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DISPROPORTIONATE SHARE HOSPITAL (DSH) PAYMENT EXAMINATION UPDATE

DSH YEAR 2016

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

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OVERVIEW

- DSH Examination Policy
- DSH Year 2016 Examination Timeline
- DSH Year 2016 Examination Impact
- Paid Claims Data Review
- Review of DSH Year 2016 Survey and Exhibits
- 2016 Clarifications / Changes
- Recap of Prior Year Examinations (2015)
- Myers and Stauffer DSH FAQ

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*"

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

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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
- Treatment of Third Party Payers in Calculating Uncompensated Care Costs, April 3, 2017 FR Vol. 82, No. 62, Final Rule
- Bi-partisan Budget Act of 2018, February 9, 2018; delayed the DSH reductions until FY2020
- December 31, 2018 Additional Information on the DSH Reporting and Audit Requirements

DSH YEAR 2016 EXAMINATION TIMELINE

- Survey files and data request uploaded to web portal on February 22nd
- The State FFS, Crossover, HMO data and supplemental/ enhanced payments will be provided to hospitals via the web portal.
- Completed surveys and patient level detail due by April 19, 2019
- Draft report to the state by September 30, 2019
- Final report to CMS by December 31, 2019

DSH YEAR 2016 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 2016 examination report is the sixth year that may result in DSH payment recoupments.

PAID CLAIMS DATA UPDATE FOR 2016

- Medicaid fee-for-service paid claims data
  - Will be uploaded to the 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 FOR 2016

- Medicare/Medicaid cross-over paid claims data
  - Will be uploaded to the 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.

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PAID CLAIMS DATA UPDATE FOR 2016

- Medicaid managed care (HMO) paid claims data
  - Will be uploaded to the 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					$ -	$ -	$ -	$ -
TPL					$ -	$ -	$ -	$ -
Patient Payments					$ 100.00	$ -	$ -	$ 100.00

Days summarized by revenue code

Charges 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	-	40	$ 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	-	-	-	-	$ -	$ -	$ -	$ -

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PAID CLAIMS DATA UPDATE FOR 2016

- 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.

PAID CLAIMS DATA UPDATE FOR 2016

- "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 FOR 2016

- "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 2016 DSH examination report.
  - Ensure that you ***separately report*** Medicaid, Medicaid HMO, Medicare, Medicare HMO, private insurance, and self-pay payments in Exhibit C.

PAID CLAIMS DATA UPDATE FOR 2016

- "Other" Medicaid Eligibles (cont.)
  - Discussion on recent withdrawal of FAQ 33 and 34 later in the presentation.
  - Private insurance and Medicare payment data is still being collected in the current year, but will not be used to offset costs in the final examination report.

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PAID CLAIMS DATA UPDATE FOR 2016

Additional Clarification on Crossover and Other Medicaid Eligible Claims:

In-State Medicare FFS Cross-Over 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 Medicaid covered hospital service)
Medicare HMO primary with Medicaid HMO secondary	

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PAID CLAIMS DATA UPDATE FOR 2016

- Uninsured Services
  - Uninsured charges/days will be reported on Exhibit A and patient payments will be reported on Exhibit B.
  - Exhibit A charges 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).

FILES EACH HOSPITAL RECEIVED

- <u>DSH data request documents:</u>
  - Notice of the 2016 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 to be provided to the hospitals:
  - Traditional FFS MMIS data (includes state-only program data)
  - Crossover data
  - HMO data
  - Supplemental/Enhanced payments

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DSH EXAMINATION 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.
  - 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 EXAMINATION SURVEYS

General Instruction – Survey Files

- Don’t 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 12/31/15 with the DSH examination of SFY 2015 in the prior year. In the DSH year 2016 exam, Hospital A would only need to submit a survey for their year ending 12/31/16.
- 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.

DSH EXAMINATION 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 do 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

Section A

- DSH Year should already be filled in.
- Hospital name may already be selected (if not, select from the drop-down box).
- 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 OB questions using drop-down boxes.

DSH SURVEY PART I – DSH YEAR DATA

Section C

- Report any Medicaid supplemental payments including UPL, HMO access payments, and other Non-Claim Specific payments, for the state fiscal year. Do NOT include DSH payments.

Certification

- Answer the “Retain DSH” question but please note that IGTs and CPEs 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.

