FLORIDA - DISPROPORTIONATE SHARE HOSPITAL (DSH) PAYMENT EXAMINATION DSH YEAR 2011
OVERVIEW

• DSH Examination Policy
• DSH Submission Changes
• DSH Year 2011 Examination Timeline
• DSH Year 2011 Examination Impact
• Paid Claims Data Review
• Review of DSH Year 2011 Survey and Exhibits
• 2011 Clarifications / Changes
• Myers and Stauffer DSH FAQ
RELEVANT DSH POLICY

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

• FR Vol. 77, No. 11, Wednesday, Jan. 18, 2012, Proposed Rule

• 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.
DSH SUBMISSION CHANGES

- Medicaid paid claims and uninsured data will be submitted on cost report period.
  
  - FR Vol. 73, No. 245, Friday, Dec. 19, 2008, page 77930 states that “States and auditors may need to review multiple audited financial reports and cost reports to fully cover the Medicaid State plan rate year under audit… The data may need to be allocated based on the months covered by the financial or cost reporting period that are included in the Medicaid State plan rate year under audit.”
DSH SUBMISSION CHANGES

- Medicaid paid claims and uninsured data will be submitted on cost report period.
  - Facilitates comparisons to financial statements and other data that is based on the cost report period.
  - Always follows hospital’s year end.
  - Allows hospitals to run one paid claims report instead of two in future years. In future years, saves hospitals the trouble of splitting paid claims reports into two periods (to match cost reports).
  - Prevents auditors from questioning two different cost reports every year – after this first year it is always one cost report period.
  - Simplifies surveys in the future.
DSH SUBMISSION CHANGES

- Patient level, revenue code detail must be submitted with the survey in Exhibits A and C.
  - Must follow Medicare cost report methodology which requires grouping charges / days at the cost center level.
DSH SUBMISSION CHANGES

- Necessary data elements included in Exhibits A, B, and C; and query logic
  - FR Vol. 73, No. 245, Friday, Dec. 19, 2008, page 77933 states that “[Auditors] must have confidence that the data accurately represents the hospital’s eligible uncompensated care costs consistent with the statutory criteria.” and that “auditors may need to examine the methodology followed to arrive at the survey data, and may need to develop methods to test, verify the accuracy of, and reconcile data from different sources.”
DSH YEAR 2011 EXAMINATION TIMELINE

- Surveys mailed by April 24, 2014
- Surveys returned by May 30, 2014
- June – August, 2014 - desk reviews
- July, 2014 - on-site/expanded reviews
- Draft report to the state by September 30, 2014
- Final report to CMS by December 31, 2014
DSH YEAR 2011 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 2011 examination report is the first year that may result in DSH payment recoupments.
PAID CLAIMS DATA FOR 2011

- Medicaid fee-for-service paid claims data
  - Sent to hospitals with the survey (some were not yet available but have been ordered and will be sent soon)
  - PCL, as in prior years.
  - Reported based on cost report year (using admit date).
  - Includes revenue code level totals.
PAID CLAIMS DATA FOR 2011

- Medicare/Medicaid cross-over paid claims data is not available.
  - Reported based on cost report year (using admit date).
  - New format – Exhibit C template
  - At revenue code and patient level.
  - Hospital is responsible for ensuring all Medicare payments are included in the final survey even if the payments are cost report payments not on the claim.
PAID CLAIMS DATA FOR 2011

- Medicaid managed care paid claims data is not available.
  - If the hospital cannot obtain a paid claims listing from the MCO, the hospital should send in a detailed listing in Exhibit C format.
  - Must EXCLUDE CHIP (if not also T19 eligible) and other non-Title 19 (non-Medicaid) services.
  - Should be reported based on cost report year (using admit date).
PAID CLAIMS DATA FOR 2011

• Out-of-State Medicaid paid claims data should be obtained from the state making the payment
  
  o If the hospital cannot obtain a paid claims listing from the state, the hospital should send in a detailed listing in Exhibit C format.

  o EXCLUDE CHIP (if not also T19 eligible) and other non-Title 19 (non-Medicaid) services.

  o Should be reported based on cost report year (using admit date).

  o In future years, request out-of-state paid claims listing at the time of your cost report filing
PAID CLAIMS DATA FOR 2011

• “Other” Medicaid Eligibles
  
  o Medicaid-eligible patient services where Medicaid did not receive the claim or have any cost-sharing may not be included in the state’s data. The hospital must submit these eligible services on Exhibit C for them to be eligible for inclusion in the DSH uncompensated care cost (UCC).

  o Report Medicaid concurrent nursery days in a separate Exhibit C (exclude charges).

  o EXCLUDE CHIP (if not also T19 eligible) and other non-Title 19 (non-Medicaid) services.

  o Should be reported based on cost report year (using admit date).
PAID CLAIMS DATA FOR 2011

• Uninsured Services
  o Uninsured charges/days will be reported on Exhibit A and all patient payments will be reported on Exhibit B.
  o Exhibit A charges/days should be reported based on cost report year (using admit date).
  o Exhibit B patient payments will be reported based on cash basis (received during the cost report year).
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 more than one cost report period overlapping the 6/30/2011 year end have to complete 2 or 3 year ends this first year but then it should only be one year thereafter
DSH EXAMINATION SURVEYS

General Instruction – Survey Files

• Both surveys have an Instructions tab. Please refer to those tabs if you are unsure of what to enter in a section. If it still isn’t clear, please contact Myers and Stauffer.

Myers and Stauffer LC
Attn: Florida DSH Survey
11440 Tomahawk Creek Parkway
Leawood, KS 66211
(800) 374-6858
fldsh@mslc.com
DSH EXAMINATION SURVEYS

General Instruction – HCRIS Data

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

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

- DSH Year should already be filled in
- Hospital name may already be selected (if not, select from the drop-down box)
- Verify the cost report year end dates (should only include those that weren’t previously submitted)
  - If these are incorrect, please call Myers and Stauffer and request a new copy

Section B

- Answer all OB questions using drop-down boxes
- List OB physician names
Section C

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

Certification

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

1. DSH Year: Begin 07/01/2010, End 06/30/2011

2. Select your facility from the drop-down menu: SELECT HOSPITAL NAME

Identification of cost reports needed to cover the DSH Year:

3. Cost Report Year 1
4. Cost Report Year 2 (if applicable)
5. Cost Report Year 3 (if applicable)

<table>
<thead>
<tr>
<th>Data</th>
</tr>
</thead>
<tbody>
<tr>
<td>MCard #</td>
</tr>
<tr>
<td>MCard Sub 1 #</td>
</tr>
<tr>
<td>MCard Sub 2 #</td>
</tr>
</tbody>
</table>

6. Medicaid Provider Number:

B. DSH OB Qualifying Information

Questions 1-3 below should be answered in accordance with Sec. 1022(d) of the Social Security Act.

