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DISPROPORTIONATE SHARE HOSPITAL (DSH) PAYMENT EXAMINATION UPDATE DSH YEAR 2020

PLEASE STAY MUTED DURING THE PRESENTATION
TODAY'S PRESENTATION IS BEING RECORDED

DEDICATED TO GOVERNMENT HEALTH PROGRAMS


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OVERVIEW

- DSH Examination Policy
- DSH Year 2020 Examination Timeline
- DSH Year 2020 Examination Impact
- Paid Claims Data Review
- Review of DSH Year 2020 Survey and Exhibits
- 2020 Clarifications / Changes
- Recap of Prior Year Examinations (2019)
- Myers and Stauffer Q&A (Via Chat in Teams)

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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.

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RELEVANT DSH POLICY (CONT.)

- Audit/Reporting implemented in FR Vol. 79, No. 232, Wednesday, Dec. 03, 2014, Final Rule
- “Medicare Access and CHIP Reauthorization Act” - Public Law, April 16, 2015, Sec. 412 delayed DSH reductions until FY 2018
- State DSH Hospital Allotment Reductions, July 28, 2017 FR Vol. 82, No. 144, Proposed Rule
- Bi-partisan Budget Act of 2018, enacted on February 9, 2018 delayed DSH reductions until FY 2020
- CARES Act § 3813 delayed until December 1, 2020
- Consolidated Appropriations Act for 2021 delayed DSH reductions until FY 2024

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DSH YEAR 2020 EXAMINATION TIMELINE

- Survey files and data request uploaded to web portal on April 28th
- MMIS Data will be uploaded to web portal
- Survey's returned by June 9, 2023
- Draft report to the state by October 31, 2023
- Final report to CMS by December 31, 2023

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DSH YEAR 2020 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 2020 examination report is a recoupment year.

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PAID CLAIMS DATA UPDATE FOR 2020

- Medicaid fee-for-service paid claims data
  - Will be uploaded to web portal.
  - Same format as last year.
  - Reported based on cost report year (using discharge date).
  - At revenue code level.
  - Will exclude non-Title 19 services (such as CHIP).

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PAID CLAIMS DATA UPDATE FOR 2020

- Medicare/Medicaid cross-over paid claims data
  - Will be uploaded to web portal.
  - Same format as last year.
  - Reported based on cost report year (using discharge date).
  - At revenue code level.
  - Will exclude non-Title 19 services (such as CHIP).

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PAID CLAIMS DATA UPDATE FOR 2020

- Medicare/Medicaid cross-over paid claims data (cont.)
- Hospital is responsible for ensuring all Medicare payments are included in the final survey even if the payments are not reflected in the paid claim totals. Non-claims based Medicare payments can include:

Medicare Cost Report settlement	Bad Debt reimbursement
Direct GME payments	IME payments
Medicare DSH adjustments	Inpatient capital payments
Organ Acquisition payments	Intern and resident payments
Pass-through cost payments	Transitional corridor payments

- Note: The expectation is that Critical Access Hospitals are reimbursed at cost after sequestration.

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PAID CLAIMS DATA UPDATE FOR 2020

- 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 2020

- "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).

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PAID CLAIMS DATA UPDATE FOR 2020

- "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 2020 DSH examination report.
  - Ensure that you ***separately report*** Medicaid, Medicaid MCO, Medicare, Medicare HMO, private insurance, and self-pay payments in Exhibit C.

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PAID CLAIMS DATA UPDATE FOR 2020

- 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).

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FILES EACH HOSPITAL RECEIVED

- DSH data request documents:
  - Notice of the 2020 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

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FILES EACH HOSPITAL WILL RECEIVE

- Data received from the State to be provided to the hospitals:
  - Traditional FFS MMIS data (includes state-only program data)
  - Crossover 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 year ends.

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DSH EXAMINATION SURVEYS

General Instruction – Survey Files

- Do not complete a DSH Part II survey for a cost report year already submitted in a previous DSH exam year.
    - Example: Hospital A provided a survey for their year ending 12/31/19 with the DSH examination of SFY 2019 in the prior year. In the DSH year 2020 exam, Hospital A would only need to submit a survey for their year ending 12/31/20.
- 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 is not clear, please contact Myers and Stauffer.

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DSH EXAMINATION SURVEYS

General Instruction – HCRIS Data

- If applicable to your state, Myers and Stauffer may 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 see any data pre-loaded will need to complete all lines as instructed.

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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 were not 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.

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DSH SURVEY PART I – DSH YEAR DATA

Section C

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

Certification

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

State of Oklahoma
Disproportionate Share Hospital (DSH) Examination Survey Part I
For State DSH Year 2017

DSH Version 5.25 4/17/2019

A. General DSH Year Information

	Begin	End
1. DSH Year:	10/01/2016	09/30/2017

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

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	01/01/2017	12/31/2017
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 here.

	Data
6. Medicaid Provider Number:	111111111
7. Medicaid Subprovider Number 1 (Psychiatric or Rehab):	0
8. Medicaid Subprovider Number 2 (Psychiatric or Rehab):	0
9. Medicare Provider Number:	370000

B. DSH OB Qualifying Information

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

During the DSH Examination Year:

	DSH Examination Year (10/01/16 - 09/30/17)
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?	

Answer all OB questions.

State of Oklahoma
Disproportionate Share Hospital (DSH) Examination Survey Part I
For State DSH Year 2018

C. Disclosure of Other Medicaid Payments Received:

1. **Medicaid Supplemental Payments for Hospital Services DSH Year 10/01/2017 - 09/30/2018**
   (Should include UPL and non-claim specific payments paid based on the state fiscal year. However, DSH payments should NOT be included.)

2. **Medicaid Managed Care Supplemental Payments for hospital services for DSH Year 10/01/2017 - 09/30/2018**
   (Should include all non-claim specific payments for hospital services such as lump sum payments for full Medicaid pricing (FMP), supplementals, quality payments, bonus payments, capitation payments received by the hospital (not by the MCO), or other incentive payments.
   NOTE: Hospital portion of supplemental payments reported on DSH Survey Part II, Section E, Question 14 should be reported here if paid on a SFY basis.