A. General DSH Year Information

	Begin	End
1. DSH Year:	10/01/2014	09/30/2015

2. Select Your Facility from the Drop-Down Menu Provided: Hospital ABC

Select hospital name.

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	07/01/2015	06/30/2016
4. Cost Report Year 2 (if applicable)		
5. Cost Report Year 3 (if applicable)		

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

	Data
6. Medicaid Provider Number:	123456789
7. Medicaid Subprovider Number 1 (Psychiatric or Rehab):	0
8. Medicaid Subprovider Number 2 (Psychiatric or Rehab):	0
9. Medicare Provider Number:	230000

B. DSH OB Qualifying Information

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

Answer all OB questions.

During the DSH Examination Year:

	DSH Examination Year (10/01/14 - 09/30/15)
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?	

C. Disclosure of Other Medicaid Payments Received:

1. **Medicaid Supplemental Payments for DSH Year 10/01/2014 - 09/30/2015**
   (Should include UPL and Non-Claim Specific payments paid based on the state fiscal year. However, DSH payments should NOT be included.)

Input all supplemental payments for the DSH year (UPL, etc...). Should agree to the state's report.

Certification:

	Answer
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.	

Must answer the retain DSH question.

Explanation for "No" answers: _____

_____

_____

Complete certification and contact information.

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.

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:		Outside Preparer:	
Name		Name	
Title		Title:	
Telephone Number		Firm Name:	
E-Mail Address		Telephone Number	
Mailing Street Address		E-Mail Address	
Mailing City, State, Zip			

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.**

D. General Cost Report Year Information 7/1/2015 - 6/30/2016

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		
	7/1/2015 through 6/30/2016		
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:			

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

	Data	Correct?	If Incorrect, Proper Information
4. Hospital Name:	Hospital ABC		
5. Medicaid Provider Number:	123456789		
6. Medicaid Subprovider Number 1 (Psychiatric or Rehab):	0		
7. Medicaid Subprovider Number 2 (Psychiatric or Rehab):	0		
8. Medicare Provider Number:	230000		

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

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)

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”.

E. Disclosure of Medicaid / Uninsured Payments Received: (07/01/2015 - 06/30/2016)

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

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

	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%

13. **Did your hospital receive any Medicaid <u>managed care</u> 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 <u>hospital</u> (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 payments (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 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 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 (07/01/2015 - 06/30/2016)

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 lines 5 & 6)	-

Days per cost report.

(See Note in Section F-3, below)

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

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	$ -

State or local govt. subsidies.

7.	Inpatient Hospital Charity Care Charges	
8.	Outpatient Hospital Charity Care Charges	
9.	Non-Hospital Charity Care Charges	
10.	Total Charity Care Charges	$ -

Charity care charges (only used in LIUR - NOT UCC).

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

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	$0.00			$ -	$ -	$ -	$ -
12.	Subprovider I (Psych or Rehab)	$0.00			$ -	$ -	$ -	$ -
13.	Subprovider II (Psych or Rehab)	$0.00			$ -	$ -	$ -	$ -
14.	Swing Bed - SNF			$0.00			$ -	
15.	Swing Bed - NF			$0.00			$ -	
16.	Skilled Nursing Facility			$0.00			$ -	
17.	Nursing Facility			$0.00			$ -	
18.	Other Long-Term Care			$0.00			$ -	
19.	Ancillary Services	$0.00	$0.00		$ -	$ -	$ -	$ -
20.	Outpatient Services		$0.00			$ -	$ -	$ -
21.	Home Health Agency			$0.00			$ -	
22.	Ambulance			$ -			$ -	
23.	Outpatient Rehab Providers			$0.00	$ -	$ -	$ -	$ -
24.	ASC	$0.00	$0.00		$ -	$ -	$ -	$ -
25.	Hospice			$0.00			$ -	
26.	Other	$0.00	$0.00	$0.00	$ -	$ -	$ -	$ -
27.	Total	$ -	$ -	$ -	$ -	$ -	$ -	$ -
28.	Total Hospital and Non Hospital		Total from Above	$ -		Total from Above	$ -	
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.	Adjusted Contractual Adjustments						-	
36.	Unreconciled Difference		Unreconciled Difference (Should be $0)	$ -		Unreconciled Difference (Should be $0)	$ -	

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

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.
  - 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

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G. Cost Report - Cost / Days / Charges

Cost Report Year (-) | SELECT HOSPITAL NAME

Routine charges are populated here. These are strictly informational and do not flow into any calculations.