During the DSH Year 07/01/2010 - 06/30/2011:

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 obstetric procedures.)
2. Was the hospital exempt from the requirement listed under #1 above because the hospital's inpatients are predominantly under 16 years of age?
3. Was the hospital exempt from the requirement listed under #1 above because it did not offer nonemergency obstetric services to the general population when federal Medicaid DSH regulations were enacted on December 22, 1987?

C. Disclosure of Other Medicaid Payments Received:

1. Medicaid Supplemental Payments for DSH Year 07/01/2010 - 06/30/2011 (should include LIP, UPL, and Non-Claim Specific payments paid based on the state fiscal year. However, DSH payments should NOT be included.)

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

Answer all OB questions.

List the names of the OBs here.

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

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

   Explanation for “No” answers:

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

I hereby certify that the information in Sections A, B, C, D, E, F, G, H, I, J, K, and L of the DSH Survey files are true and accurate to the best of our ability, and supported by the financial and other records of the hospital. 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:

<table>
<thead>
<tr>
<th>Hospital Contact</th>
<th>Outside Preparer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name</td>
<td>Name</td>
</tr>
<tr>
<td>Title</td>
<td>Title</td>
</tr>
<tr>
<td>Telephone Number</td>
<td>Firm Name</td>
</tr>
<tr>
<td>E-Mail Address</td>
<td>Telephone Number</td>
</tr>
<tr>
<td>Mailing Street Address</td>
<td>E-Mail Address</td>
</tr>
<tr>
<td>Mailing City, State, Zip</td>
<td></td>
</tr>
</tbody>
</table>
Submit one copy of the part II survey for each cost report year that overlaps the 6/30/2011.

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

• Question #3 – This question may be already answered based on pre-loaded HCRIS data. If your hospital is going to update the cost report data to a more recent version of the cost report, select the status of the cost report you are using with this drop-down box.
D. General Cost Report Year Information
1/1/2010 - 12/31/2010

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
   - [Check box] 1/1/2010 through 12/31/2010
   - [Check box] 2 -审计 with Audit

2. Select Cost Report Year Covered by this Survey (enter “X”):
   - [Check box] 1/1/2010 through 12/31/2010

3. Status of Cost Report Used for this Survey (Should be actual if available):
   - [Data] Hospital ABC
   - [Correct?] Yes
   - [Data] 12345
   - [Correct?] Yes
   - [Data] 67890
   - [Correct?] Yes
   - [Data] 01234
   - [Correct?] Yes

4. Out-of-State Medicaid Provider Number: List all states where you had a Medicaid provider agreement during the cost report year:
   - [State Name] [Provider No.]
     - [State Name] [Provider No.]
     - [State Name] [Provider No.]
     - [State Name] [Provider No.]
     - [State Name] [Provider No.]

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

Should have an “X” for the cost report year you are reporting on. Should have a separate Excel file for each year listed here.
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.
E. Disclosure of Medicaid / Uninsured Payments Received / Malpractice: (01/01/2011 - 12/31/2011)

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
  - $10,000
  - $5,000
  - $2,500
  - $7,500
- Outpatient
  - $1,000

Total: $15,250,000

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 your 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.

1011 Payment (undocumented patients) Reconciliation.

Out-of-State DSH payments.

Should agree to the total cash-basis payments on the submitted Exhibit B.

Report hospital malpractice insurance cost that has been included in per diems and cost to charge ratios in Section G.
The state must report your actual MIUR and LIUR for the DSH year - data is needed to calculate the MIUR/LIUR.

Section F-1: Total hospital days from cost report. Myers and Stauffer will pre-load CMS HCRIS cost report data into this section. If it is incorrect or doesn’t agree to a more recently audited version of the cost report, please correct as needed and update question #3 in Section D.

Section F-2: If cash subsidies are specified for I/P or O/P services, record them as such, otherwise record entire amount as unspecified.

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

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

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

- Contractuals by service center are set-up to calculate based on total revenues and the total contractuals from G-3. If you have contractuals by service center or the calculation does not reasonably state the contractual split between hospital and non-hospital, overwrite the formulas as needed and submit the necessary support.
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 28 and 29 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 30 and 31 so they can be properly excluded in calculating net patient service revenue also.

- Medicaid Provider Taxes included on G-3, line 2 should be entered on line 32 so they can be properly excluded in calculating net patient service revenue.
### F. MUUR / LIUR Qualifying Data from the Cost Report (01/01/2011 - 12/31/2011)

#### F-1. Total Hospital Days Used in Medicaid Inpatient Utilization Rate (MUUR)

<table>
<thead>
<tr>
<th>Description</th>
<th>Days (01/01/2011 - 12/31/2011)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Hospital Days Per Cost Report</td>
<td>61,825</td>
</tr>
</tbody>
</table>

#### F-2. Cash Subsidies for Patient Services Received from State or Local Governments and Charity Care Charges (used in Low-income Utilization Rate (LIUR) Calculation)

<table>
<thead>
<tr>
<th>Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient Hospital Subsidies</td>
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</tr>
<tr>
<td>Outpatient Hospital Subsidies</td>
<td>100,000</td>
</tr>
<tr>
<td>Unspecified IP and OIF Hospital Subsidies</td>
<td>450,000</td>
</tr>
<tr>
<td>Total Hospital Subsidies</td>
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</tr>
<tr>
<td>Inpatient Charity Care Charges</td>
<td>300,000</td>
</tr>
<tr>
<td>Outpatient Charity Care Charges</td>
<td>300,000</td>
</tr>
<tr>
<td>Total Charity Care Charges</td>
<td>600,000</td>
</tr>
</tbody>
</table>

#### F-3. Calculation of Net Hospital Revenue from Patient Services (Used for LIUR) (01/01/2011 - 12/31/2011)

<table>
<thead>
<tr>
<th>Hospital Service</th>
<th>Inpatient Hospital</th>
<th>Outpatient Hospital</th>
<th>Non-Hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Patient Revenues (Charges)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>$276,489,268</td>
<td>$182,520,304</td>
<td>$4,607,658</td>
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</tr>
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</table>

<table>
<thead>
<tr>
<th>Contractual Adjustments (formulas below can be overwritten if amounts are known)</th>
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<tr>
<td>$20,059,469</td>
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</table>

#### Reconciling Lines

- **Reconciling lines utilized to ensure that only true contractuals are included in the calculation of the LIUR.**
- **Days per cost report.**
- **State or Local Govt. Subsidies.**
- **Charity Care Charges (only used in LIUR - NOT UCC).**
- **Overwrite contractual formulas if unreasonable or hospital has actual numbers by service center.**
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
### Cost Report - Cost / Days / Charges

