicaid Eligibles (Private Insurance/Medicaid) have to be included in the Medicaid UCC?

Days, costs, and revenues associated with patients that are dually eligible for Medicaid and private insurance should be included in the calculation of the Medicaid inpatient utilization rate (MIUR) for the purposes of determining a hospital eligible to receive DSH payments. Section 1923(g)(1) does not contain an exclusion for individuals eligible for Medicaid and also enrolled in private health insurance. Therefore, days and costs associated with patients that are eligible for Medicaid and also have private insurance should be included in the calculation of the hospital-specific DSH limit. *(January, 2010 CMS FAQ 33 titled, "Additional Information on the DSH Reporting and Audit Requirements")*