

Kentucky Medicaid
DSH Survey – Examination Project
Frequently Asked Questions

1. What should I do if the HCRIS data on the DSH survey does not match my as-filed/final cost report?

Response: If there are discrepancies between the HCRIS data and your cost report, please update the survey to reflect the most recent cost report relating to the 2009 DSH survey and send the cost report with your DSH survey.

2. Do I need to fill out survey if I did not receive DSH payments during the DSH year?

Response: No, if you did not receive DSH payments during the DSH year being examined then the survey is not required.

3. Which Medicare cost report do I use the as submitted or final?

Response: Use the best information available. If audited Medicare cost reports are available, they should be used to complete the survey. If the final Medicare cost report is not available, the Medicare as filed cost report can be used.

4. Should the information on the survey be reported in the state's DSH year or the provider's FYE (Cost Report period)?

Response: DSH Survey Part I only relates to the state's DSH year; DSH Survey Part II includes all data reported on hospital specific cost report year basis. **The entire cost report FYE should be reported.** If you need to report multiple cost report years, you must submit a DSH Survey Part II for each additional year.

5. Do I report all or sample FFS and managed care payments?

Response: All payments related to the cost reporting periods should be reported.

6. Should I include all cost to charge and fixed fee charges and payments from the Medicaid FFS PCLs?

Response: Yes

7. Should KHCP days be included on the DSH survey?

Response: Yes, these are your DSH indigent care days. However, make sure all uninsured patient days reported satisfy the CMS definition of uninsured.

8. Do I need data from my PCLs?

Response: Yes, we encourage you to utilize the Medicaid paid claims listings, FFS Crossover, and MCO data provided.

9. Which Medicaid PCL do I use – should I use the PCL that was filed with my cost report?

Response: No, DMS will send you an updated Kentucky Medicaid FFS PCL.

10. Where do I get the remaining data? (i.e., the out-of-state and uninsured data)?

Response: A provider can utilize several data strategies. a.) the provider can contact the out-of-state payer and request paid claims data, or b.) if out-of-state patient data is available, remittance advice documentation may also be helpful.

The uninsured data has to come from the provider's internal patient accounting system. This typically involves getting their IT department involved to pull data in order to complete Exhibit A, and B.

11. If I can't obtain my out-of-state PCL records, can I use my remittance advices as source documentation for Section E of the survey?

Response: Yes, but we would need a summary worksheet or summary log submitted with the survey. Please keep available all the source documentation used to create the summary in the event it is requested during examination.

12. Should non-covered charges from the PCL be included in the survey?

Response: No.

13. Which revenue code crosswalk should be used to report the data in the appropriate cost center: a.) the current crosswalk, or b.) the crosswalk used to

originally complete the relevant cost report periods (i.e., crosswalk in place during the 2009 period)

Response: Providers should utilize the crosswalk in place at the time of completion of the cost reports, if available. Only if the 2009 crosswalk can not be located should a provider use the current crosswalk to group data to the cost centers on the survey. If the current crosswalk is used, a note in the survey submission should be provided that describes why the original crosswalk was not utilized.

14. Should discounts be netted from gross charges?

Response: All gross charges should be reported in the survey.

15. On Section F of the survey, if I use my Medicare G-3 to complete the section F – the G-3 Medicare schedule has contractals with bad debt included. Can I back out the bad debt and provide supporting documentation?

Response: Yes, bad debts can be removed from contractals to complete section F of the survey. Please provide documentation of the removal.

16. Can I submit consolidated Financial Statements – if the notes detail the charity amount for the hospital?

Response: Yes, as long as we can identify the charity amount related to the hospital on the survey.

17. Are home health and ambulance on Schedule F as non-hospital?

Response: Yes, report these in the non-hospital column.

18. Can I add additional ancillary cost centers on Schedule H?

Response: Yes, all data should reconcile, additional lines are provided to ensure your data can be fully reported. These cost centers are consistent with your Cost Report Worksheet C – Part 1.

19. Do I include the zero paid nursery days from the PCL on Schedule H?

Response: Yes, zero paid nursery days are included, along with the nursery per diem cost on Schedule H. These are Medicaid eligible patients that are receiving an approved State Plan service, so their cost is part of the hospital-specific DSH limit.

Note – just to clarify, this is different than the non-covered charges on the PCL. Those are NOT included on Schedule H – because they are not an approved state plan service and should not be included in the DSH limit.

20. How should additional cost centers on the PCL be treated if they didn't have their own cost to charge ratio on Sch. C?

Response: Those should be treated consistent to how they were treated on their Medicare cost report then provide support for where those charges are reported.

21. How should professional fees be handled?

Response: For Schedule H and I – professional fees should not be included in the charges for hospital inpatient or outpatient services.

Note: Professional fees are not included in the hospital-specific DSH limit therefore not reported throughout the survey in data used to arrive at the DSH limit.