3. **Total Medicaid and Medicaid Managed Care Non-Claims Payments for Hospital Services10/01/2017 - 09/30/2018** $ -

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

Input all Medicaid Managed Care supplemental payments for the DSH year. Please provide documentation to support any amount entered.

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:

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			

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

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DSH Version 7.25 10/23/2017

D. General Cost Report Year Information **1/1/2016 - 12/31/2016**

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		
	1/1/2016 through 12/31/2016		
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:	12:00:00 AM		

	Data	Correct?
4. Hospital Name:	Hospital ABC	
5. Medicaid Provider Number:	111111	
6. Medicaid Subprovider Number 1 (Psychiatric or Rehab):	0	
7. Medicaid Subprovider Number 2 (Psychiatric or Rehab):	0	
8. Medicare Provider Number:	111111	

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

	State Name & Number
9. State Name & Number	
10. State Name & Number	
11. State Name & Number	
12. State Name & Number	
13. State Name & Number	
14. State Name & Number	
15. State Name & Number	

(List additional states on a separate attachment)

Should have an "X" for the cost report year for which you are reporting. You will have a separate excel file for each year listed here.

Please indicate the status of the cost report being used to complete the survey. Example: As-filed, Settled with audit, Settled without audit, Reopened, etc.

If HCRIS data is used, the date that CMS processed the HCRIS file will populate here.

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

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

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

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

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E. Disclosure of Medicaid / Uninsured Payments Received: (01/01/2015 - 12/31/2015)

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)**			

	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)	$-	$-	$-
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 managed care payments not paid at the claim level?**
Should include all non-claim-specific payments such as lump sum payments for full Medicaid pricing, supplementals, quality payments, bonus payments, capitation payments received by the hospital (not by the MCO), or other incentive payments.

14. Total Medicaid managed care non-claims payments (see question 13 above) received applicable to hospital services	
15. Total Medicaid managed care non-claims payments (see question 13 above) received applicable to non-hospital services	
16. Total Medicaid managed care non-claims payments (see question 13 above) received	$-

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

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

Section1011 undocumented alien payments reconciliation

Out-of-State DSH Payments

Insured and uninsured patient payments reconciliation (from Exhibit B)

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.

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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 does not 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).

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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 does not 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.

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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.

Days per cost report

State and local govt. subsidies

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

F. MIUR / LIUR Qualifying Data from the Cost Report (07/01/2017 - 06/30/2018)

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)	130,000 (See Note in Section F-1)

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

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	$225,000,000.00			$ 180,000,000	$ -	$ -	$ 45,000,000
12.	Subprovider I (Psych or Rehab)	$0.00			$ -	$ -	$ -	$ -
13.	Subprovider II (Psych or Rehab)	$7,000,000.00			$ 5,500,000	$ -	$ -	$ 1,500,000
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	$1,300,000,000.00	$860,000,000.00		$ 1,000,000,000	$ 680,000,000	$ -	$ 480,000,000
20.	Outpatient Services		$130,000,000.00			$ 100,000,000	$ -	$ 30,000,000
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	$5,000.00	$650,000.00	$0.00	$ 4,000	$ 500,000	$ -	$ 151,000
27.	Total	$ 1,532,005,000	$ 990,650,000	$ -	$ 1,185,504,000	$ 780,500,000	$ -	$ 556,651,000
28.	Total Hospital and Non Hospital		Total from Above	$ 2,522,655,000		Total from Above	$ 1,966,004,000	
29.	Total Per Cost Report		Total Patient Revenues (G-3 Line 1)	2,522,655,000		Total Contractual Adj. (G-3 Line 2)	1,966,004,000	
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						1,966,004,000	
36.	Unreconciled Difference		Unreconciled Difference (Should be $0)	$ -		Unreconciled Difference (Should be $0)	$ -	

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

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

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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.

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

DSH YEAR SURVEY PART II SECTION G, COST REPORT DATA

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

State of Oklahoma
Disproportionate Share Hospital (DSH) Examination Survey Part II

Version 8.02

G. Cost Report - Cost / Days / Charges

Cost Report Year (7/1/2019 - 6/30/2020) Hospital ABC

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

Provider tax calculation will populate here once the Sec. L tab is filled out.

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

Line #	Cost Center Description	Total Allowable Cost	Intern & Resident Costs Removed on Cost Report *	RCE and Therapy Add-Back (If Applicable)		Provider Tax Assessment	Total Cost	I/P Days and I/P Ancillary Charges	I/P Routine Charges and O/P Ancillary Charges	Total Charges	Medicaid Per Diem / Cost or Other Ratios
		Cost Report Worksheet B, Part I, Col. 26	*Cost Report Worksheet B, Part I, Col. 25 (Intern & Resident Offset ONLY*	*Cost Report Worksheet C, Part I, Col.2 and Col. 4*	*Swing-Bed Carve Out - Cost Report Worksheet D-1, Part I, Line 26*	*Allocation of Provider Tax from Section L of the Survey Based on Total Cost*	*Calculated*	*Days - Cost Report W/S D-1, Pt. I, Line 2 for Adults & Peds; W/S D-1, Pt. 2, Lines 42-47 for others*	*Inpatient Routine Charges - Cost Report Worksheet C, Pt. I, Col. 6 (Informational only unless used in Section L charges allocation)*		*Calculated Per Diem*
1	03000 ADULTS & PEDIATRICS	$ 62,000,000	$ 3,0		$0.00	$ -	$ 65,000,000	91,000	$128,000,000.00		$ 714.29
2	03100 INTENSIVE CARE UNIT	$ 11,000,000	$			$ -	$ 11,000,000	7,500	$33,000,000.00		$ 1,466.67
3	03200 CORONARY CARE UNIT	$ 12,000,000	$			$ -	$ 12,000,000	10,000	$40,000,000.00		$ 1,200.00
4	03300 BURN INTENSIVE CARE UNIT	$ 5,000,000	$			$ -	$ 5,000,000	4,000	$21,000,000.00		$ 1,250.00
5	03400 SURGICAL INTENSIVE CARE UNIT	$ -	$			$ -	$ -	-	$0.00		$ -
6	03500 OTHER SPECIAL CARE UNIT	$ 9,000,000	$			$ -	$ 9,000,000	9,000	$55,000,000.00		$ 1,000.00
7	04000 SUBPROVIDER I	$ -	$			$ -	$ -	-	$0.00		$ -
8	04100 SUBPROVIDER II	$ 6,000,000	$			$ -	$ 6,000,000	6,000	$9,000,000.00		$ 1,000.00
9	04200 OTHER SUBPROVIDER	$ -	$			$ -	$ -	-	$0.00		$ -
10	04300 NURSERY	$ 4,000,000	$ 1			$ -	$ 4,100,000	4,000	$6,000,000.00		$ 1,025.00
11		$ -	$			$ -	$ -	-	$0.00		$ -
12		$ -	$ -	$ -		$ -	$ -	-	$0.00		$ -
13		$ -	$ -	$ -		$ -	$ -	-	$0.00		$ -
14		$ -	$ -	$ -		$ -	$ -	-	$0.00		$ -
15		$ -	$ -	$ -		$ -	$ -	-	$0.00		$ -
16		$ -	$ -	$ -		$ -	$ -	-	$0.00		$ -
17		$ -	$ -	$ -		$ -	$ -	-	$0.00		$ -
18	Total Routine	$ 109,000,000	$ 3,100,000	$ -	$ -		$ 112,100,000	131,500	$ 292,000,000		
19	Weighted Average										$ 852.47

