Frequently Asked Questions
Disproportionate Share Hospital (DSH) Exam

1. For services provided to a patient between the ages of 21 and 65 in an Institution for Mental Disease (IMD):

   a) Are those days included in the Medicaid Inpatient Utilization Rate (MIUR)?
   b) For the Hospital Specific Limit (HSL), are they in Medicaid or uninsured?

   In a letter to State Medicaid Directors issued August 17, 1994, the Centers for Medicare and Medicaid Services (CMS) provided guidance that: “It is important to note that the numerator of the MIUR formula does not include days attributable to Medicaid patients between 21 and 65 years of age in Institution for Mental Disease (IMDs). These patients may not be counted as Medicaid days in computing the Medicaid utilization rate.” However, these services should be included in the hospital-specific DSH limit. (73 FR dated 12/19/08, page 77929)

   For purposes of the Indiana DSH Exam survey, these services are required to be included in the uninsured section to ensure that the days are not included in the Medicaid days used to calculate the MIUR.

2. Are ambulance services included in the hospital specific limit (HSL) (are they hospital services)? Does the treatment differ if you own the ambulance service vs. paid another party for ambulance services?

   Ambulance services are not to be included in DSH calculations as a hospital service. For DSH Exam purposes, there may be limited paid ambulance services included in the paid claims data reports. Only these paid ambulance services may be included in the DSH Exam survey response.

3. If a patient has insurance coverage for other medical services, but not inpatient hospital services, would they be included in the uninsured shortfall?

   The DSH examination is performed using the uninsured definition set forth in the January 18, 2012 Federal Register Proposed Rule. This rule clarified costs of this type; costs of services provided to individuals whose coverage specifically excludes the hospital service can be included in calculating the hospital-specific DSH limit.

4. What about people with a high deductible health plan? Would they be included in the uninsured shortfall?

   No. (73 FR dated 12/19/08, page 77911)
5. *If the patient has met their lifetime maximum, would they be included in the uninsured shortfall?*

The DSH examination is performed using the uninsured definition set forth in the January 18, 2012 Federal Register Proposed Rule. This rule specifies that services beyond annual or lifetime limits on insurance coverage would not be considered to be within a covered benefit package, therefore they can be included in calculating the hospital-specific DSH limit.

6. *For dual-eligible services, should we report Medicare payments on an accrual or cash basis?*

Report on an accrual basis.

7. *How should we report Hoosier Assurance Plan (HAP) payments from the Department of Mental Health and Addiction?*

These payments are not included in calculations for either Medicaid eligibility or hospital-specific DSH limit.

8. *To what extent is the definition of hospital services for inclusion in HSL affected by the OP rule or the withdrawal thereof?*

There is no impact.

9. *Regarding the independent auditors when it comes to the DSH exam: If a CPA firm completes our cost report and then the firm prepared our DSH submission, can the firm still perform the DSH exam? If not, could we receive a list of CPA firms that would be proficient in this area?*

While each hospital is required to have a CPA perform their DSH exam, the hospital can choose to use their current CPA firm or select another CPA firm to perform the exam. The state was anticipating that hospitals would generally choose to have their current CPA firms complete the exams, as they would already have a working relationship with the hospital. However, the rule requires that your CPA needs to be able to express an opinion on the DSH exam survey. Your CPA needs to determine if they are able to do that pursuant to the DSH exam rule and professional standards.

Here are some excerpts from the DSH rule that you may find helpful. The first comment/response does not fit your situation entirely, but will provide you with a general idea to CMS' independence requirements:

Comment: One commenter questioned whether it is CMS’s intent to prevent an independent CPA firm, contracted by a State to audit Medicaid cost reports on the State’s
behalf, from being able to audit that same state’s DSH program through the independence requirements of the Government Auditing Standards. If so, the commenter questioned if any contract with a State's Medicaid agency would impair the independence of a CPA firm in performing the DSH exam required in the rule.

Response: The intent of the requirement that States use independent auditors to certify the DSH exam is to provide a quality end product based on consistently applied auditing standards to produce unbiased findings. An independent auditor must operate independently from the Medicaid agency and the subject hospitals. The fact that a CPA firm contracts with the Medicaid agency to audit Medicaid cost reports does not disqualify that firm from being considered independent and therefore qualified to perform the DSH exam as long as the contract permits the auditor to exercise independent judgment.

The term “independent” means that the Single State Audit Agency or any other CPA firm that operates independently from either the Medicaid agency (or other agency making Medicaid payments) or the subject hospital(s) may perform the DSH exam. States may not rely on non-CPA firms, fiscal intermediaries, independent certification programs currently in place to audit uncompensated care costs, nor expand audits of hospital financial statements to obtain audit certification of the hospital-specific DSH limits.