<table>
<thead>
<tr>
<th>Line #</th>
<th>Cost Center Description</th>
<th>Total Allowable Cost</th>
<th>Intern &amp; Resident Costs Removed on Cost Report</th>
<th>RCE and Therapy Add-Back (if Applicable)</th>
<th>Provider Tax Assessment</th>
<th>Total Cost</th>
<th>IP</th>
<th>OOP Charges</th>
<th>Total Charges</th>
<th>Medicaid Per Diem / Cost-to-Charge Ratios</th>
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<tbody>
<tr>
<td>1</td>
<td>Cost Report - Pediatrics, Part I, Col 26</td>
<td>$200,000,000</td>
<td>$55,000,000</td>
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<td>258,705,927</td>
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<tr>
<td>2</td>
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<tr>
<td>3</td>
<td>Cost Report - Coronary Care Unit</td>
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<td>4</td>
<td>Cost Report - Burn Intensive Care Unit</td>
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<td>$500,000</td>
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<td>-</td>
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<td>Cost Report - Surgical Intensive Care Unit</td>
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<td>-</td>
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<td>1,980,000</td>
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<td>-</td>
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<tr>
<td>6</td>
<td>Cost Report - Other Special Care Unit</td>
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<td>$1,000,000</td>
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<td>-</td>
<td>$2,000,000</td>
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<td>3,960,000</td>
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<tr>
<td>7</td>
<td>Cost Report - Subprovider I</td>
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<td>-</td>
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<td>7,920,000</td>
<td>-</td>
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<td>8</td>
<td>Cost Report - Subprovider II</td>
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<td>-</td>
<td>-</td>
<td>$1,000,000</td>
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<td>1,980,000</td>
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<td>-</td>
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<tr>
<td>9</td>
<td>Cost Report - Other Subprovider</td>
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<td>10</td>
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<tr>
<td>11</td>
<td>Cost Report - Other Service</td>
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<td>12</td>
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<tr>
<td>13</td>
<td>Cost Report - Other Service</td>
<td>$1,000,000</td>
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<td>-</td>
<td>-</td>
<td>$1,000,000</td>
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<tr>
<td>14</td>
<td>Cost Report - Other Service</td>
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<td>$1,000,000</td>
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<tr>
<td>15</td>
<td>Cost Report - Other Service</td>
<td>$1,000,000</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>$1,000,000</td>
<td>990,000</td>
<td>1,980,000</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>16</td>
<td>Cost Report - Other Service</td>
<td>$1,000,000</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>$1,000,000</td>
<td>990,000</td>
<td>1,980,000</td>
<td>-</td>
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<tr>
<td>17</td>
<td>Cost Report - Other Service</td>
<td>$1,000,000</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>$1,000,000</td>
<td>990,000</td>
<td>1,980,000</td>
<td>-</td>
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</tr>
<tr>
<td>18</td>
<td>Total Routine</td>
<td>$249,000,000</td>
<td>$67,040,000</td>
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<td>-</td>
<td>$316,040</td>
<td>310,300,524</td>
<td>480,078</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>

**Routine Cost Centers (list below):**

- Hospital Observation Days
- Subprovider I Observation Days
- Subprovider II Observation Days
- Calculated (Per Diems Above Multiplied by Days)
- Inpatient Charges - Cost Report Worksheet C, Pt. 1, Col 6
- Outpatient Charges - Cost Report Worksheet C, Pt. 1, Col 7
- Total Charges - Cost Report Worksheet C, Pt. 1, Col 8

**Cost Report Data Calculation of Routine Cost Per Diems:**

**Calculation of Observation CCR - uses per diems calculated in first section to carve out and calculate observation cost.**
### G. Cost Report - Cost / Days / Charges

Cost Report Year (01/01/2011 - 12/31/2011)  Hospital ABC

<table>
<thead>
<tr>
<th>Line #</th>
<th>Cost Center Description</th>
<th>Total Allowable Cost</th>
<th>Intern &amp; Resident Costs Removed on Cost Report</th>
<th>RCE and Therapy Add-Back (if Applicable)</th>
<th>Cost Report Worksheet B, Part I, Col. 25</th>
<th>Allocation of Provider Tax from Section L of the Survey Based on Total Cost</th>
<th>Total Cost</th>
<th>IPP</th>
<th>OOP Charges</th>
<th>Total Charges</th>
<th>Medicaid Per Diem / Cost-to-Charge Ratios</th>
</tr>
</thead>
<tbody>
<tr>
<td>21</td>
<td>5600. OPERATING ROOM</td>
<td>$70,000,000.00</td>
<td>$20,000,000.00</td>
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<td>$99,021.71</td>
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</tr>
<tr>
<td>22</td>
<td>5620. DELIVERY ROOM &amp; LABOR ROOM</td>
<td>$25,000,000.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
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<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
</tr>
<tr>
<td>23</td>
<td>5640. RADIOLOGY-DIAGNOSTIC</td>
<td>$110,000,000.00</td>
<td>$1,280,000.00</td>
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</tr>
<tr>
<td>24</td>
<td>5650. ANESTHESIA-THERAPEUTIC</td>
<td>$25,000,000.00</td>
<td>$7,580,000.00</td>
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</tr>
<tr>
<td>25</td>
<td>5660. CARDIAC CATHETERIZATION LABORATORY</td>
<td>$40,000,000.00</td>
<td>$10,000,000.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
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<td>$0.00</td>
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</tr>
<tr>
<td>26</td>
<td>5670. LABORATORY</td>
<td>$110,000,000.00</td>
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<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
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<tr>
<td>27</td>
<td>5680. RESPIRATORY THERAPY</td>
<td>$95,000,000.00</td>
<td>$175,000,000.00</td>
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<tr>
<td>28</td>
<td>5690. PHYSICAL THERAPY</td>
<td>$12,200,000.00</td>
<td>$6,400,000.00</td>
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<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
</tr>
<tr>
<td>29</td>
<td>5710. OCCUPATIONAL THERAPY</td>
<td>$11,000,000.00</td>
<td>$250,000.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
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<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
</tr>
<tr>
<td>30</td>
<td>5602. SPEECH PATHOLOGY</td>
<td>$40,000,000.00</td>
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<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
</tr>
<tr>
<td>31</td>
<td>5655. ELECTROCARDIOGRAPHY</td>
<td>$11,500,000.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
</tr>
<tr>
<td>32</td>
<td>5730. MEDICAL SUPPLIES CHARGED TO PATIENTS</td>
<td>$39,000,000.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
</tr>
<tr>
<td>33</td>
<td>5720. MEDICAL DEVICES CHARGED TO PATIENTS</td>
<td>$200,000.00</td>
<td>$200,000.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
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<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
</tr>
<tr>
<td>34</td>
<td>5735. DRUGS CHARGED TO PATIENTS</td>
<td>$120,000,000.00</td>
<td>$500,000.00</td>
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<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
</tr>
<tr>
<td>35</td>
<td>5740. RENAL DIALYSIS</td>
<td>$9,000,000.00</td>
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<td>$0.00</td>
<td>$0.00</td>
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<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
</tr>
<tr>
<td>36</td>
<td>5745. EMERGENCY ROOM</td>
<td>$30,000,000.00</td>
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<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
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<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
</tr>
<tr>
<td>101</td>
<td>Total Ancillary</td>
<td>$469,150,000.00</td>
<td>$37,105,000.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
</tr>
<tr>
<td>102</td>
<td>Weighted Average</td>
<td>$469,150,000.00</td>
<td>$37,105,000.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
</tr>
<tr>
<td>103</td>
<td>Total Weighted Average</td>
<td>$718,150,000.00</td>
<td>$104,235,000.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
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<td>$0.00</td>
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</tr>
<tr>
<td>104</td>
<td>Cost as a Percent of Other Allowable Cost</td>
<td>$8,000,000.00</td>
<td>$839,885,000.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
</tr>
</tbody>
</table>