However, for Exhibit B – professional charges for I/P and O/P should be reported in the separate column in order to accurately calculate the collections attributed to the hospital's uninsured. Reporting professional charges on Exhibit B will apportion the cash collections between the services.

22. How should crossover bad debt payments be reported? Can the cost report W/S E, Part I, be used?

Response: Yes, if you have a break-out of your cross-over bad debts on your cost report including any rehab or psychiatric units. If you can't get it from the cost report you can use your own records and supply documentation to support it.

Please note: This amount will be compared to a calculated estimate based on the cross-over claims data and may be adjusted.

23. Should the receipt of the appeal settlement money that was previously paid out be included as payments on the 2009 survey?

Response: DMS is treating the DRG and OP appeals settlements prospectively, therefore, any payments received within SFY 2009 will be included on the 2009 survey as a supplemental payment.

24. How should outpatient settlement payments be handled? Reported for the cost report year, or reported in the year received / paid? Should you include the payment made when filing the cost report?

Response: When an outpatient settlement is completed and a payment is either received or paid, those payments should be reported in the year that the payment relates to (i.e., accrual basis, not cash basis). Yes, those interim payments made when filing the cost report should be reported since the payment is not reflected in the PCL.

25. Please provide an example of a subsidy.

Response: Anything received to subsidize uninsured patient care. These vary from state to state and are rare – would come from state or county, typically.

26. On Exhibit A, what do patient identifier and routine days of care mean?

Response: Patient identifier is the internal patient account number and routine days of care are the patient length of stay.

27. How should I sort my data on Exhibit A?

Response: Exhibit A should be sorted by service indicator and then by revenue code this will enable you to group your charges on Section H of the survey.

Basically service indicator should separate the data between inpatient and outpatient. Once the data is separated in that fashion, the inpatient days and charges should transfer to the Schedule H for uninsured. Once separated by revenue code – all the same revenue codes can be summed up and transferred through the provider's crosswalk into the appropriate cost center on the survey. This process is identical to your Medicare cost reporting principles.

28. If I don't have detailed information, can I spread my charges or estimate?

Response: Spreading is acceptable as long as you have patient level detail for the charges.

29. On Exhibit B, should the Self pay payments be reported on the DSH year?

Response: No, Exhibit B should be reported on the cost report periods.

30. How do I handle cash collections through an external collection agent?

Response: The actual cash remitted back to the provider via the third party collector is the amount to be reported on Exhibit B.

31. What is considered a self pay cash collection for Exhibit B?

Response: All payments received from patients. For insured patients these would include payments such as deductible, copay, and coinsurance.

Note: An indicator must be provided on Exhibit B to show if the patient is insured or uninsured.

32. In the “insured” column on Exhibit B – should we include co-pay and deductibles?

Response: Yes, it would include any payment from the patient.

33. Should Exhibit B be including all self-payments?

Response: Exhibit B should include all insured and uninsured self-payments.

34. Is it necessary to split out I/P and O/P on self pay – the cost to charge ratios are the same for ancillary services for both I/P and O/P?

Response: Yes – These should be reported separately.

35. For self pay, can we include charges and related expenses for Ambulance and DME service lines?

Response: According to CMS, Ambulance and DME are not considered hospital services – therefore should not be included in the survey to determine the hospital-specific DSH limit.

36. What is required on Exhibit B-1?

Response: Exhibit B-1 is not required and is only used if a provider doesn't have insurance status on old records.

37. Are Exhibit A, B, and B-1 supposed to allow data entry – are these a template or merely an example data layout?

Response: These exhibits were not designed for data entry. These are for illustrative purposes of how a provider may pull data from their system. This detailed information must be submitted along with the survey. Each provider may report this differently, although these basic data elements as illustrated in the exhibits are required. Please note – providers should follow the formula methodology outlined in the exhibit for calculating the hospital uninsured collections. By pulling up the electronic file, a provider can see the formula in the last column and mirror that methodology using their created exhibit and relevant columns.

38. If a patient is totally **self-insured**, do they appear on Exhibit A and Exhibit B for the survey?

Response: Yes, a patient that is self-insured with no health insurance or other third party coverage receiving services defined as inpatient or outpatient hospital services consistent with services under the Medicaid state plan would be considered as uninsured.

The patients should be included on Exhibit A and Exhibit B (self-insured charges and relevant data is reported on Exhibit A, and all payments received related to the self-insured patient's service is reported on Exhibit B).

Note: Exhibit B may also include other payments received during the cost report period that relate to patients from a prior period that are not reported on Exhibit A.

39. Is my cost report being audited?

Response: No

40. How should I get started on my survey?

Response: See a copy of DSH Tips located at <http://chfs.ky.gov/dms/dsh.htm> or please contact Myers and Stauffer and we will email you a copy.