		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)	5,000	-	-		$ 3,571,450	$2,000,000.00	$17,000,000.00	$ 19,000,00	0.187971

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

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

G. Cost Report - Cost / Days / Charges

Cost Report Year (7/1/2019 - 6/30/2020) Hospital ABC

Line #	Cost Center Description	Total Allowable Cost	Intern & Resident Costs Removed on Cost Report *	RCE and Therapy Add-Back (If Applicable		Provider Tax Assessment	Total Cost	I/P Days and I/P Ancillary Charges	I/P Routine Charges and O/P Ancillary Charges	Total Charges	Medicaid Per Diem / Cost or Other Ratios
		Cost Report Worksheet B, Part I, Col. 26	*Cost Report Worksheet B, Part I, Col. 25 (Intern & Resident Offset ONLY*	*Cost Report Worksheet C, Part I, Col.2 and Col. 4*		*Allocation of Provider Tax from Section L of the Survey Based on Total Cost*	*Calculated*	*Inpatient Charges - Cost Report Worksheet C, Pt. I, Col. 6*	*Outpatient Charges - Cost Report Worksheet C, Pt. I, Col. 7*	*Total Charges - Cost Report Worksheet C, Pt. I, Col. 8*	*Medicaid Calculated Cost-to-Charge Ratio*
	Ancillary Cost Centers (from W/S C excluding Observation) (list below):										
21	5000 OPERATING ROOM	$27,000,000.00	$ 80,000	$ -		$ -	$ 27,080,000	$254,000,000.00	$232,000,000.00	$ 486,000,000	0.055720
22	5100 RECOVERY ROOM	$3,000,000.00	$ -	$ -		$ -	$ 3,000,000	$24,000,000.00	$26,000,000.00	$ 50,000,000	0.060000
23	5200 DELIVERY ROOM & LABOR ROOM	$1,000,000.00	$ 1,120,796	$ -		$ -	$ 2,120,796	$31,000,000.00	$4,000,000.00	$ 35,000,000	0.060594
24	5400 RADIOLOGY-DIAGNOSTIC	$13,000,000.00	$ -	$ -		$ -	$ 13,000,000	$70,000,000.00	$141,000,000.00	$ 211,000,000	0.061611
25	5500 RADIOLOGY-THERAPEUTIC	$6,000,000.00	$ -	$ -		$ -	$ 6,000,000	$3,000,000.00	$67,000,000.00	$ 70,000,000	0.085714
26	5700 CT SCAN	$4,000,000.00	$ -	$ -		$ -	$ 4,000,000	$67,000,000.00	$74,000,000.00	$ 141,000,000	0.028369
27	5800 MRI	$1,000,000.00	$ -	$ -		$ -	$ 1,000,000	$11,000,000.00	$24,000,000.00	$ 35,000,000	0.028571
28	6000 LABORATORY	$20,000,000.00	$ -	$ -		$ -	$ 20,000,000	$470,000,000.00	$124,000,000.00	$ 594,000,000	0.033670
29	6500 RESPIRATORY THERAPY	$7,000,000.00	$ -	$ -		$ -	$ 7,000,000	$83,000,000.00	$6,000,000.00	$ 89,000,000	0.078652
30	6600 PHYSICAL THERAPY	$5,000,000.00	$ -	$ -		$ -	$ 5,000,000	$10,000,000.00	$4,000,000.00	$ 14,000,000	0.357143
31	6700 OCCUPATIONAL THERAPY	$3,000,000.00	$ -	$ -		$ -	$ 3,000,000	$9,000,000.00	$1,000,000.00	$ 10,000,000	0.300000
32	6800 SPEECH PATHOLOGY	$1,000,000.00	$ -	$ -		$ -	$ 1,000,000	$4,000,000.00	$1,000,000.00	$ 5,000,000	0.200000
33	6900 ELECTROCARDIOLOGY	$11,000,000.00	$ -	$ -		$ -	$ 11,000,000	$56,000,000.00	$61,000,000.00	$ 117,000,000	0.094017
34	7100 MEDICAL SUPPLIES CHARGED TO PATIENT	$60,000,000.00	$ -	$ -		$ -	$ 60,000,000	$67,000,000.00	$42,000,000.00	$ 109,000,000	0.550459
35	7200 IMPL. DEV. CHARGED TO PATIENTS	$37,000,000.00	$ -	$ -		$ -	$ 37,000,000	$97,000,000.00	$40,000,000.00	$ 137,000,000	0.270073
36	7300 DRUGS CHARGED TO PATIENTS	$73,000,000.00	$ -	$ -		$ -	$ 73,000,000	$198,000,000.00	$160,000,000.00	$ 358,000,000	0.203911
37	7400 RENAL DIALYSIS	$2,000,000.00	$ -	$ -		$ -	$ 2,000,000	$11,000,000.00	$2,000,000.00	$ 13,000,000	0.153846
38	7600 ANCILLARY PSYCH	$260,000.00	$ 90,000	$ -		$ -	$ 350,000	$150,000.00	$97,000.00	$ 247,000	1.417004
39	7601 DIABETES CENTER	$1,000,000.00	$ -	$ -		$ -	$ 1,000,000	$5,000,000.00	$1,000,000.00	$ 6,000,000	0.166667
40	7602 CARDIAC CATHERIZATION LAB	$13,000,000.00	$ -	$ -		$ -	$ 13,000,000	$65,000,000.00	$79,000,000.00	$ 144,000,000	0.090278
41	9100 EMERGENCY	$13,000,000.00	$ 1,700,000	$ -		$ -	$ 14,700,000	$59,000,000.00	$104,000,000.00	$ 163,000,000	0.090184
126	**Total Ancillary**	$ 301,260,000	$ 2,990,796	$ -		$ -	$ 304,250,796	$ 1,596,150,000	$ 1,210,097,000	$ 2,808,247,000	
127	**Weighted Average**										0.109692
128	**Sub Totals**	$ 410,260,000	$ 6,090,796	$ -		$ -	$ 416,350,796	$ 1,888,150,000	$ 1,210,097,000	$ 3,098,247,000	
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 Payers *(Hospital must calculate. Submit support for calculation of cost.)*										
131.01	Other Cost Adjustments (support must be submitted)										
132	**Grand Total**						$ 416,350,796				
133	Total Intern/Resident Cost as a Percent of Other Allowable Cost						1.48%				

