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**DISPROPORTIONATE SHARE HOSPITAL (DSH) PAYMENT EXAMINATION UPDATE
DSH YEAR 2012**

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OVERVIEW

- DSH Examination Policy
- DSH Year 2012 Examination Timeline
- DSH Year 2012 Examination Impact
- Paid Claims Data Review
- Review of DSH Year 2012 Survey and Exhibits
- 2012 Clarifications / Changes
- Recap of Prior Year Examinations (2011)
- Myers and Stauffer DSH FAQ

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RELEVANT DSH POLICY

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

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■ RELEVANT DSH POLICY (CONT.)

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

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■ DSH YEAR 2012 EXAMINATION TIMELINE

- Surveys mailed January 16, 2015
- Surveys returned by March 20, 2015
- March - June 2015 - desk reviews
- June - August 2015 - on-site/expanded reviews
- Draft report to the state by September 30, 2015
- Final report to CMS by December 31, 2015



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■ DSH YEAR 2012 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 2012 examination report is the second year that may result in DSH payment recoupments.

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PAID CLAIMS DATA UPDATE FOR 2012

All paid claims data

- Will be sent at a later date.
- Fee for service will be in Excel format.
- Reported based on cost report year (using discharge date).
- At revenue code level.
- Detailed data is available upon request.
- Will exclude non-Title 19 services (such as CHIP).
- MCO claims will exclude KY Spirit. Provider will need to reconcile and submit internal data.

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PAID CLAIMS DATA UPDATE FOR 2012

- Medicare/Medicaid cross-over paid claims data
 - Same format as last year.
 - Reported based on cost report year (using discharge date).
 - At revenue code level.
 - This data should be thoroughly reviewed upon receipt.
 - If the hospital does not agree with the claims data received please submit a detailed listing using the Exhibit C format along with a reconciliation between claims data and internal data.
- Must EXCLUDE CHIP and other non-Title 19 services.
- Medicare crossover payments will be estimated using the Medicare cost report.

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PAID CLAIMS DATA UPDATE FOR 2012

- Medicaid managed care paid claims data
- Same format as last year.
- Reported based on cost report year (using discharge date).
- At revenue code level.
- This data should be thoroughly reviewed upon receipt.
- If the hospital does not agree with the claims data received please submit a detailed listing using the Exhibit C format along with a reconciliation between claims data and internal data.
- Must EXCLUDE CHIP and other non-Title 19 services.

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PAID CLAIMS DATA UPDATE FOR 2012

- 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.

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PAID CLAIMS DATA UPDATE FOR 2012

- Other Medicaid Eligibles
- Medicaid-eligible patient services where Medicaid did not receive the claim or have any cost-sharing 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).

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PAID CLAIMS DATA UPDATE FOR 2012

- Other Medicaid Eligibles (cont.)
- 2008 DSH Rule and January, 2010 CMS FAQ #33 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, we may have to list the hospital as non-compliant in the 2012 DSH examination report.
- Ensure that you separately report Medicaid, Medicare, third party liability (TPL), and self-pay payments in Exhibit C.
- Discussion on current federal court injunction later in the presentation.

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PAID CLAIMS DATA UPDATE FOR 2012

- Uninsured Services
- As in years past, uninsured charges/days will be reported on Exhibit A and patient payments will be reported on Exhibit B.
- 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, regardless of service date).

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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 12/31/11 with the DSH audit of SFY 2011 in the prior year. In the DSH year 2012 exam, Hospital A would only need to submit a survey for their year ending 12/31/12.
- Both surveys have an Instructions tab that has been updated. Please refer to those tabs if you are unsure of what to enter in a section. If it still isn't clear, please contact Myers and Stauffer.

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■ DSH 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.



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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)

All cost report data, calculation of routine cost per diems

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

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G. Cost Report - Cost (Days/Charges)

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

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■ DSH SURVEY PART II
SECTION H, IN-STATE MEDICAID

- Medicaid Payments Include:
 - Claim payments.
 - Medicaid cost report settlements.
 - Medicare bad debt payments (cross-overs).
 - Medicare cost report settlement payments (cross-overs).
 - Other third party payments (TPL).

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Table with columns for various financial metrics and rows for different categories. A red box highlights a specific instruction: "Enter in all Medicaid, TPL, and Medicare crossover payments."

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■ DSH SURVEY PART II
SECTION H, UNINSURED

- 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.

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2012 CLARIFICATIONS

- *DSH Allotments*
 - Allotment reduction has been delayed until federal fiscal year 2016, through a budget agreement signed December 26, 2013. However, the legislation doubles the reduction that would otherwise have applied in that year.
 - Allotment reduction has been delayed even further until federal fiscal year 2017, through the Protecting Access to Medicare Act (P.L. 113-93). The total reduction amount was increased to \$1,800,000,000.