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

---

All cost report data. Calculation of ancillary cost-to-charge ratios.
Enter 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*)
- In-State Medicaid Managed Care Primary (*Medicaid MCO*)
- In-State Medicare FFS Cross-Overs (*Traditional Medicare with Traditional Medicaid Secondary*)
- In-State Other Medicaid Eligibles (*May include Medicare MCO cross-overs and other Medicaid not included elsewhere*)
H. In-State Medicaid and All Uninsured Inpatient and Outpatient Hospital Data:

<table>
<thead>
<tr>
<th>Line #</th>
<th>Routine Cost Centers (from Section G):</th>
<th>Medicaid Per Diem Cost for Routine Cost Centers</th>
<th>Medicaid Cost Rate for Ancillary Cost Centers</th>
<th>In-State Medicaid PPS Primary</th>
<th>In-State Medicaid Managed Care Primary</th>
<th>In-State Medicaid PPS with Medicaid Secondary</th>
<th>In-State Other Medicaid Inpatients (Not Included Elsewhere)</th>
</tr>
</thead>
<tbody>
<tr>
<td>01</td>
<td>02900 ADULTS ALTERNATIVES</td>
<td>$1,020.00</td>
<td>From Section G</td>
<td>20,865 Days</td>
<td>11,009 Days</td>
<td>12,000 Days</td>
<td>6 Days</td>
</tr>
<tr>
<td>02</td>
<td>02904 INTENSIVE CARE UNIT</td>
<td>$1,360.00</td>
<td>From Section G</td>
<td>1,000 Days</td>
<td>1,000 Days</td>
<td>1,000 Days</td>
<td>1,000 Days</td>
</tr>
<tr>
<td>02</td>
<td>02906 CONTINUITY CARE UNIT</td>
<td>$1,600.00</td>
<td>From Section G</td>
<td>500 Days</td>
<td>500 Days</td>
<td>500 Days</td>
<td>500 Days</td>
</tr>
<tr>
<td>02</td>
<td>02910 SURGICAL INTENSIVE CARE UNIT</td>
<td>$1,750.00</td>
<td>From Section G</td>
<td>1,000 Days</td>
<td>1,000 Days</td>
<td>1,000 Days</td>
<td>1,000 Days</td>
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<tr>
<td>02</td>
<td>02930 OTHER SPECIAL CARE UNIT</td>
<td>$1,272.23</td>
<td>From Section G</td>
<td>3,000 Days</td>
<td>2,500 Days</td>
<td>2,500 Days</td>
<td>2,500 Days</td>
</tr>
<tr>
<td>03</td>
<td>03010 SUBPROCTOR</td>
<td>$100.00</td>
<td>From Section G</td>
<td>1,380 Days</td>
<td>4,003 Days</td>
<td>4,003 Days</td>
<td>4,003 Days</td>
</tr>
<tr>
<td>03</td>
<td>03020 MATERNITY</td>
<td>$340.00</td>
<td>From Section G</td>
<td>1,380 Days</td>
<td>4,003 Days</td>
<td>4,003 Days</td>
<td>4,003 Days</td>
</tr>
<tr>
<td>04</td>
<td></td>
<td></td>
<td>From Section G</td>
<td>1,380 Days</td>
<td>4,003 Days</td>
<td>4,003 Days</td>
<td>4,003 Days</td>
</tr>
<tr>
<td>05</td>
<td></td>
<td></td>
<td>From Section G</td>
<td>1,380 Days</td>
<td>4,003 Days</td>
<td>4,003 Days</td>
<td>4,003 Days</td>
</tr>
<tr>
<td>06</td>
<td></td>
<td></td>
<td>From Section G</td>
<td>1,380 Days</td>
<td>4,003 Days</td>
<td>4,003 Days</td>
<td>4,003 Days</td>
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<tr>
<td>07</td>
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<td></td>
<td>From Section G</td>
<td>1,380 Days</td>
<td>4,003 Days</td>
<td>4,003 Days</td>
<td>4,003 Days</td>
</tr>
<tr>
<td>08</td>
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<td></td>
<td>From Section G</td>
<td>1,380 Days</td>
<td>4,003 Days</td>
<td>4,003 Days</td>
<td>4,003 Days</td>
</tr>
<tr>
<td>09</td>
<td></td>
<td></td>
<td>From Section G</td>
<td>1,380 Days</td>
<td>4,003 Days</td>
<td>4,003 Days</td>
<td>4,003 Days</td>
</tr>
<tr>
<td>10</td>
<td></td>
<td></td>
<td>From Section G</td>
<td>1,380 Days</td>
<td>4,003 Days</td>
<td>4,003 Days</td>
<td>4,003 Days</td>
</tr>
</tbody>
</table>

Total Days: 58,865
Unreqtd Days (Explain Variance):

18 | Total Days per PSR or Other Paid Claims Summary
19 | Unreqtd Days (Explain Variance)

| 21 | Routine Charges
| 21.01 | Calculated Per Diem

Enter in Medicaid days and total routine charges. Per diem cost amounts carry over from Section G cost report data.
DSH SURVEY PART II
SECTION H, IN-STATE MEDICAID

• Medicaid Payments Include:
  • Claim payments
  • Medicaid cost report settlements
  • Medicare bad debt payments (cross-overs)
  • Medicare cost report settlement payments (cross-overs)
  • Other third party payments (TPL)
### In-State Medicaid and All Uninsured Inpatient and Outpatient Hospital Data:

#### Total Payments

<table>
<thead>
<tr>
<th>Description</th>
<th>In-State Medicaid EFS Priority</th>
<th>In-State Medicaid Managed Care Priority</th>
<th>In-State Medicare FFY Cross-Over (with Medicaid Subsidies)</th>
<th>In-State Other Medicaid Eligibles (Not included Subsidies)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Charges (includes organ acquisition from Section J)</td>
<td>$166,564,020</td>
<td>$96,964,020</td>
<td>$39,866,020</td>
<td>$31,776,020</td>
</tr>
<tr>
<td>Total Charges per PSSR or Other Paid Claims Summary</td>
<td>$166,564,020</td>
<td>$96,964,020</td>
<td>$39,866,020</td>
<td>$31,776,020</td>
</tr>
<tr>
<td>Unrecorded Charges (Rebates Variance)</td>
<td>$166,564,020</td>
<td>$96,964,020</td>
<td>$39,866,020</td>
<td>$31,776,020</td>
</tr>
<tr>
<td>Total Calculated Cost (Includes organ acquisition from Section J)</td>
<td>$33,914,021</td>
<td>$26,978,021</td>
<td>$23,549,021</td>
<td>$18,315,021</td>
</tr>
<tr>
<td>Medicaid Paid Amount (includes TPL, Co-Pay, and Spend-Down)</td>
<td>$33,914,021</td>
<td>$26,978,021</td>
<td>$23,549,021</td>
<td>$18,315,021</td>
</tr>
<tr>
<td>Other Third Party Liability (including Co-Pay and Spend-Down)</td>
<td>$33,914,021</td>
<td>$26,978,021</td>
<td>$23,549,021</td>
<td>$18,315,021</td>
</tr>
<tr>
<td>Medicaid Private Payments</td>
<td>$33,914,021</td>
<td>$26,978,021</td>
<td>$23,549,021</td>
<td>$18,315,021</td>
</tr>
<tr>
<td>Medicaid Private Payments</td>
<td>$33,914,021</td>
<td>$26,978,021</td>
<td>$23,549,021</td>
<td>$18,315,021</td>
</tr>
<tr>
<td>Medicare Private Payments</td>
<td>$33,914,021</td>
<td>$26,978,021</td>
<td>$23,549,021</td>
<td>$18,315,021</td>
</tr>
<tr>
<td>Medicare Private Payments</td>
<td>$33,914,021</td>
<td>$26,978,021</td>
<td>$23,549,021</td>
<td>$18,315,021</td>
</tr>
<tr>
<td>Other Medicaid Cross-Over Payments (Col. Note C)</td>
<td>$33,914,021</td>
<td>$26,978,021</td>
<td>$23,549,021</td>
<td>$18,315,021</td>
</tr>
<tr>
<td>Payment from Hospital Uninsured During Cost Report Year (Coash B)</td>
<td>$33,914,021</td>
<td>$26,978,021</td>
<td>$23,549,021</td>
<td>$18,315,021</td>
</tr>
<tr>
<td>Other Medicaid Cross-Over Payments (Col. Note C)</td>
<td>$33,914,021</td>
<td>$26,978,021</td>
<td>$23,549,021</td>
<td>$18,315,021</td>
</tr>
<tr>
<td>Section 1011 Payment Related to Inpatient Hospital Services NTF Included in Exhibits B &amp; E1 (from Section E)</td>
<td>$33,914,021</td>
<td>$26,978,021</td>
<td>$23,549,021</td>
<td>$18,315,021</td>
</tr>
</tbody>
</table>

**Calculations and Percentages**

- Total Payments as a Percentage of Total Cost
- 55%
- 95%
- 55%
- 95%
- 100%
- 20%
- 20%
- 100%
- 100%

### Comment

Enter in all Medicaid, TPL, and Medicare crossover payments.
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.
Uninsured days - should agree to Exhibit A

Uninsured Charges must agree to Exhibit A

Uninsured cash-basis payments must agree to the UNINSURED on Exhibit B
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 as UPL, LIP, GME, outlier, and supplemental payments.

2. The hospital provides a certification that it incurred additional uncompensated care costs serving uninsured individuals.
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 are partially based on states targeting DSH payments to hospitals with high uninsured and Medicaid populations.
2011 CLARIFICATIONS

- **DSH Allotments**
  - Allotment reduction has been delayed until federal fiscal year 2016, through a budget agreement signed December 26, 2013. However, the legislation doubles the reduction that would otherwise have applied in that year.
  - Allotment reduction has been delayed even further until federal fiscal year 2017, through the Protecting Access to Medicare Act (P.L. 113-93). The total reduction amount was increased to $1,800,000,000.
2011 CLARIFICATIONS

• State-Specific Annual DSH Allotment Reduction Factors
  o High Volume of Medicaid Inpatients Factor (HMF)
    • Imposes larger percentage reductions on states that do not target their DSH payments on hospitals with high volumes of Medicaid inpatients.
  o High Level of Uncompensated Care Factor (HUF)
    • Imposes larger percentage reductions on states that do not target their DSH payments on hospitals with high levels of uncompensated care.
DSH SURVEY PART II – SECTION H, IN-STATE MEDICAID AND UNINSURED

• Additional Edits
  • In the far right column, you will see an edit message if your total charges or days by cost center exceed those reported from the cost report in Section G of the survey. Please clear these edits prior to filing the survey.
  • Calculated payments as a percentage of cost by payor (at bottom)
  • Review percentage for reasonableness
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 PCL, PS&R (or similar) claim payment summary. If no summary is available, submit Exhibit C (hospital data) as support.

- If your hospital provided services to several other states, please consolidate your data and provide support for your survey responses.
DSH SURVEY PART II – SECTIONS J & K, ORGAN ACQUISITION

• Total organ acquisition cost and total useable organs will be pre-loaded from HCRIS data. If it is incorrect or doesn’t agree to a more recently audited version of the cost report, please correct as needed and update question #3 in Section D.

• These schedules should be used to calculate organ acquisition cost for Medicaid (in-state and out-of-state) and uninsured.

• Summary claims data (PS&R) or similar documents and provider records (organ counts) must be provided to support the charges and useable organ counts reported on the survey. The data for uninsured organ acquisitions should be reported separately from the Exhibit A.
DSH SURVEY PART II - SECTIONS J & K, ORGAN ACQUISITION

- All organ acquisition charges should be reported in Sections J & K of the survey and should be EXCLUDED from Section H & I of the survey. (days should also be excluded from H & I)

- Medicaid and uninsured charges/days included in the cost report D-6/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

<table>
<thead>
<tr>
<th>Factor</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>I&amp;R</td>
<td>10.5</td>
</tr>
</tbody>
</table>

### In-State organ acquisitions

<table>
<thead>
<tr>
<th>Organ Type</th>
<th>Cost 1</th>
<th>Cost 2</th>
<th>Cost 3</th>
<th>Cost 4</th>
<th>Cost 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heart</td>
<td>$1000</td>
<td>$1200</td>
<td>$1400</td>
<td>$1600</td>
<td>$1800</td>
</tr>
<tr>
<td>Liver</td>
<td>$2000</td>
<td>$2400</td>
<td>$2800</td>
<td>$3200</td>
<td>$3600</td>
</tr>
<tr>
<td>Kidney</td>
<td>$3000</td>
<td>$3600</td>
<td>$4200</td>
<td>$4800</td>
<td>$5400</td>
</tr>
</tbody>
</table>