We proposed to define that an “independent audit” means an audit conducted according to the standards specified in the generally accepted government auditing standards issued by the Comptroller General of the United States.

10. Section A: Charity charges – Do we include only those charity charges for uninsured patients or do we include charity for both uninsured and after insurance pays? I would assume we could count only charity for uninsured.

Charity care is a term used by hospitals to describe an individual hospital's program of providing free or reduced charge care to those that qualify for the particular hospital's charity care program. Charity care is addressed in the Medicaid statute at Section 1923(b)(3)(B)(i) of the Act and is a variable in the formula used to determine a hospital’s low-income utilization rate (LIUR) as part of the qualification criteria for DSH payments. Specifically, CMS recognizes that hospital charity care policies may go beyond individuals with no source of third party coverage and may include underinsured individuals. For purposes of the LIUR only, individuals that qualify under a hospital's charity care policy may be included. Charity care for LIUR purposes is reported on the DSH Exam Survey in Section A. Per the instructions, “these charges must reconcile to the charity care charges reported in your financial statements and/or annual audit.”

11. Section F: Total Allowed Amount from Medicaid MSR or RA detail (All payments) – Confirm that this is actual payments plus TPL amount.

Yes.
12. Section F: Are paid claims and denied claims added together and used for the charge breakdown or do we count only paid claims?

The reports provided by Myers & Stauffer that provide revenue code detail were pulled from the detailed claims information (rather than the header). In order to include the full charges from the claim (and therefore the full cost), we also provided a report with any detail lines that were denied (for claims that were otherwise paid). In other words, the denied report does not include those claims that were denied entirely. You should include charges from both reports in the schedules to arrive at the cost of care.

13. Note D: Other Medicaid supplemental payments such as UPL and Non-Claim Specific payments should be included. However, DSH payments should NOT be included. Is this based on the year received or year it was for? Is it based on calendar year or SFY?

This is based on the SFY for which it was received.

14. The hospitals may not have revenue codes on all lines, so is it permissible to apply a proportional methodology?

This does not follow the requirements of the program audit, so the CPA will have to note this in the statements/certification. Since this approach is not compliant with the federal DSH exam rule, CMS may disallow a hospital’s UCC as sufficient to support its DSH payment if calculated in this manner.

15. Will results of this survey affect past payments, or be applied to future payments only?

As stated in the rule, “Beginning in Medicaid State plan rate year 2011, to the extent that exam findings demonstrate that DSH payments exceed the document hospital-specific cost limits CMS will regard them as representing discovery of overpayments to providers…” (73 FR dated 12/19/08, page 77906)

16. If a hospital’s Medicaid shortfall exceeds their total DSH payment, are they required to complete the uninsured portion? If not, will this be considered a scope limitation?

Hospitals need to complete only the Medicaid portion, not the uninsured portion, if they are certain that they do not have an uninsured long fall. Auditors will need to also consider this possibility in their audits, and perform steps to verify there is no uninsured long fall. Since CMS has indicated this is acceptable in the final rule, it will not be considered a scope limitation. However, if the hospital’s DSH payment calculation was based on a percentage of their total Hospital Specific Limit, they would need to report their total Medicaid and uninsured shortfall to demonstrate that the DSH payment was calculated correctly. In addition, any DSH payments recouped as a result of the exam
results will be redistributed to hospitals. That redistribution may be based on a proportion of the hospital’s audited UCC. Therefore, an understatement of that UCC may result in a lower DSH payment.

17. For charity care, do hospitals need to submit complete audited financials or just that one page?

Hospitals may submit just that page, but should also include any documents that provide detail regarding the period so that we may access the complete financial statements in our files.

18. How should the detailed trial balance be handled in instances where the Medicare auditors made adjustments?

The hospital can indicate that we have it on file. However, please note that it may be requested if we cannot locate it in our files, or the filed copy does not support survey responses.

19. What about the detail of any errors that are extrapolated or adjusted by the auditors – should posted adjustments or unposted adjustments be used?

Only final adjusted surveys should be submitted, but we do want the detail on any adjustments that were made as a result of the exam.

20. Do you want the OB doctor names to be submitted with the DSH exam survey?

It is not necessary to submit these names to Myers and Stauffer with the survey. However, you should maintain these records because Myers and Stauffer may request it. It is also likely your auditor will want to review this information.

21. The survey seems to indicate that we should exclude TPL and spend down from the crossovers reported on Schedule F. Should this information be reported in the other TPL line?