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)		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*	*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									$ -

Routine cost per diems - calculated based on cost report data entered below.

		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
	Observation Data (Non-Distinct)								
20	09200 Observation (Non-Distinct)	-	-	-	$ -	$ -	$ -	$ -	-

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

G. Cost Report - Cost / Days / Charges

Cost Report Year (07/01/2015-06/30/2016) Hospital ABC

Line #	Cost Center Description	Total Allowable Cost	Intern & Resident Costs Removed on Cost Report *	RCE and Therapy Add-Back (If Applicable)		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*		*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		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
22		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
23		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
24		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
25		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
26		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
27		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
28		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
29		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
30		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
31		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
32		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
33		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
34		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
35		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
36		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
37		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
38		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
39		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
40		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
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)*					$0.00				
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)*					$0.00				
131	NF, SNF, and Swing Bed Cost for Other Payors *(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 Cross-Overs *(Traditional/HMO Medicare with Traditional/HMO Medicaid Secondary) from state's paid claims summaries.*
  - In-State Other Medicaid Eligibles *(May include other Medicaid not included elsewhere) submitted Exhibit C.*

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

All Medicaid categories.

Cost Report Year (07/01/2015-06/30/2016) | Hospital ABC

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 FFS Cross-Overs (with Medicaid Secondary)		In-State Other Medicaid Eligibles (Not Included Elsewhere)	
				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)*
	Routine Cost Centers (from Section G):			Days		Days		Days		Days	
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		$ -									
18			Total Days	-		-		-		-	
19	Total Days per PS&R or Exhibit Detail			-		-		-		-	
20	Unreconciled Days (Explain Variance)			-		-		-		-	
				Routine Charges		Routine Charges		Routine Charges		Routine Charges	
21	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.

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

Cost Report Year (07/01/2015-06/30/2016) Hospital ABC

	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 FFS Cross-Overs (with Medicaid Secondary)		In-State Other Medicaid Eligibles (Not Included Elsewhere)	
					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
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				-								
45				-								
					$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -

Enter in all Medicaid ancillary charges. Cost-to-charge 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 (cross-overs).
- Medicare cost report settlement payments (cross-overs).
- Other third party payments (TPL).

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

Cost Report Year (07/01/2015-06/30/2016) Hospital ABC

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 FFS Cross-Overs (with Medicaid Secondary)		In-State Other Medicaid Eligibles (Not Included Elsewhere)	
				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 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)										
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%
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%			

Note A - These amounts must agree to your inpatient and outpatient Medicaid paid claims summary. For Managed Care, Cross-Over data, and other eligibles, use the hospital's logs if PS&R summaries are not available (submit logs with survey).

Note B - Medicaid cost settlement payments refer to payments made by Medicaid during a cost report settlement that are not reflected on the claims paid summary (RA summary or PS&R).

Note C - Other Medicaid Payments such as Outliers and Non-Claim Specific payments. DSH payments should NOT be included. UPL payments made on a state fiscal year basis should be reported in Section C of the survey.

Note D - Should include other Medicare cross-over payments not included in the paid claims data reported above. This includes payments paid based on the Medicare cost report settlement (e.g., Medicare Graduate Medical Education 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.

Enter in all Medicaid, Medicare, Private Insurance, Self Pay, Cost Settlement, and 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.

Uninsured days - must agree to Exhibit A

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

Cost Report Year (07/01/2015-06/30/2016) Hospital ABC

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):			**Days**		**Days**	
1	03000 ADULTS & PEDIATRICS	$ 1,179.55					
2	03100 INTENSIVE CARE UNIT	$ 1,541.67					
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	$ 847.67					
18			**Total Days**	-		-	
19	Total Days per PS&R or Exhibit Detail					-	
20	Unreconciled Days (Explain Variance)			-		-	
				Routine Charges		**Routine Charges**	
21	Routine Charges						
21.01	Calculated Routine Charge Per Diem			$ -		$ -	