### Out-of-State organ acquisitions

<table>
<thead>
<tr>
<th>Organ Type</th>
<th>Cost 1</th>
<th>Cost 2</th>
<th>Cost 3</th>
<th>Cost 4</th>
<th>Cost 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heart</td>
<td>$1100</td>
<td>$1300</td>
<td>$1500</td>
<td>$1700</td>
<td>$1900</td>
</tr>
<tr>
<td>Liver</td>
<td>$2100</td>
<td>$2500</td>
<td>$3000</td>
<td>$3500</td>
<td>$4000</td>
</tr>
<tr>
<td>Kidney</td>
<td>$3100</td>
<td>$3700</td>
<td>$4300</td>
<td>$4900</td>
<td>$5500</td>
</tr>
</tbody>
</table>
DSH SURVEY PART II
SECTION L, PROVIDER TAXES

• Federal Register / Vol. 75, No. 157 dated Monday, August 16, 2010 (CMS-1498-F)
  • Discussion on costs of provider taxes as allowable costs for CAHs (page 50362)
  • CMS is concerned that, even if a particular tax may be an allowable cost that is related to the care of Medicare beneficiaries, providers may not, in fact, “incur” the entire amount of these assessed taxes. (page 50363)
"This clarification will not have an effect of disallowing any particular tax but rather make clear that our Medicare contractors will continue to make a determination of whether a provider tax is allowable, on a case-by-case basis, using our current and longstanding reasonable cost principles. In addition, the Medicare contractors will continue to determine if an adjustment to the amount of allowable provider taxes is warranted to account for payments a provider receives that are associated with the assessed tax." (emphasis added)
• Due to Medicare cost report tax adjustments, an adjustment to cost may be necessary to properly reflect the Medicaid and uninsured share of the provider tax assessment for some hospitals.

• Medicaid and uninsured share of the provider tax assessment is an allowable cost for Medicaid DSH even if Medicare offsets some of the tax.
The Medicaid DSH audit rule clearly indicates that the portion of permissible provider taxes applicable to Medicaid and uninsured is an allowable cost for the Medicaid DSH UCC (FR Vol. 73, No. 245, Friday, Dec. 19, 2008, page 77923).

By "permissible", they are referring to a "valid" tax in accordance with 42 CFR §433.68(b).
DSH SURVEY PART II
SECTION L, PROVIDER TAXES

• Ober Kaler 2005 and 2006 Illinois Tax Groups v. Blue Cross Blue Shield Association/National Government Services, ¶82,616, (Mar. 30, 2010) supports allowing the provider taxes to be treated differently for Medicare than for Medicaid

• Abraham Lincoln Memorial Hospital v. Sebelius, No. 11-2809 (7th Cir. October 16, 2012) also states that because the two programs are independent of one another, CMS’s decisions with respect to a State’s Medicaid program are not controlling on how CMS interprets the application of Medicare provisions.
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.
• 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., cost).
DSH SURVEY PART II
SECTION L, PROVIDER TAXES

• At a minimum the following should still be excluded from the final 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 audit survey. However, depending on how your hospital reports it on the Medicare cost report, an adjustment may be necessary to ensure the costs are properly reflected in determining your hospital-specific DSH limit. For instance, if your hospital reported 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 under stated 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 Meyers and Warfield, Inc along with your hospital’s DSH audit surveys.

<table>
<thead>
<tr>
<th>Cost Report Year: 01/01/2011-12/31/2011</th>
<th>Hospital ABC</th>
</tr>
</thead>
</table>

Worksheet A Provider Tax Assessment Reconciliation:

<table>
<thead>
<tr>
<th>Line</th>
<th>Description</th>
<th>Dollar Amount</th>
<th>WIS A Cost Center Line</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>1. Hospital Gross Provider Tax Assessment (from general ledger)*</td>
<td>$ 8,503,000</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>2. Hospital Gross Provider Tax Assessment Included in Expense on the Cost Report (W/S A, Col. 2)</td>
<td>$ 8,503,000</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>3. Difference (Explain Here ————)</td>
<td></td>
<td>$ 0.00</td>
</tr>
<tr>
<td>4</td>
<td>Provider Tax Assessment Reclassification (from w/s A-6 of the Medicare cost report)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Reclassification Code</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Reclassification Code</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>Reclassification Code</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>DSH UCC ALLOWABLE - Provider Tax Assessment Adjustments (from w/s A-6 of the Medicare cost report)</td>
<td>$ (8,503,000)</td>
<td>$ 0.00</td>
</tr>
<tr>
<td>9</td>
<td>Reason for adjustment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>Reason for adjustment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>Reason for adjustment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>DSH UCC NON-ALLOWABLE Provider Tax Assessment Adjustments (from w/s A-6 of the Medicare cost report)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>13</td>
<td>Reason for adjustment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>14</td>
<td>Reason for adjustment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>15</td>
<td>Reason for adjustment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>16</td>
<td>Total Net Provider Tax Assessment Expense Included in the Cost Report</td>
<td>$ 0.00</td>
<td></td>
</tr>
</tbody>
</table>

- Tax reclassifications if any, on W/S A-6
- Enter in tax adjustments on your W/S A-6 that are allowable for Medicaid DSH
- Enter in tax adjustments on your W/S A-6 that are not allowable for Medicaid DSH
- Tax that flows to allocation of Section G of DSH Survey Part II

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

  o Total hospital charges / routine days from Exhibit A must agree to the total entered in Section H of the survey.

  o Must be for dates of service in the cost report fiscal year.

  o Line item data must be at patient date of service level with multiple lines showing revenue code level charges.
EXHIBIT A - UNINSURED

- Exhibit A:
  - Include *Primary Payor Plan*, *Secondary Payor Plan*, Provider #, PCN, Name, Admit, Discharge, Service Indicator, Revenue Code, Total Charges, Days, Patient Payments, TPL, and Claim Status fields.

- A complete list (key) of payor plans is required to be submitted separately with the survey.
EXHIBIT A - UNINSURED

• Claim Status (Column R) – need to indicate if Exhausted / Non-Covered Insurance claims are being included under the proposed rule since that rule is not final. There is no guarantee that these can be included until the rule is final. It is imperative that these are properly identified within Exhibit A and Exhibit B.

  o 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).
## Exhibit A - Uninsured Charges / Days