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

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

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

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 MCO) from submitted Exhibit C.*
  - In-State Medicare FFS Cross-Overs *(Traditional Medicare with Medicaid Secondary) from state's paid claims summaries.*
  - In-State Other Medicaid Eligible claims *(May include Medicare MCO cross-overs and other Medicaid not included elsewhere) from submitted Exhibit C.*

State of Oklahoma
Disproportionate Share Hospital (DSH) Examination Survey Part II

Version 7.30

All Medicaid Categories

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

Cost Report Year (07/01/2017-06/30/2018) 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	$ 691.56									
2	03100 INTENSIVE CARE UNIT	$ 1,428.57									
3	03200 CORONARY CARE UNIT	$ 909.09									
4	03300 BURN INTENSIVE CARE UNIT	$ 1,666.67									
5	03400 SURGICAL INTENSIVE CARE UNIT	$ -									
6	03500 OTHER SPECIAL CARE UNIT	$ 900.00									
7	04000 SUBPROVIDER I	$ -									
8	04100 SUBPROVIDER II	$ 830.77									
9	04200 OTHER SUBPROVIDER	$ -									
10	04300 NURSERY	$ 782.61									
11		$ -									
12		$ -									
13		$ -									
14		$ -									
15		$ -									
16		$ -									
17		$ -									
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 report data.

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

Cost Report Year (07/01/2017-06/30/2018) HOSPITAL ABC

	Ancillary Cost Centers (from W/S C) (from Section G):			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)	
				Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges
22	09200	Observation (Non-Distinct)	0.363083								
23	5000	OPERATING ROOM	0.073203								
24	5100	RECOVERY ROOM	0.137920								
25	5200	DELIVERY ROOM & LABOR ROOM	0.322787								
26	5400	RADIOLOGY-DIAGNOSTIC	0.083345								
27	5500	RADIOLOGY-THERAPEUTIC	0.110789								
28	5700	CT SCAN	0.036385								
29	5800	MRI	0.064372								
30	6000	LABORATORY	0.038663								
31	6500	RESPIRATORY THERAPY	0.055067								
32	6600	PHYSICAL THERAPY	0.440026								
33	6700	OCCUPATIONAL THERAPY	0.255366								
34	6800	SPEECH PATHOLOGY	0.293057								
35	6900	ELECTROCARDIOLOGY	0.169820								
36	7100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.446259								
37	7200	IMPL. DEV. CHARGED TO PATIENTS	0.287016								
38	7300	DRUGS CHARGED TO PATIENTS	0.196820								
39	7400	RENAL DIALYSIS	0.213564								
40	7600	ANCILLARY PSYCH	0.264254								
41	7601	DIABETES CENTER	0.331197								
42	7602	CARDIAC CATHERIZATION LAB	0.093583								
43	9100	EMERGENCY	0.097570								
				$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
	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)**			$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -

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

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

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).
  - Medicaid Managed Care Quality Incentive Payments, or other lump sum payments received from Medicaid Managed Care organizations, if applicable.

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

Cost Report Year (7/1/2019 - 6/30/2020) Hospital ABC

		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)	
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%
									ERROR! No other eligibles reported! See c
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)**					60,000			
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, Medicaid Managed Care, Private Insurance, Self Pay, Cost Settlements, Medicare, Medicare Managed Care, Crossover Bad Debt, and Other Medicare Crossover Payments.

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

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.

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

Cost Report Year (07/01/2017-06/30/2018) HOSPITAL ABC

Line #		Cost Center Description	Medicaid Per Diem Cost for Routine Cost Centers	Medicaid Cost to Charge Ratio for Ancillary Cost Centers	Uninsured: Inpatient (See Exhibit A)	Uninsured: Outpatient (See Exhibit A)
			From Section G	*From Section G*	*From Hospital's Own Internal Analysis*	*From Hospital's Own Internal Analysis*
	Routine Cost Centers (from Section G):				**Days**	
1	03000	ADULTS & PEDIATRICS	$ 691.56			
2	03100	INTENSIVE CARE UNIT	$ 1,428.57			
3	03200	CORONARY CARE UNIT	$ 909.09			
4	03300	BURN INTENSIVE CARE UNIT	$ 1,666.67			
5	03400	SURGICAL INTENSIVE CARE UNIT	$ -			
6	03500	OTHER SPECIAL CARE UNIT	$ 900.00			
7	04000	SUBPROVIDER I	$ -			
8	04100	SUBPROVIDER II	$ 830.77			
9	04200	OTHER SUBPROVIDER	$ -			
10	04300	NURSERY	$ 782.61			
11			$ -			
12			$ -			
13			$ -			
14			$ -			
15			$ -			
16			$ -			
17			$ -			
18				Total Days	-	
19	Total Days per PS&R or Exhibit Detail				-	
20		Unreconciled Days (Explain Variance)			-	
					Routine Charges	
21		Routine Charges				
21.01		Calculated Routine Charge Per Diem			$ -	