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

State-Only Claims charges from MMIS data

Uninsured Charges - must agree to Exhibit A

Cost Report Year (07/01/2015-06/30/2016) Hospital ABC

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)		0.374114				
23	5000 OPERATING ROOM		0.346695				
24	5200 DELIVERY ROOM & LABOR ROOM		0.595009				
25	5300 ANESTHESIOLOGY		0.142858				
26	5400 RADIOLOGY-DIAGNOSTIC		0.182670				
27	5500 RADIOLOGY-THERAPEUTIC		0.127989				
28	6000 LABORATORY		0.189795				
29	6500 RESPIRATORY THERAPY		0.289250				
30	6600 PHYSICAL THERAPY		0.554828				
31	6700 OCCUPATIONAL THERAPY		0.426861				
32	7010 CARDIOPULMONARY		0.520918				
33	7020 SLEEP LAB		0.373642				
34	7100 MEDICAL SUPPLIES CHARGED TO PAT		0.204680				
35	7200 IMPL. DEV. CHARGED TO PATIENTS		1.112603				
36	7300 DRUGS CHARGED TO PATIENTS		0.502998				
37	7500 ASC (NON-DISTINCT PART)		2.417745				
38	7510 GI SERVICES		0.281305				
39	7620 ONCOLOGY/CLINIC SERVICE		0.510556				
40	9000 CLINIC		3.367625				
41	9100 EMERGENCY		0.316071				
				$ -	$ -	$ -	$ -
	Totals / Payments						
128	**Total Charges** ***(includes organ acquisition from Section J)***			$ -	$ -	$ - (Agrees to Exhibit A)	$ - (Agrees 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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State-Only Claims payments from MMIS Data

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

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

Cost Report Year (07/01/2015 - 06/30/2016) Hospital ABC

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*
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)					(Agrees to Exhibit B and B-1)	(Agrees 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 / (Longfall) (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, and other eligibles, use the hospital's logs if PS&R summaries are not available (submit logs with survey).

Note B - Medicaid cost settlement payments refer to payments made by Medicaid during a cost report settlement that are not reflected on the claims paid summary (RA summary or PS&R).

Note C - Other Medicaid Payments such as Outliers and Non-Claim Specific payments. DSH payments should NOT be included. UPL payments made on a state fiscal year basis should be reported in Section C of the survey.

Note D - Should include other Medicare cross-over payments not included in the paid claims data reported above. This includes payments paid based on the Medicare cost report settlement (e.g., Medicare Graduate Medical Education 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.

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, cross-over, In-State, Out-of-State) cost less all applicable payments in the survey and non-claim payments such a 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 may be used to establish future DSH payments.

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

2016 CLARIFICATIONS

- *DSH Allotments*
  - Allotment reduction has been delayed even further until federal fiscal year 2020, through the Bi-partisan Budget Act of 2018. The total reduction amount is $4B the first year (2020) then $8B each remaining year (2021-2025).

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

- <u>Additional Edits</u>
  - In the far right column, you will see an edit 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 edits 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

- <u>Additional Edits</u>
  - On Section H and I, in the cross-over columns, there will be an edit above the days section that will pop up if you enter more cross-over 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

- <u>Additional Edits</u>
  - 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.

DSH SURVEY PART II
SECTION I, OUT OF STATE MEDICAID

- Report Out-of-State Medicaid days, ancillary 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 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.
- 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.

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

Cost Report Year (07/01/2015-06/30/2016) | Hospital ABC

In-State organ acquisitions.

		Total Organ Acquisition Cost	Additional Add-In Intern/Resident Cost	Total Adjusted Organ Acquisition Cost	Revenue for Medicaid/ Cross-Over / Uninsured Organs Sold	Total Useable Organs (Count)	In-State Medicaid FFS Primary		In-State Medicaid Managed Care Primary		In-State Medicare FFS Cross-Overs (with Medicaid Secondary)		In-State Other Medicaid Eligibles (Not Included Elsewhere)		Uninsured	
							Charges	Useable Organs (Count)	Charges	Useable Organs (Count)	Charges	Useable Organs (Count)	Charges	Useable Organs (Count)	Charges	Useable Organs (Count)
		Cost Report Worksheet D-4, Pt. III, Col. 1, Ln 61	*Add-On Cost Factor on Section G, Line 133 x Total Cost Report Organ Acquisition Cost*	*Sum of Cost Report Organ Acquisition Cost and the Add-On Cost*	*Similar to Instructions from Cost Report WS D-4 Pt. III, Col. 1, Ln 66 (substitute Medicare with Medicaid/ Cross-Over & uninsured). See Note C below.*	*Cost Report Worksheet D-4, Pt. III, Line 62*	*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 Own Internal Analysis*	*From Hospital's Own Internal Analysis*
	Organ Acquisition Cost Centers (list below):															
1	Lung Acquisition	$0.00	$ -	$ -		0										
2	Kidney Acquisition	$0.00	$ -	$ -		0										
3	Liver Acquisition	$0.00	$ -	$ -		0										
4	Heart Acquisition	$0.00	$ -	$ -		0										
5	Pancreas Acquisition	$0.00	$ -	$ -		0										
6	Intestinal Acquisition	$0.00	$ -	$ -		0										
7	Islet Acquisition	$0.00	$ -	$ -		0										
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 as 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 (07/01/2015-06/30/2016) | Hospital ABC

Out-of-State organ acquisitions.