Yes, TPL and spend down received relating to Medicare / Medicaid crossover services should be reported in the line, “Other Total Third Party Liability (including spend-down but excluding Medicare)”.

22. Can we include more than one Exhibit C since we will have more than one population we are testing? For example, different cost report years will be audited separately and will have separate Ratios of Cost to Charges applied?
Yes, exhibits should be separately submitted to support the different schedules. Since you would submit a separate Schedule F for each cost report year, separate exhibits should be submitted, so that each the totals from each exhibit will tie to each amount reported on Schedule F.

23. For some hospitals, Cost Report Worksheet G may have been completed prior to the audited financial statements and may not have been adjusted, can we show this reconciliation if there are changes? The line says that unreconciled variances should be zero.

Cost Report Worksheet G is used to complete Section C of the DSH exam survey. The instructions and the survey indicate that the amounts from the cost report are to be used to complete the Section. It does not mention the audited financial statements. The “unreconciled differences should be 0” refer to the fact that the total from the detail reported (from the cost report) should be equal to the amounts reported on the Cost Report G-3, Lines 1 and 2.

24. Should HCI service charges / payments be included in either the Medicaid or uninsured shortfall calculations?

HCI patients, by definition, are not Medicaid-eligible. Therefore, the charges, costs and any private payments received for those services should be reported in the uninsured shortfall.

25. On previous Medicaid DSH HSL Surveys, the Hospital had the option of including in the Medicaid shortfall the costs/payments of Medicaid-eligible services when the patient was also eligible for other insurance (Anthem, SIHO, etc.). Does the Hospital still have this option on the current DSH surveys or are these services required to be included on the survey? I’m not sure how the Hospital would identify such claims if this is required (they are not listed on the supplied MSRs).

The rule requires that costs and payments for dually eligible patients be included. Based on the language in the rule, the type of dual eligibility (Medicaid/Medicare or Medicaid/other insurance) does not matter.

The DSH examination is performed in accordance with the CMS final rule, CMS-2399-F, published in the April 3, 2017 Federal Register. Specifically, the UCC must include all payments made to hospitals by or on behalf of Medicaid eligible individuals, including Medicare and third party payments.

26. On previous Medicaid DSH HSL Surveys, the Hospital has been allowed to allocate total Medicaid charges to the respective cost report cost center based upon the Medicaid charges reported on the cost report. Can we continue to use a responsible allocation methodology for the Medicaid and uninsured charges or do we have to identify the
charges by Revenue Code at the individual patient level in order to map to the cost report lines?

CMS has provided the following requirements included in their document, “General DSH Audit and Reporting Protocol”:

DSH Hospitals:
1. Use the Medicare 2552-96 hospital cost report to determine cost center specific routine per diems and ancillary ratios of cost to charges (RCC) based on Medicare Cost Principles (Medicare cost allocation process).

2. Utilize MMIS data provided by the state for Medicaid FFS IP/OP hospital ancillary charges and Medicaid FFS IP hospital routine days.

3. Utilize hospital financial statements and other auditable hospital accounting records as source for IP/OP hospital Medicaid managed care ancillary charges and routine days and IP/OP hospital uninsured ancillary charges and routine days (individuals with no source of third party coverage). These charges and days will be used with cost center specific RCCs and per diems, respectively, to allocate hospital costs to each relevant payer category described above.

27. It is possible that we will have to make a few changes to the audited Medicare cost reports in order to properly report the costs of Hospital services. For example, the hospital qualified for a CRNA fee schedule exemption in 2006 and the corresponding costs were included on the Medicare cost report beginning 1/1/2006. For DSH purposes, it seems like these costs should be removed. Do we simply need to submit explanations of such cost report modifications when we submit the DSH surveys?

CMS requires that the reports and exams be based on the best available information. If audited Medicare cost reports are not available, the DSH report and exam may need to be based on Medicare cost reports as filed. Given CMS has not indicated that non-filed cost report information will be acceptable, we recommend that if the hospital wants to base the DSH exam survey responses on a revised cost report, that the cost report be filed as an amended cost report.

28. Our hospital did not come close to qualifying for DSH based upon the LIUR. In past DSH surveys, you have allowed us to not complete the LIUR sections because they were not applicable to our eligibility. Can we again be granted an exemption from completing the LIUR sections of the survey (Sections A and C)?

Since Indiana utilizes both the MIUR and the LIUR in calculating DSH eligibility, the federal DSH exam rule requires Indiana to report both the MIUR and LIUR for all hospitals that received DSH payments for the years under exam.