Uninsured days - must agree to Exhibit A

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

Cost Report Year (07/01/2017-06/30/2018) HOSPITAL ABC

					Uninsured	
	Ancillary Cost Centers (from W/S C) (from Section G):				**Ancillary Charges**	**Ancillary Charges**
22	09200	Observation (Non-Distinct)		0.363083		
23	5000	OPERATING ROOM		0.073203		
24	5100	RECOVERY ROOM		0.137920		
25	5200	DELIVERY ROOM & LABOR ROOM		0.322787		
26	5400	RADIOLOGY-DIAGNOSTIC		0.083345		
27	5500	RADIOLOGY-THERAPEUTIC		0.110789		
28	5700	CT SCAN		0.036385		
29	5800	MRI		0.064372		
30	6000	LABORATORY		0.038663		
31	6500	RESPIRATORY THERAPY		0.055067		
32	6600	PHYSICAL THERAPY		0.440026		
33	6700	OCCUPATIONAL THERAPY		0.255366		
34	6800	SPEECH PATHOLOGY		0.293057		
35	6900	ELECTROCARDIOLOGY		0.169820		
36	7100	MEDICAL SUPPLIES CHARGED TO PATIENT		0.446259		
37	7200	IMPL. DEV. CHARGED TO PATIENTS		0.287016		
38	7300	DRUGS CHARGED TO PATIENTS		0.196820		
39	7400	RENAL DIALYSIS		0.213564		
40	7600	ANCILLARY PSYCH		0.264254		
41	7601	DIABETES CENTER		0.331197		
42	7602	CARDIAC CATHERIZATION LAB		0.093583		
43	9100	EMERGENCY		0.097570		
					$ -	$ -

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)**	$ -	$ -
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)	(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 Se	$ -	$ -
145	**Calculated Payment Shortfall / (Longfall) (PRIOR TO SUPPLEMENTAL PAYMENTS AND DSH)**	$ -	$ -
146	**Calculated Payments as a Percentage of Cost**	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 l**		
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
Note B - Medicaid cost settlement payments refer to payments made by Medicaid during a cost report settlement that are not reflected on the claims pa
Note C - Other Medicaid Payments such as Outliers and Non-Claim Specific payments. DSH payments s
Note D - Should include other Medicare cross-over payments not included in the paid claims data reported above. This includes payments paid based
Note E - Medicaid Managed Care payments should includeall Medicaid Managed Care payments related to the services provided, including, but not limi

Uninsured charges - must agree to Exhibit A

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

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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, MCO, 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.

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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.

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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.
    - 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.

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

- Additional Edits
  - 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.

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

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

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

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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.

Add-On Cost Factor for I&R, Provider Tax.

In-State organ acquisitions.

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

Cost Report Year (07/01/2017-06/30/2018) HOSPITAL ABC

		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 W/S 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										
8		$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.

Out-of-State organ acquisitions.

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

Cost Report Year (07/01/2017-06/30/2018) HILLCREST MEDICAL CENTER

		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 Primar		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 W/S 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								
18		$ -	$ -	$ -	$ -	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.

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DSH SURVEY PART II
SECTION L, PROVIDER TAXES

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

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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

- 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

- Include the Worksheet A line number the tax is included on or provide a reason for the variance between the tax per the general ledger and the amount included in the cost report.
- The tax expense should be reflected based on the cost reporting period rather than the DSH year.
- 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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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 (7/1/2019 - 6/30/2020) Hospital ABC

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*
3	Difference (Explain Here ---------->)	$ -		
	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*			*(Reclass*
7	*Reclassification Code*			*(Reclass*
	DSH UCC ALLOWABLE - Provider Tax Assessment Adjustments (from w/s A-8 of the Medicare cost report)			
8	*Reason for adjustment*			*(Adjuste*
9	*Reason for adjustment*			*(Adjuste*
10	*Reason for adjustment*			*(Adjuste*
11	*Reason for adjustment*			*(Adjuste*
	DSH UCC NON-ALLOWABLE Provider Tax Assessment Adjustments (from w/s A-8 of the Medicare cost report)			
12	*Reason for adjustment*			
13	*Reason for adjustment*			
14	*Reason for adjustment*			
15	*Reason for adjustment*			
16	Total Net Provider Tax Assessment Expense Included in the Cost Report	$ -		

DSH UCC Provider Tax Assessment Adjustment:

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

** Assessment must exclude any non-hospital assessment such as Nursing Facility.*

Enter in GL and cost report total tax amount

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

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

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

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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, Name, Admit, Discharge, Service Indicator, Revenue Code, Total Charges, Days, Patient Payments, Private Insurance Payments, and Claim Status* fields. *Birth Date, SSN*, and *Gender* may also be requested.
    - 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 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 letter to request 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

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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 2020 cost report year that relates to a service provided in the 2013 cost report year, must be used to reduce uninsured cost for the 2020 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 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 letter to request revisions to get the data into the prescribed Exhibit B format.

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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

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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 “Other” Medicaid eligibles (Section H).
  - All self-reported Out-of-State Medicaid categories (Section I).
  - Additional or adjusted Medicaid FFS/Crossover claims noted during reconciliation of state and internal hospital data (Section H).

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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 #, 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. *DOB, Social,* and *Gender* may also be requested.
    - 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).

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EXHIBIT C - HOSPITAL-PROVIDED MEDICAID DATA

- Exhibit C:
  - Data not submitted in the correct format may be returned to the hospital with a letter to request 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.