		Total Organ Acquisition Cost	Additional Add-In Intern/Resident Cost	Total Adjusted Organ Acquisition Cost	Revenue for Medicaid/ Cross-Over / Uninsured Organs Sold	Total Useable 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)	
							Charges	Useable Organs (Count)	Charges	Useable Organs (Count)	Charges	Useable Organs (Count)	Charges	Useable Organs (Count)
		Cost Report Worksheet D-4, Pt. III, Col. 1, Ln 61	*Add-On Cost Factor on Section G, Line 133 x Total Cost Report Organ Acquisition Cost*	*Sum of Cost Report Organ Acquisition Cost and the Add-On Cost*	*Similar to Instructions from Cost Report WS D-4 Pt. III, Col. 1, Ln 66 (substitute Medicare with Medicaid/ Cross-Over & uninsured). See Note C below.*	*Cost Report Worksheet D-4, Pt. III, Line 62*	*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)*
	Organ Acquisition Cost Centers (list below):													
11	Lung Acquisition	$ -	$ -	$ -	$ -	0								
12	Kidney Acquisition	$ -	$ -	$ -	$ -	0								
13	Liver Acquisition	$ -	$ -	$ -	$ -	0								
14	Heart Acquisition	$ -	$ -	$ -	$ -	0								
15	Pancreas Acquisition	$ -	$ -	$ -	$ -	0								
16	Intestinal Acquisition	$ -	$ -	$ -	$ -	0								
17	Islet Acquisition	$ -	$ -	$ -	$ -	0								
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.

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.

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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)
- By "permissible", they are referring to a "valid" tax in accordance with 42 CFR §433.68(b).

DSH SURVEY PART II
SECTION L, PROVIDER TAXES

- Section L is used to report allowable Medicaid Provider Tax.
- Added 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.

DSH SURVEY PART II
SECTION L, PROVIDER TAXES

- 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., charges).

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).

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 (07/01/2015 - 06/30/2016) | Hospital ABC

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 Gross Provider Tax Assessment*			*(WTB Account #)*
2	Hospital Gross Provider Tax Assessment Included in Expense on the Cost Report (W/S A, Col. 2)			*(Where is the cost included on w/s A?)*
3	Difference (Explain Here ---------->)	$ -		

Tax reclassications, 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))*

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

DSH UCC ALLOVABLE - Provider Tax Assessment Adjustments (from w/s A-8 of the Medicare cost report)

8	*Reason for adjustment*			*(Adjusted to / (fr*
9	*Reason for adjustment*			*(Adjusted to / (fr*
10	*Reason for adjustment*			*(Adjusted to / (fr*
11	*Reason for adjustment*			*(Adjusted to / (fr*

DSH UCC NON-ALLOVABLE 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*			

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

16	Total Net Provider Tax Assessment Expense Included in the Cost Report	$ -

DSH UCC Provider Tax Assessment Adjustment:

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

Apportionment of Provider Tax Assessment Adjustment to Medicaid & Uninsured:

18	Medicaid Hospital	**Charges Sec. G**	-
19	Uninsured Hospital	**Charges Sec. G**	-
20	Total Hospital	**Charges Sec. G**	-
21	Percentage of Provider Tax Assessment Adjustment to include in DSH Medicaid UCC		0.00%
22	Percentage of Provider Tax Assessment Adjustment to include in DSH Uninsured UCC		0.00%
23	Medicaid Provider Tax Assessment Adjustment to DSH UCC		$ -
24	Uninsured Provider Tax Assessment Adjustment to DSH UCC		$ -
25	Provider Tax Assessment Adjustment to DSH UCC		$ -

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.

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EXHIBIT A - UNINSURED

- Exhibit A:
    - Include *Primary Payor Plan*, *Secondary Payor Plan*, *Provider #, PCN, Birth Date, SSN*, and *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.

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

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.