<table>
<thead>
<tr>
<th>Claim Type</th>
<th>Provider #</th>
<th>Patient Identifier</th>
<th>Patient's Name</th>
<th>Patient's DOB</th>
<th>Patient's Gender</th>
<th>Discharge Date</th>
<th>Revenue Code</th>
<th>Total Charges for Services Provided</th>
<th>Total Patient Payments for Services Provided</th>
<th>Total Third Party Payments for Services Provided</th>
<th>Reason for Exhausted or Non-Covered Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>Uninsured Charges</td>
<td>12345</td>
<td>22222222</td>
<td>Doe, Jane</td>
<td>1/1/1980</td>
<td>Female</td>
<td>3/1/2010</td>
<td>1150</td>
<td>$2,700.00</td>
<td>200</td>
<td>4,250.00</td>
<td>Exhausted</td>
</tr>
<tr>
<td>Medicare</td>
<td>12345</td>
<td>4444444</td>
<td>Jones, John</td>
<td>2/2/1985</td>
<td>Male</td>
<td>6/1/2010</td>
<td>450</td>
<td>$1,000.50</td>
<td>250</td>
<td>151.00</td>
<td>Exhausted</td>
</tr>
<tr>
<td>Blue Cross</td>
<td>12345</td>
<td>11111111</td>
<td>Smith, Mike</td>
<td>3/3/1990</td>
<td>Male</td>
<td>8/1/2010</td>
<td>450</td>
<td>$1,560.00</td>
<td>250</td>
<td>900.00</td>
<td>Non-Covered Service</td>
</tr>
</tbody>
</table>

**DEDICATED TO GOVERNMENT HEALTH PROGRAMS**

Page 3 of 1
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.
  
  o Exhibit B should include all patient payments regardless of their insurance status.
  
  o Total patient payments from this exhibit are entered in Section E of the survey.
  
  o Insurance status should be noted on each patient payment so you can sub-total the uninsured hospital patient payments and enter them in Section H of the survey.
EXHIBIT B – ALL PATIENT PAYMENTS (SELF-PAY) ON A CASH BASIS

• Patient payments received for uninsured services need to be reported on a cash basis.
  
  o For example, a cash payment received during the 2011 cost report year relating to a service provided in the 2005 cost report year, must be used to reduce uninsured cost for the 2011 cost report year.
EXHIBIT B – ALL PATIENT PAYMENTS (SELF-PAY) ON A CASH BASIS

- Exhibit B
  - Include Primary Payor Plan, Secondary Payor Plan, Provider #, PCN, Name, 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).
### Exhibit B - Cash Basis Patient Payments

<table>
<thead>
<tr>
<th>Claim Type</th>
<th>Primary payer</th>
<th>Secondary payer</th>
<th>Medical group</th>
<th>Patient ID</th>
<th>Patient's Name</th>
<th>Birthday</th>
<th>Social Security number</th>
<th>Admit Date</th>
<th>Discharge Date</th>
<th>Date of Care</th>
<th>Amount of Cash Collected</th>
<th>Indicators (Original/Non-Original)</th>
<th>Total hospital charges for services provided</th>
<th>Total other non-hospital charges for services provided</th>
<th>Insurance status</th>
<th>Claim status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self Pay/Payments Missouri Medical</td>
<td>500</td>
<td>12345</td>
<td>JKL123</td>
<td>John Doe</td>
<td>75</td>
<td>123456789</td>
<td>1/1/2020</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Self Pay/Payments Missouri Medical</td>
<td>500</td>
<td>12345</td>
<td>JKL123</td>
<td>Jane Doe</td>
<td>75</td>
<td>123456789</td>
<td>1/1/2020</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Self Pay/Payments Missouri Medical</td>
<td>500</td>
<td>12345</td>
<td>JKL123</td>
<td>John Doe</td>
<td>75</td>
<td>123456789</td>
<td>1/1/2020</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Self Pay/Payments Missouri Medical</td>
<td>500</td>
<td>12345</td>
<td>JKL123</td>
<td>Jane Doe</td>
<td>75</td>
<td>123456789</td>
<td>1/1/2020</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Legend for Claim Status**:
- Inbound
- Non-Covered Service
- Uninsured
- Medicaid
- Uninsured
- Insured
- Self Pay/Payments
- Missouri Medical
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.

  o If not available, the hospital must submit the detail behind the reported survey data in the Exhibit C format. Otherwise, the data may not be allowed in the final UCC.
EXHIBIT C – HOSPITAL-PROVIDED MEDICAID DATA

• Types of data that may require an Exhibit C are as follows:
  o Self-reported Medicaid MCO data (Section H)
  o Self-reported Medicaid/Medicare cross-over data (Section H)
  o Self-reported “Other” Medicaid eligibles (Section H)
  o All self-reported Out-of-State Medicaid categories (Section I)
EXHIBIT C – HOSPITAL-PROVIDED MEDICAID DATA

• Exhibit C
  o 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 Payments, Medicaid Payments, TPL Payments, Self-Pay Payments, and Sum All Payments fields.

  ▪ A complete list (key) of payor plans is required to be submitted separately with the survey.

  o Submit Exhibit C in the format shown using Excel or a CSV file using the tab or | (pipe symbol above the enter key).
<table>
<thead>
<tr>
<th>Claim Type</th>
<th>Primary/Secondary</th>
<th>Hospital Identification Number</th>
<th>Hospital ID</th>
<th>Patient's Name</th>
<th>Patient's SSN</th>
<th>Service Provider</th>
<th>Revenue Code</th>
<th>Total Charges</th>
<th>Gross billed</th>
<th>Outpatient</th>
<th>Inpatient</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicaid</td>
<td>Health Care USA</td>
<td>12345</td>
<td>666899</td>
<td>1234567890</td>
<td>John Doe</td>
<td>1234567890</td>
<td>9876543210</td>
<td>34567890</td>
<td>10000.00</td>
<td>5000.00</td>
<td>5000.00</td>
</tr>
<tr>
<td>Medicaid</td>
<td>Health Care USA</td>
<td>12345</td>
<td>666899</td>
<td>1234567890</td>
<td>Jane Smith</td>
<td>1234567890</td>
<td>9876543210</td>
<td>34567890</td>
<td>10000.00</td>
<td>5000.00</td>
<td>5000.00</td>
</tr>
</tbody>
</table>

EXHIBIT C - MANAGED CARE

DEDICATED TO GOVERNMENT HEALTH PROGRAMS
DSH SURVEY PART I – DSH YEAR DATA

Checklist

• Separate tab in Part I of the survey.

• Should be completed after Part I and Part II surveys are prepared.

• Includes list of all supporting documentation that needs to be submitted with the survey for audit.

• Includes Myers and Stauffer address and phone numbers.
DSH SURVEY PART I – DSH YEAR DATA

Submission Checklist

1. Electronic copy of the DSH Survey Part I – DSH Year Data.

2. Electronic copy of the DSH Survey Part II – Cost Report Year Data.

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

4. Description of logic used to compile Exhibit A. Include a copy of all financial classes and payor plan codes utilized during the cost report period and a description of which codes were included or excluded if applicable.
Submission Checklist (cont.)

5. Electronic Copy of Exhibit B – Self-Pay Payments.
   - Must be in Excel (.xls or .xlsx) or CSV (.csv) using either a TAB or | (pipe symbol above the ENTER key)

6. Description of logic used to compile Exhibit B. Include a copy of all transaction codes utilized to post payments during the cost reporting period and a description of which codes were included or excluded if applicable.
DSH SURVEY PART I – DSH YEAR DATA
Submission Checklist (cont.)