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)
Medicaid MCO	Healthcare USA	BCBS Blue Advantage	12345	888888	123456789	1/1/1960	999-99-999	Male	James, Samuel	9/1/2009	9/4/2009
Medicaid MCO	Healthcare USA	BCBS Blue Advantage	12345	888888	123456789	1/1/1960	999-99-999	Male	James, Samuel	9/1/2009	9/4/2009
Medicaid MCO	Healthcare USA	BCBS Blue Advantage	12345	888888	123456789	1/1/1960	999-99-999	Male	James, Samuel	9/1/2009	9/4/2009
Medicaid MCO	Healthcare USA	BCBS Blue Advantage	12345	888888	123456789	1/1/1960	999-99-999	Male	James, Samuel	9/1/2009	9/4/2009
Medicaid MCO	Healthcare USA	BCBS Blue Advantage	12345	888888	123456789	1/1/1960	999-99-999	Male	James, Samuel	9/1/2009	9/4/2009
Medicaid MCO	Family Health Partners		12345	666666	978654321	7/12/1985	999-99-999	Female	Johnson, Sandy	6/30/2010	6/30/2010
Medicaid MCO	Family Health Partners		12345	666666	978654321	7/12/1985	999-99-999	Female	Johnson, Sandy	6/30/2010	6/30/2010
Medicaid MCO	Family Health Partners		12345	666666	978654321	7/12/1985	999-99-999	Female	Johnson, Sandy	6/30/2010	6/30/2010
Medicaid MCO	BCBS	Self-Pay	12345	555555	654321978	3/5/2000	999-99-999	Female	Jeffery, Susan	2/28/2010	2/28/2010
Medicaid MCO	BCBS	Self-Pay	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 Traditional Payments for Services Provided (Q)	Total Medicare HMO Payments for Services Provided (R)	Total Medicaid Payments for Services Provided (S)	Total Medicaid MCO Payments for Services Provided (T)	Total Private Insurance Payments for Services Provided (U)	Self-Pay Payments (V)	Sum of All Payments Received on Claim (Q)+(R)+(S)+(T)+(U)+(V)	Does claim have any coverage other than Medicaid FFS/Medicaid Managed Care? (Y/N)	Comments
Inpatient	120	$ 1,200	3	$ -	$ -	$ -	$ 1,500	$ 50	$ -	$ 1,550		
Inpatient	206	$ 1,500	1	$ -	$ -	$ -	$ 1,500	$ 50	$ -	$ 1,550		
Inpatient	250	$ 100	-	$ -	$ -	$ -	$ 1,500	$ 50	$ -	$ 1,550		
Inpatient	300	$ 375	-	$ -	$ -	$ -	$ 1,500	$ 50	$ -	$ 1,550		
Inpatient	450	$ 1,500	-	$ -	$ -	$ -	$ 1,500	$ 50	$ -	$ 1,550		
Outpatient	250	$ 100	-	$ -	$ -	$ -	$ 900	$ -	$ 75	$ 975		
Outpatient	300	$ 375	-	$ -	$ -	$ -	$ 900	$ -	$ 75	$ 975		
Outpatient	450	$ 1,500	-	$ -	$ -	$ -	$ 900	$ -	$ 75	$ 975		
Outpatient	300	$ 375	-	$ -	$ -	$ -	$ 1,000	$ 100	$ -	$ 1,100		
Outpatient	450	$ 1,500	-	$ -	$ -	$ -	$ 1,000	$ 100	$ -	$ 1,100		

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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 our email addresses and phone numbers.
- Include Item # in file name (e.g. 5(b)_Exh A Logic)

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DSH SURVEY PART I – DSH YEAR DATA

Submission Checklist

1. Electronic copy of the DSH Survey Part I – DSH Year Data.
2. Signed copy of the DSH Survey Part I – Cost Report Year Data.
3. Electronic copy of the DSH Survey Part II – Cost Report Year Data.
4. N/A

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DSH SURVEY PART I – DSH YEAR DATA

Submission Checklist (cont.)

5. (a). Electronic Copy of Exhibit A – Uninsured Days and Charges.

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

5. (b). Description of logic used to compile Exhibit A. 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.)

6. (a). 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. (b). 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. (a). Electronic copy of Exhibit C for hospital-generated data (includes Medicaid eligibles, Medicare crossover, 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) or CSV (.csv) using either a TAB or | (pipe symbol above the ENTER key).*

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

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DSH SURVEY PART I – DSH YEAR DATA

Submission Checklist (cont.)

8. Copies of all out-of-state Medicaid fee-for-service PS&Rs (Remittance Advice Summary or Paid Claims Summary including crossovers)
9. Copies of all out-of-state Medicaid managed care PS&Rs (Remittance Advice Summary or Paid Claims Summary including crossovers).
10. Copies of in-state Medicaid managed care PS&Rs (Remittance Advice Summary or Paid Claims Summary including crossovers).
11. Support for Section 1011 (Undocumented Alien) payments if not applied at patient level in Exhibit B.

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DSH SURVEY PART I – DSH YEAR DATA

Submission Checklist (cont.)

12. Documentation supporting out-of-state DSH payments received.

    Examples may include remittances, detailed general ledgers, or add-on rates.

13. Financial statements or other documentation to support total charity care charges and subsidies reported on Section F of DSH Survey Part II.

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

15. (b). 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).

15. (c). Worksheet A Mapping, showing how WTB accounts map to worksheet A lines on the cost report.

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

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DSH SURVEY PART I – DSH YEAR DATA

Submission Checklist (cont.)

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

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

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UPDATES - CONSOLIDATED APPROPRIATIONS ACT

Signed into Law December 27, 2020

- Medicaid DSH allotment reductions delayed until FFY 2024.
- Changes to calculation of hospital-specific DSH limit to exclude dually-eligible claims.
- Some hospitals may qualify for exception to include dual eligibles.

Dually-Eligible Claims Exclusion

- DSH limit calculated with all dually-eligible (Medicare/Private Insurance primary, Medicaid secondary) **cost and payments** excluded.
- Effective October 1, 2021.
- Exception based on Medicare SSI days or percentage of SSI days.