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2012 CLARIFICATIONS

- *State-Specific Annual DSH Allotment Reduction Factors*
 - High Volume of Medicaid Inpatients Factor (HMF).
 - Imposes larger percentage reductions on states that do not target their DSH payments on hospitals with high volumes of Medicaid inpatients.
 - High Level of Uncompensated Care Factor (HUF).
 - Imposes larger percentage reductions on states that do not target their DSH payments on hospitals with high levels of uncompensated care.

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

- Additional Edits
 - 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.
 - Calculated payments as a percentage of cost by payor (at bottom).
 - Review percentage for reasonableness.

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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.

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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.

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■ 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.

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■ DSH SURVEY PART II SECTION L, PROVIDER TAXES

- **Federal Register / Vol. 75, No. 157 dated Monday, August 16, 2010 (CMS-1498-F)**
 - Discussion on costs of provider taxes as allowable costs for CAHs. (page 50362)
 - CMS is concerned that, even if a particular tax may be an allowable cost that is related to the care of Medicare beneficiaries, providers may not, in fact, "incur" the entire amount of these assessed taxes. (page 50363)

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■ DSH SURVEY PART II
SECTION L, PROVIDER TAXES

"This clarification will not have an effect of disallowing any particular tax but rather make clear that our **Medicare contractors** will continue to **make a determination** of whether a provider tax is allowable, on a **case-by-case basis**, using our current and longstanding reasonable cost principles. In addition, the **Medicare contractors** will continue to determine if an adjustment to the amount of allowable provider taxes is warranted to account for payments a provider receives that are associated with the assessed tax." (emphasis added)

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■ DSH SURVEY PART II
SECTION L, PROVIDER TAXES

- Due to Medicare cost report tax adjustments, an adjustment to cost may be necessary to properly reflect the Medicaid and uninsured share of the provider tax assessment for some hospitals.
- 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).

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**■ DSH SURVEY PART II
SECTION L, PROVIDER TAXES**

- *Ober Kaler 2005 and 2006 Illinois Tax Groups v. Blue Cross Blue Shield Association/National Government Services*, ¶82,616, (Mar. 30, 2010) supports allowing the provider taxes to be treated differently for Medicare than for Medicaid.
- *Abraham Lincoln Memorial Hospital v. Sebelius*, No. 11-2809 (7th Cir. October 16, 2012) also states that because the two programs are independent of one another, CMS's decisions with respect to a State's Medicaid program are not controlling on how CMS interprets the application of Medicare provisions.

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**■ 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.

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**■ 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).

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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, TPL, and Claim Status* fields.
 - A complete list (key) of payor plans is required to be submitted separately with the survey.

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■ 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 in Excel only.

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The screenshot shows an Excel spreadsheet with a table containing columns for patient information and charges. A red box highlights the 'CLAIM STATUS' column. The table includes columns for Patient ID, Name, DOB, SSN, Gender, Admit Date, Discharge Date, Service Indicator, Revenue Code, Total Charges, Days, Patient Payments, TPL, and Claim Status.

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

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

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

- Patient payments received for uninsured services need to be reported on a cash basis.
- For example, a cash payment received during the 2012 cost report year that relates to a service provided in the 2005 cost report year, must be used to reduce uninsured cost for the 2012 cost report year.

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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 in Excel only.

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Chart B - Total Medicaid Payments

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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.

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EXHIBIT C – HOSPITAL-PROVIDED MEDICAID DATA

- Types of data that may require an Exhibit C are as follows:
 - Self-reported Medicaid MCO 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).

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■ 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 Payments, Medicaid Payments, TPL 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.

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Case #	DOB	Gender	Admit Date	Discharge Date	Service Indicator	Rev Code	Total Charges	Days	Medicare Payments	Medicaid Payments	TPL Payments	Self-Pay Payments	Sum All Payments
1													
2													

EXHIBIT C - MANAGED CARE

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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 audit.
- 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).*
- 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).*
- 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 cross-over, Medicaid MCO, or Out-Of-State Medicaid data that isn't supported by a state-provided or MCO-provided report).
 - *Must be in Excel (.xls or .xlsx).*
- 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.

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■ 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).

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■ DSH SURVEY PART I – DSH YEAR DATA

Submission Checklist (cont.)

- 11. Support for Section 1011 (Undocumented Alien) payments if not applied at patient level in Exhibit B.
- 12. Documentation supporting out-of-state DSH payments received. Examples may include remittances, detailed general ledgers, or add-on rates.
- 13. Financial statements to support total charity care charges and state / local govt. cash subsidies reported.
- 14. Revenue code cross-walk used to prepare cost report.