7. Electronic copy of Exhibit C for hospital-generated data
   (includes other Medicaid eligibles, Medicare cross-over, Medicaid MCO, and Out-Of-State Medicaid data that isn't supported by a state-provided or MCO-provided report).
   - Note: If applicable, Medicaid concurrent nursery days should be included in the Other Medicaid Eligibles Exhibit C.
   - Must be in Excel (.xls or .xlsx) or CSV (.csv) using either a TAB or | (pipe symbol above the ENTER key)

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

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

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

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

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


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

15. Revenue code cross-walk used to prepare cost report.
Submission Checklist (cont.)

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

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

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

19. Documentation supporting cost report payments calculated for Medicaid/Medicare cross-overs (dual eligibles).
2011 CLARIFICATIONS / CHANGES

- *Labor and delivery days and costs associated with L&D equivalent days must be properly matched in the Medicaid version of the cost report for accurate calculation of costs.*

- In some states, hospitals are adding labor and delivery days from line 32 of S-3 to total adults and peds days on line 1 of S-3 in the Medicaid version of their cost reports. However, the costs associated with these days are not reclassified from labor and delivery to adults and peds.

- This understates the A&P per diem for the calculation of the DSH UCC.

- If L&D day costs are included in adults and peds in the cost report, it is proper to add the L&D days to A&P days in calculating the per diem.
2011 CLARIFICATIONS / CHANGES

- Labor and delivery days and costs (Continued)

- The methodology used to capture labor and delivery cost and days is also dependent on whether labor and delivery days are counted in the hospital census and whether they are billed as an inpatient day.

- According to Medicare guidelines, a labor and delivery day is defined as a day during which a maternity patient is in the labor/delivery room ancillary area at midnight at the time of census taking and is not included in the census of the inpatient routine care area because the patient has not occupied an inpatient routine bed at some time before admission. In the case where the maternity patient is in a single multipurpose labor, delivery and postpartum room, hospital must determine the proportion of each inpatient stay that is associated with ancillary services versus routine adult and pediatric services and report the days associated with the labor and delivery portion of the stay on line 32 of S-3.

- If the L&D days are billed as inpatient days, the days should also be included in total days.
2011 CLARIFICATIONS / CHANGES

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

  - Section 1923(d) of the SSA includes exceptions to OB service requirements. One exception is that hospitals that did not offer emergency OB services to the general population as of December 22, 1987 are not required to meet the two-OB rule for DSH payment eligibility.

  - CMS issued a clarification titled *Additional Information on the DSH Reporting and Auditing Requirements* on April 7, 2014.
    - “The law does not contemplate a grandfathering clause or otherwise make exception to the obstetrician requirement for hospitals that came into existence after December 22, 1987; therefore, such hospitals would not be considered exempt from the obstetrician requirement at section 1923(d) of the act.”
2011 CLARIFICATIONS / CHANGES

- Changes to Annual Reporting Requirements
  - Medicare & Medicaid #
  - Total Hospital Cost
    - Total Hospital Cost from Section G of DSH survey (includes I&R, RCE, Provider tax)
COMMON ISSUES NOTED DURING DSH EXAMINATIONS

- Hospitals had duplicate patient claims in the uninsured, cross-over, 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.
COMMON ISSUES NOTED DURING DSH EXAMINATIONS

Significant Data Issues in Final Report

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

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

• 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.
COMMON ISSUES NOTED DURING DSH EXAMINATIONS

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

• Under the proposed rule, hospitals reported “Exhausted” / “Insurance Non-Covered” on Exhibit A (Uninsured) but did not report the payments on Exhibit B.
COMMON ISSUES NOTED DURING DSH EXAMINATIONS

• “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
COMMON ISSUES NOTED DURING DSH EXAMINATIONS

- Exhibit B – Patient payments didn’t always include all patient payments – some hospitals incorrectly limited their data to uninsured patient payments.

- Some hospitals didn’t include their charity care patients in the uninsured even though they had no third party coverage.
COMMON ISSUES NOTED DURING DSH EXAMINATIONS

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

• Only uninsured payments are to be on cash basis – all other payor payments must include all payments made for the dates of service as of the audit date.
COMMON ISSUES NOTED DURING DSH EXAMINATIONS

- Liability insurance claims were incorrectly included in uninsured even when the insurance (e.g., auto policy) made a payment on the claim.
- Hospitals didn’t report their charity care in the LIUR section of the survey or didn’t include a break-down of inpatient and outpatient charity.
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). If the patient had health insurance, even if the third party insurer did not pay, those services are insured and cannot be reported as uninsured on the survey. Prisoners must be excluded.

- CMS released a proposed rule in the January 18, 2012 Federal Register to clarify the definition of uninsured and prisoners.

- Under this proposed rule, the DSH examination will now look at whether a patient is uninsured using a “service-specific” approach as opposed to the creditable coverage approach previously employed.

- The rule is still not “final” but the survey does allow for hospitals to report “exhausted” and “insurance non-covered” services separately as uninsured in case they can be allowed at a later date.
1. What is the definition of uninsured for Medicaid DSH purposes? (Continued from previous slide)

Excluded prisoners were defined in the proposed 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.
2. **What is meant by “Exhausted” and “Non-Covered” in the uninsured Exhibits A and B?**

   Under the January 18, 2012 proposed rule, hospitals can report services if insurance is “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.

   Since the rule is not final, these services must be segregated on Exhibits A and B of the survey.
3. **What categories of services can be included in uninsured on the DSH survey?**

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

- There has been some confusion with this issue. CMS attempts to clarify this in #24 of their FAQ titled “Additional Information on the DSH Reporting and Audit Requirements”. It basically says if a service is a hospital service it can be included even if Medicaid only covered a specific group of individuals for that service.

- **EXAMPLE:** A state Medicaid program covers speech therapy for beneficiaries under 18 at a hospital. However, a hospital provides speech therapy to an uninsured individual over the age of 18. Can they include it in uninsured? The answer is “Yes” since speech therapy is a Medicaid hospital service even though they wouldn’t cover beneficiaries over 18.
4. Can a service be included as uninsured, if insurance didn’t pay due to improper billing, late billing, or lack of medical necessity?

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

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

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

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

  - Under the Proposed Rule, these patients may be included in the DSH UCC if Medicare is exhausted.
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)
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.
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)
14. Do dual eligibles (Medicare/Medicaid) have to be included in the Medicaid UCC?

Yes. CMS believes the costs attributable to dual eligible patients should be included in the calculation of the uncompensated care costs, but in calculating the uncompensated care costs, it is necessary to take into account both the Medicare and Medicaid payments made. In calculating the Medicare payment, the hospital should include all Medicare adjustments (DSH, IME, GME, etc.) (Reporting pg. 77912)

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

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

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

Send survey and other data to:
Myers and Stauffer LC
Attn: Florida DSH Survey
11440 Tomahawk Creek Parkway
Leawood, KS 66211
(800) 374-6858
fldsh@mslc.com

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