*****EXTREMELY IMPORTANT TO ENSURE THAT CLAIMS ARE PROPERLY CLASSIFIED IN SUBMITTED EXHIBITS AND DSH SURVEYS BASED ON PRIMARY AND SECONDARY INSURANCE PLANS*****

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PROPOSED CMS RULE CLARIFICATIONS

Effective Date October 1, 2021

- The proposed rule clarifies the October 1, 2021 effective date to be effective starting with each state's first state plan year beginning on or after October 1, 2021.
- State Fiscal Year – SFY 2023 (7/1/2022 – 6/30/2023)

Exception to Dual Eligible Exclusion

- Hospitals in the 97th percentile of all hospitals with respect to inpatient days made up of patients who, for such days, were entitled to Medicare Part A benefits and to supplemental security income (SSI) benefits can include dually eligible claims if it is beneficial for the hospital to do so.
- The 97th percentile list will be calculated by CMS and published annually prior to October 1st of each year.

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UPDATES - CONSOLIDATED APPROPRIATIONS ACT

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

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

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UPDATES – CONSOLIDATED APPROPRIATIONS ACT

- When reporting payor plans in columns B and C of Exhibit C, use the payor plan description rather than the payor plan code from your hospital's accounting system.
  - Example: "UHC Community Plan MCD" or "UHC Community Plan Medicaid" instead of "UHCCOMPL"
- Provide a detailed payor plan crosswalk that clearly identifies Medicaid payor plans and non-Medicaid payor plans.
- Ensure payments from commercial insurance are included in the Total Private Insurance Payments column (U) and that patient payments are included in Self-Pay Payments column (V).

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TAKEAWAYS FOR SFY 2020 DSH

Dual-eligible days, cost, and payments must still be reported on the DSH survey **by all hospitals** until CMS provides sufficient clarification on the items from the previous slide.

Grouping all claims into the proper columns on the DSH survey is extremely important to ensuring your hospital's uncompensated care cost can be accurately calculated.

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UPDATES – PROVIDER RELIEF FUNDS

- Under the CARES act enacted March 27, 2020, a portion of the provider relief funds were used to reimburse health care providers who provided COVID-19 treatment for uninsured individuals with a COVID-19 primary diagnosis on or after February 4, 2020.
- Providers could request claims reimbursement and were generally reimbursed at Medicare rates.
- Impact to DSH and UCC survey
  - Hospitals must include all claims-based provider relief fund payments for uninsured patients
  - Must include all payments applicable to their cost report period (accrual basis)
  - Included in Exhibit B

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PRIOR YEAR DSH EXAMINATION (2019)

Significant Data Issues during 2019 Examination

- Incomplete DSH Survey Part I and Part II files.
- Charges, Days and/or payment amounts reported on DSH Survey Pt. II Sec. H did not tie to detail claims data submitted in Exhibits A, B, or C.
- 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
    - Please do not use the old version of the Exhibit A-C templates.

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PRIOR YEAR DSH EXAMINATION (2019)

Common Issues Noted During Examination

- Hospitals had duplicate patient claims in the Uninsured, Medicaid MCO, FFS Cross-over, Other Medicaid Eligibles, and State's Medicaid FFS data.
- 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 (2019)

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 (2019)

Common Issues Noted During Examination

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

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PRIOR YEAR DSH EXAMINATION (2019)

Common Issues Noted During Examination

- Medicare cross-over payments did not 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.
- Exhibit B – Patient payments did not always include all patient payments – some hospitals incorrectly limited their data to uninsured patient payments.
- Hospitals did not report their charity care in the LIUR section of the survey or did not include a break-down of inpatient and outpatient charity.

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PRIOR YEAR DSH EXAMINATION (2019)

Common Issues Noted During Examination

- Some hospitals didn't include their charity care patients in the uninsured even though they had no third party coverage.
- Liability insurance claims were incorrectly included in uninsured even when the insurance (e.g., auto policy) made a payment on the claim.

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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.

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WEB PORTAL

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

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DEDICATED TO GOVERNMENT HEALTH PROGRAMS