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 <u>received</u> during the 2016 cost report year that relates to a service provided in the 2005 cost report year, must be used to reduce uninsured cost for the 2016 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.

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 Medicaid HMO data (Section H).
  - Self-reported Medicaid/Medicare cross-over data (Section H).
  - Self-reported “Other” Medicaid eligibles (Section H).
  - All self-reported Out-of-State Medicaid categories (Section I).
  - Additional or adjusted Medicaid FFS/HMO 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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Exhibit C - Other Medicaid Eligibles

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 Eligibles	Blue Cross	Medicaid	12345	888888	123456789	1/1/1960	999-99-999	Male	James, Samuel	9/1/2009	9/4/2009
Other Medicaid Eligibles	Blue Cross	Medicaid	12345	888888	123456789	1/1/1960	999-99-999	Male	James, Samuel	9/1/2009	9/4/2009
Other Medicaid Eligibles	Blue Cross	Medicaid	12345	888888	123456789	1/1/1960	999-99-999	Male	James, Samuel	9/1/2009	9/4/2009
Other Medicaid Eligibles	Blue Cross	Medicaid	12345	888888	123456789	1/1/1960	999-99-999	Male	James, Samuel	9/1/2009	9/4/2009
Other Medicaid Eligibles	Blue Cross	Medicaid	12345	888888	123456789	1/1/1960	999-99-999	Male	James, Samuel	9/1/2009	9/4/2009
Other Medicaid Eligibles	Aetna	Medicaid	12345	666666	978654321	7/12/1985	999-99-999	Female	Johnson, Sandy	6/30/2010	6/30/2010
Other Medicaid Eligibles	Aetna	Medicaid	12345	666666	978654321	7/12/1985	999-99-999	Female	Johnson, Sandy	6/30/2010	6/30/2010
Other Medicaid Eligibles	Aetna	Medicaid	12345	666666	978654321	7/12/1985	999-99-999	Female	Johnson, Sandy	6/30/2010	6/30/2010
Other Medicaid Eligibles	Cigna	Medicaid	12345	555555	654321978	3/5/2000	999-99-999	Female	Jeffery, Susan	2/28/2010	2/28/2010
Other Medicaid Eligibles	Cigna	Medicaid	12345	555555	654321978	3/5/2000	999-99-999	Female	Jeffery, Susan	2/28/2010	2/28/2010

Service Indicator (Inpatient / Outpatient) (M)	Revenue Code (N)	Total Charges for Services Provided (O) *	Routine Days of Care (P)	Total Medicare 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)	Sum of All Payments Received on Claim (Q)+(R)+(S)+(T)+(U)+(V)
Inpatient	120	$ 1,200	3	$ -	$ -	$ 50	$ -	$ 1,500	$ -	$ 1,550
Inpatient	206	$ 1,500	1	$ -	$ -	$ 50	$ -	$ 1,500	$ -	$ 1,550
Inpatient	250	$ 100	-	$ -	$ -	$ 50	$ -	$ 1,500	$ -	$ 1,550
Inpatient	300	$ 375	-	$ -	$ -	$ 50	$ -	$ 1,500	$ -	$ 1,550
Inpatient	450	$ 1,500	-	$ -	$ -	$ 50	$ -	$ 1,500	$ -	$ 1,550
Outpatient	250	$ 100	-	$ -	$ -	$ -	$ -	$ 900	$ 75	$ 975
Outpatient	300	$ 375	-	$ -	$ -	$ -	$ -	$ 900	$ 75	$ 975
Outpatient	450	$ 1,500	-	$ -	$ -	$ -	$ -	$ 900	$ 75	$ 975
Outpatient	300	$ 375	-	$ -	$ -	$ 100	$ -	$ 1,000	$ -	$ 1,100
Outpatient	450	$ 1,500	-	$ -	$ -	$ 100	$ -	$ 1,000	$ -	$ 1,100

Exhibit C - Other Medicaid Eligibles

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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. Electronic copy of the DSH Survey Part II – Cost Report Year Data.
3. 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)*.
4. Description of logic used to compile Exhibit A. 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.

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DSH SURVEY PART I – DSH YEAR DATA

Submission Checklist (cont.)

5. 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).*
6. 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.

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DSH SURVEY PART I – DSH YEAR DATA

Submission Checklist (cont.)

7. 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*

8. 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.)

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

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

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

DSH SURVEY PART I – DSH YEAR DATA

Submission Checklist (cont.)