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■ DSH SURVEY PART I – DSH YEAR DATA

Submission Checklist (cont.)

- 15. A detailed working trial balance used to prepare each cost report (including revenues).
- 16. 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).
- 17. Electronic copy of all cost reports used to prepare each DSH Survey Part II.
- 18. Documentation supporting cost report payments calculated for Medicaid/Medicare cross-overs (dual eligibles).

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2012 CLARIFICATIONS / CHANGES

- Labor and delivery days and costs associated with L&D equivalent days must be properly matched in the Medicaid version of the cost report for accurate calculation of costs.
- In some states, hospitals are adding labor and delivery days from line 32 of S-3 to total adults and peds days on line 1 of S-3 in the Medicaid version of their cost reports. However, the costs associated with these days are not reclassified from labor and delivery to adults and peds.
- This understates the A&P per diem for the calculation of the DSH UCC.
- If L&D day costs are included in adults and peds in the cost report, it is proper to add the L&D days to A&P days in calculating the per diem.

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2012 CLARIFICATIONS / CHANGES

- Labor and delivery days and costs (Continued)
- The methodology used to capture labor and delivery cost and days is also dependent on whether labor and delivery days are counted in the hospital census and whether they are billed as an inpatient day.
- According to Medicare guidelines, a labor and delivery day is defined as a day during which a maternity patient is in the labor/delivery room ancillary area at midnight at the time of census taking and is not included in the census of the inpatient routine care area because the patient has not occupied an inpatient routine bed at some time before admission. In the case where the maternity patient is in a single multipurpose labor, delivery and postpartum room, hospital must determine the proportion of each inpatient stay that is associated with ancillary services versus routine adult and pediatric services and report the days associated with the labor and delivery portion of the stay on line 32 of S-3.
- If the L&D days are billed as inpatient days, the days should also be included in total days.

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2012 CLARIFICATIONS

- This does **not** change how Myers and Stauffer or any other independent CPA firm must calculate a hospital's uncompensated care cost for the 2012 DSH examinations at this time.
- Until new CMS audit guidance is issued, we must continue to calculate each hospital's UCC including all Other Medicaid Eligibles (including those with private insurance).
- 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, Medicare, Third Party Liability (TPL), and Self-Pay payments into their individual columns as laid out in the Exhibit A-C template that was provided on your disc.

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PRIOR YEAR DSH EXAMINATION (2011)

Significant Data Issues in Final Report

- Medicaid Managed Care data and Medicaid FFS data may have incorrectly included non-Title 19 services such as CHIP.
- Hospitals couldn't obtain out-of-state Medicaid Paid Claims Summaries (PS&Rs).
- Some hospitals couldn't document their uninsured cost/payments.
- Hospitals had duplicate patient claims in the uninsured, cross-over, and state's Medicaid FFS data.

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■ PRIOR YEAR DSH EXAMINATION (2011)

Significant Data Issues in Final Report

- 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.

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■ PRIOR YEAR DSH EXAMINATION (2011)

Common Issues Noted During Examination

- Patient payor classes that were not updated. (ex. a patient was listed as self-pay and it was determined that they later were Medicaid eligible and paid by Medicaid yet the patient was still claimed as uninsured).
- Incorrectly reporting elective (cosmetic surgeries) services, and non-Medicaid untimely filings as uninsured patient claims.

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■ PRIOR YEAR DSH EXAMINATION (2011)

Common Issues Noted During Examination

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

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■ PRIOR YEAR DSH EXAMINATION (2011)

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 (2011)

Common Issues Noted During Examination

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

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■ PRIOR YEAR DSH EXAMINATION (2011)

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.

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■ PRIOR YEAR DSH EXAMINATION (2011)

Common Issues Noted During Examination

- 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 audit date.
- 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.

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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.

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■ 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.
 - Prisoner Exception
 - 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 policies 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, but in calculating the uncompensated care costs, it is necessary to take into account both the Medicare and Medicaid payments made. In calculating the Medicare payment, the hospital should include all Medicare adjustments (DSH, IME, GME, etc.). (Reporting pg. 77912)

15. Does Medicaid MCO 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 77820 & 77826)

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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, costs and revenues associated with patients that are eligible for Medicaid and also have private insurance should be included in the calculation of the hospital-specific DSH limit. (January, 2010 CMS FAQ 33 listed. "Additional Information on the DSH Reporting and Audit Requirements")

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■ OTHER INFORMATION

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

Send survey and other data to:
Myers and Stauffer LC
Attn: KY DSH Survey
104 Progress Drive
Frankfort, KY 40601
(888) 749-5799
kydsh@mssc.com



Note: Exhibits A-C include protected health information and must be sent accordingly (no e-mail).

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