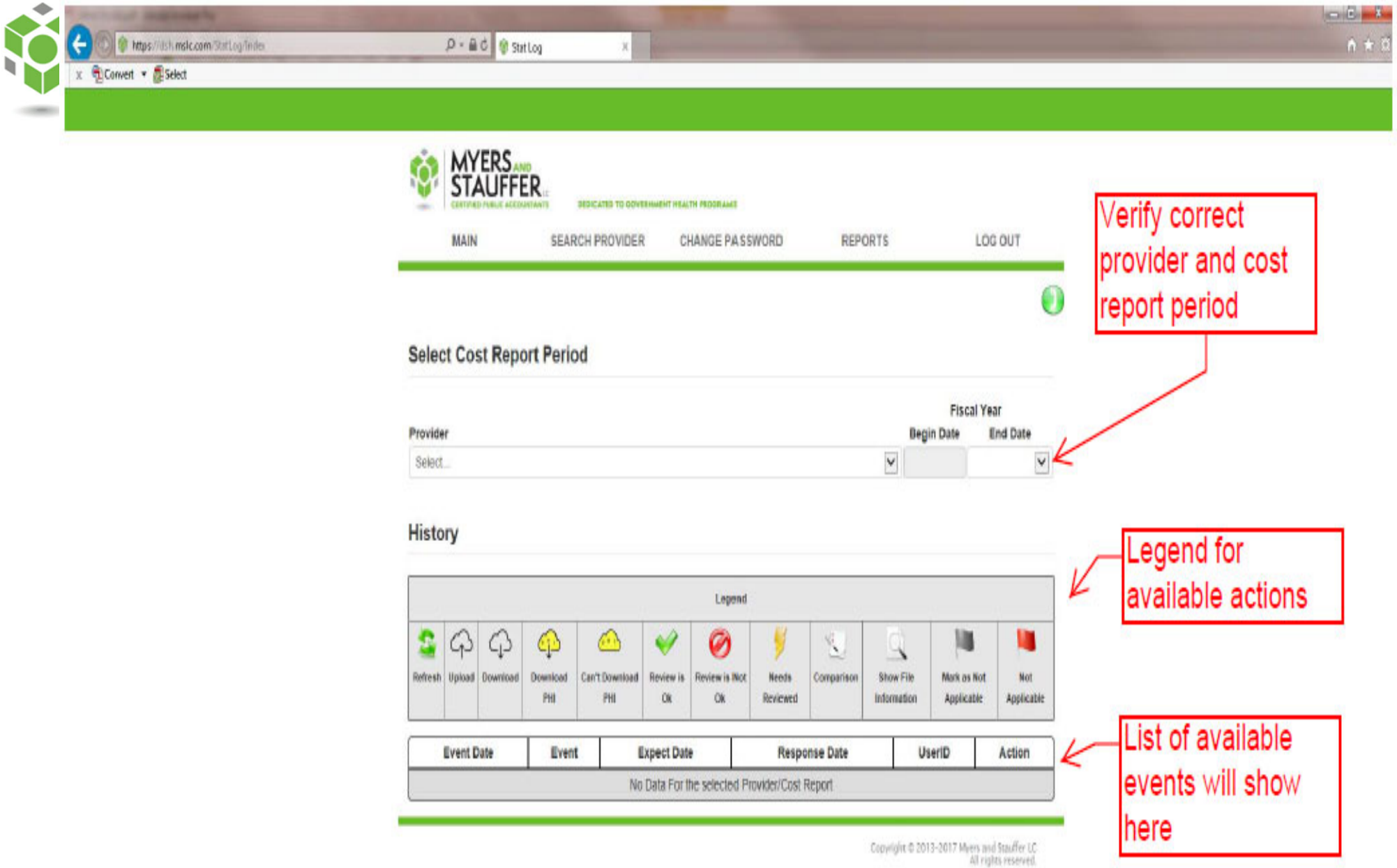
CHANGE PASSWORD LOG OUT

Select a Project

Select appropriate project

Project

OK 2020 DSH Examination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DEDICATED TO GOVERNMENT HEALTH PROGRAMS
MAIN
SEARCH PROVIDER
CHANGE PASSWORD
REPORTS
LOG OUT
Select Cost Report Period
Provider
Fiscal Year
Begin Date
End Date
Select...
History
Legend
Refresh
Upload
Download
Download PHI
Can't Download PHI
Review is Ok
Review is INot 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
Verify correct provider and cost report period
Legend for available actions
List of available events will show here

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
4/27/2023	Initial DSH Data Request (please download)			SSMITH	
4/28/2023	DSH Survey Part I (Excel)	6/9/2023		EGRIMES	
4/28/2023	Signed certification from DSH Survey Part I	6/9/2023		EGRIMES	
4/28/2023	DSH Survey Part II (Excel) (1 copy each CR period)	6/9/2023		EGRIMES	
4/28/2023	Exhibit A (in Excel)	6/9/2023		EGRIMES	
4/28/2023	Description of logic used to compile Exhibit A	6/9/2023		EGRIMES	
4/28/2023	Exhibit B (in Excel)	6/9/2023		EGRIMES	
4/28/2023	Description of logic used to compile Exhibit B	6/9/2023		EGRIMES	
4/28/2023	Exhibit C-In-State Mcaid MCO	6/9/2023		EGRIMES	
4/28/2023	Exhibit C-In-State FFS Cross-over	6/9/2023		EGRIMES	
4/28/2023	Exhibit C-In-State Other Medicaid Eligibles	6/9/2023		EGRIMES	
4/28/2023	Exhibit C-Out-of-State Medicaid FFS	6/9/2023		EGRIMES	
4/28/2023	Exhibit C-Out-of-State Medicaid Managed Care	6/9/2023		EGRIMES	
4/28/2023	Exhibit C-Out-of-State FFS Xover	6/9/2023		EGRIMES	
4/28/2023	Exhibit C-Out-of-State Other Medicaid Eligibles	6/9/2023		EGRIMES	
4/28/2023	Description of logic used to compile Exhibit C(s)	6/9/2023		EGRIMES	
4/28/2023	Support for Section 1011 payments	6/9/2023		EGRIMES	

To download

To upload

To indicate event is N/A

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WEB PORTAL

Website: https://dsh.mslc.com

- Contact okdsh@mslc.com to request registration form or update contact information.
- Must provide valid IP address to be set up to send/receive data.
- Work From Home – Temporary public IP address

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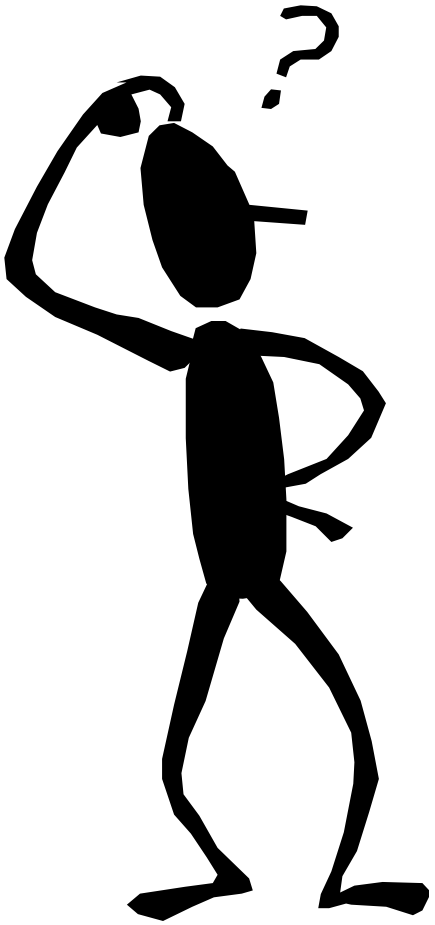

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OTHER INFORMATION

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

Questions concerning the Web Portal, DSH Surveys, and Exh. A-C can be directed to:

Scott Smith: SSmith@mslc.com
Erik Grimes: EGrimes@mslc.com

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

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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 would not cover beneficiaries over 18.

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FAQ

4. Can a service be included as uninsured, if insurance did not 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 or private insurance, 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 or private insurance 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)*

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

FAQ

14. Do dual eligible patients (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 77920 & 77926)*

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CERTIFIED PUBLIC ACCOUNTANTS

FAQ

16. Do other Medicaid eligible claims (private insurance/Medicaid) have to be included in the Medicaid UCC?

Yes. Since Section 1923(g)(1) does not contain an exclusion for dually eligible individuals, CMS believes the costs attributable to dual eligibles should be included in the calculation of the uncompensated costs of serving Medicaid eligible individuals. *(Reporting pages 77912)*