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

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

14. Financial statements to support total charity care charges and state / local govt. cash subsidies reported.

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

DSH SURVEY PART I – DSH YEAR DATA

Submission Checklist (cont.)

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

17. 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).

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

19. Documentation supporting cost report payments calculated for Medicaid/Medicare cross-overs (dual eligibles).

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

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2016 CLARIFICATIONS / CHANGES

- *Managed Care contracts with all-inclusive rates.*
  - If HMO payments are all-inclusive, providers should remove the professional fee portion of the payment from the DSH surveys, if identifiable.
  - If hospital cannot identify the pro-fee portion of the payment, a reasonable % to total allocation of payments to professional fees will be accepted.

2016 CLARIFICATIONS / CHANGES

- *OB Requirements*
  - Section 1923(d) of the SSA includes exceptions to OB service requirements. One exception is that hospitals that did not offer emergency OB services to the general population as of December 22, 1987 are not required to meet the two-OB rule for DSH payment eligibility.
  - CMS issued a clarification titled *Additional Information on the DSH Reporting and Auditing Requirements* on April 7, 2014.
    - "The law does not contemplate a grandfathering clause or otherwise make exception to the obstetrician requirement for hospitals that came into existence after December 22, 1987; therefore, such hospitals would not be considered exempt from the obstetrician requirement at section 1923(d) of the act."

2016 CLARIFICATIONS / CHANGES

- *December 3, 2014 Final Rule*
  - Definitions of uninsured as laid out in the January 2012 proposed rule have been finalized.
  - Myers and Stauffer has been utilizing the definitions of uninsured as stated in the January 2012 proposed rule since the 2009 DSH examinations.
  - Now that the proposed rule has been finalized, Myers and Stauffer will continue to utilize those definitions as they have been since the 2009 DSH examinations.
  - For details and examples of the definition of uninsured based on the December 3, 2014 Final Rule, see the “Uninsured Definitions” tab of DSH Survey Part II.

2016 CLARIFICATIONS

- The 2008 DSH rule requires that a hospital's DSH uncompensated care cost include all Other Medicaid Eligibles.

- The 2008 DSH rule specifically states that the UCC calculation must include "regular Medicaid payments, Medicaid managed care organization payments, supplemental/enhanced Medicaid payments, uninsured revenues, and 1011 payments." *FR Vol. 73, No. 245, Friday, Dec. 19, 2008, Final Rule, 77904*

- Seattle Children's and Texas Children's Hospitals have sued to stop recoupments of their DSH overpayments that have resulted from the inclusion of private insurance claims in their DSH UCC. On December 29, 2014, a federal court ordered an injunction against Washington and Texas state Medicaid agencies and CMS preventing the state and/or CMS from recouping the overpayments as included in the DSH examination report. On December 31, 2018, CMS removed FAQs #33 and 34, meaning that private insurance and Medicare payments should not offset cost for periods prior to June 2, 2017.

2016 CLARIFICATIONS

- Myers and Stauffer, or any other independent CPA firm, must calculate a hospital's uncompensated care cost for the 2016 DSH examinations without offsetting private insurance and Medicare payments.

- CMS still plans to enforce the 2017 rule, pending their appeal of the Texas court case. As a result, we are still collecting data related to private insurance and Medicare payments, but will not include them in our final report for the 2016 DSH examination.

- However, we do recommend that you submit your Other Medicaid Eligibles exactly as requested in Exhibit C. Specifically, ensure that you **separately identify** each claims' Medicaid FFS, Medicaid Managed Care, Medicare Traditional, Medicare Managed Care, Private Insurance and Self-Pay payments into their individual columns as laid out in the Exhibit A-C template that was provided.

PRIOR YEAR DSH EXAMINATION (2015)

Significant Data Issues During 2015 Procedures

- 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.
- 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 EXAMINATION (2015)

Significant Data Issues During 2015 Procedures

- Hospitals submitted their internal records to support Medicaid FFS days, charges, and payments rather than using the state's MMIS data.

- The 2008 DSH rule requires the use of MMIS data for Medicaid FFS cost and payments. A clarification published by CMS on April 7, 2014 reiterated that MMIS data must be used. **As a result, Myers and Stauffer will not accept internal records to support this data unless the hospital has reconciled to the MMIS detail report and identified the differences.**

PRIOR YEAR DSH EXAMINATION (2015)

Common Issues Noted During Examination

- Hospitals had duplicate patient claims in the uninsured, cross-over, and state's Medicaid FFS 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.

PRIOR YEAR DSH EXAMINATION (2015)

Common Issues Noted During Examination

- Charges and days reported on survey exceeded total charges and days reported on the cost report (by cost center).
- Provider's revenue code crosswalk or grouping schedule didn't correspond to how the Exhibits were grouped on the survey or agree with cost report groupings.
- 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.

PRIOR YEAR DSH EXAMINATION (2015)

Common Issues Noted During Examination

- Patient-level documentation on uninsured Exhibit A and uninsured patient payments from Exhibit B didn't agree to totals on the survey.
- 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.

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PRIOR YEAR DSH EXAMINATION (2015)

Common Issues Noted During Examination

- "Exhausted" / "Insurance Non-Covered" reported in uninsured <u>incorrectly</u> included the following:
- Services partially exhausted.
- Denied due to timely filing.
- Denied for medical necessity.
- Denials for pre-certification.

PRIOR YEAR DSH EXAMINATION (2015)

Common Issues Noted During Examination

- 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.

PRIOR YEAR DSH EXAMINATION (2015)

Common Issues Noted During Examination

- Medicare cross-over payments didn't include all Medicare payments (outlier, cost report settlements, lump-sum/pass-through, payments received after year end, etc.).
- 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 EXAMINATION (2015)

Common Issues Noted During Examination

- 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.

WEB PORTAL

- First Time Log-In
  - Click Forgot Password
  - Enter the email address and click Send Forgot Password Email.
  - Expect an email with a link to set the password.
  - Log-in to the website using email address and new password.
  - Review and confirm providers visible on your account.

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

CHANGE PASSWORD LOG OUT

Select a Project

Project

WI 2016 DSH Examination

Select the appropriate project - WI 2016 DSH Examination

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DEDICATED TO GOVERNMENT HEALTH PROGRAMS

MAIN | SEARCH PROVIDER | CHANGE PASSWORD | REPORTS | LOG OUT

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	

WEB PORTAL

Website: https://dsh.mslc.com

- Contact WIDSH@mslc.com to request registration form or update contact information.
- Must provide valid IP address to be set up to send/receive data.

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:

Jayme Via: JVia@mslc.com

Bernard Hough: BHough@mslc.com

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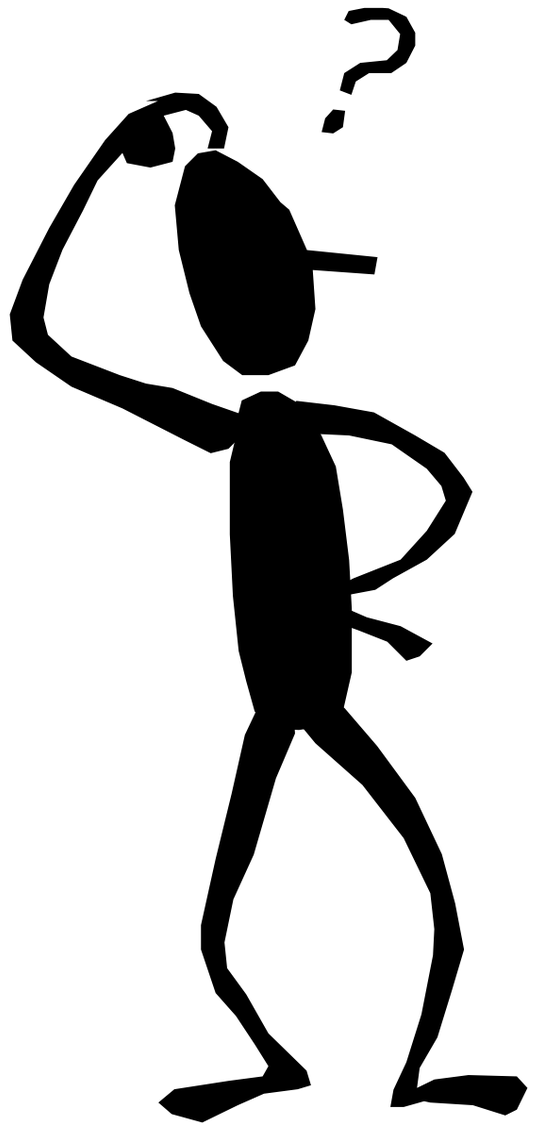

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FAQ

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).

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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)*

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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.