

FREQUENTLY ASKED QUESTIONS
Texas Disproportionate Share Hospital (DSH) Program Audit
Medicaid State Plan Rate Year (10/01/2010 – 09/30/2011)

1. Why do we have to report two Part II Surveys for twenty-four months of Medicaid and uninsured claims instead of just reporting claims for the 12 months of the DSH year?

CMS regulations state that costs and revenues must first be determined by cost reporting period and then allocated to the Medicaid State Plan (MSP) Rate Year under review. This is a change from the methodology used in prior DSH audits.

For example, if a hospital has a cost reporting year end of 08/31 they would need to complete **two twelve month Part II surveys**, one for the year ended 08/31/2011 and one for the year ended 08/31/2012. The hospital would **NOT** complete one Part II survey for the 11 months ended in 2011 and a separate Part II survey for the one month ended in 2012.

This is evidenced by the citations below from the DSH Auditing Final Rule and the General DSH Audit and Reporting Protocol.

a. From: FR Vol. 73, No. 245, Friday, Dec. 19, 2008

(Auditing pg. 77930) In instances where the hospital financial and cost reporting periods differ from the Medicaid state plan rate year, states and auditors may need to review multiple audited hospital financial reports and cost reports to fully cover the Medicaid state plan rate year under audit. At most, two financial and/or cost reports should provide the appropriate data. 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 period under audit.

b. From: General DSH Audit and Reporting Protocol

Data Sources:

The following are to be considered the primary data sources utilized by states, hospitals and the independent auditors to complete the DSH audit and the accompanying report. In many instances, hospital financial and cost report periods will differ from the Medicaid State plan rate year. In these instances, hospitals should use multiple audited financial reports and hospital cost reports to fully cover the Medicaid State plan rate year under audit. The data should be directly allocated based on the months covered by the financial or cost reporting period that directly related to the Medicaid State plan period under audit. For instance, if a Medicaid State plan rate year runs from 7/1/04 to 6/30/05 but a DSH hospital receiving payments under the Medicaid State plan operates its financial and cost reporting based on a calendar year, the hospital would need to use

financial and cost reports for calendar years 2004 and 2005. The hospital would allocate 50% of all costs and revenues in each financial and cost reporting period to determine costs and revenues associated with the Medicaid State plan rate year 2005.

Comment: This states that the hospital would allocate 50% of all costs and revenues, not 50% of days and charges. In order to allocate 50% of all costs and revenues of each cost reporting period a hospital must first calculate 100% of all costs and revenues for each cost reporting period.

c. From: General DSH Audit and Reporting Protocol

Data Sources: - General Cost Determination: Uncompensated Care Cost Determination

The Medicare cost allocation process will be used to determine facility costs for inclusion in determining DSH eligible hospital costs. In order to provide complete financial information for the Medicaid State plan rate year under audit, hospitals must use two or more Medicare costs reports if the cost reporting period does not correspond with the Medicaid State plan rate year under audit. Once costs are allocated according to the Medicare cost allocation process, those costs should be allocated to the Medicaid State plan rate year on a pro-rata basis to develop 12 full months of costs.

Comment: This states that once costs are allocated to the cost reporting period they are then pro-rated to the MSP rate year, not pro-rated *before* costs are allocated.

2. Will we have to report two cost report years worth of claims (24 months) for every DSH audit?

No, Part II surveys completed in the previous year will be used again in the subsequent year to span that DSH year. If the hospital reports two years of uncompensated care costs for the cost report periods spanning DSH year 2010, they will only need to report one additional year of uncompensated care cost for the cost report periods spanning DSH year 2011 (assuming no change to the hospital fiscal year end).

3. Does the provider have to populate Section H, I, J, and K?

Yes, the hospital should utilize their Medicare revenue code crosswalk to report days, charges and payments by cost center for Medicaid and the uninsured. In addition, each hospital should verify that the pre-populated HRCIS data in all other Sections are properly stated.

4. 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 would 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 as uninsured. Myers and Stauffer will remove these services from the Part II survey until the rule becomes final.
- Excluded prisoners were reiterated 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

5. 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. Myers and Stauffer will remove from the part II survey any days, charges and payments indicated as exhausted or non-covered.

6. 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.

7. 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*)

8. 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*)

9. 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.

10. 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, however Myers and Stauffer will remove these patients until the rule is finalized.

11. 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, however Myers and Stauffer will remove these patients until the rule is finalized.

12. Can a hospital report services covered under automobile policies as uninsured?

Not if the automobile policy pays for the service. We interpret the phrase “who have health insurance (or other third party coverage)” to broadly refer to individuals who have creditable coverage consistent with the definitions under 45 CFR Parts 144 and 146, as well as individuals who have coverage based upon a legally liable third party payer. The phrase would not include individuals who have insurance that provides only excepted benefits, such as those described in 42 CFR 146.145, unless that insurance actually provides coverage for the hospital services at issue (such as when an automobile liability insurance policy pays for a hospital stay). *(Reporting pages 77911 & 77916)*

13. 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.

14. 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.

15. 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)*

16. 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)*

17. 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 even if the Medicaid payment is zero. In calculating the Medicare payment, the hospital should include all Medicare adjustments (DSH, IME, GME, etc.) *(Reporting pg. 77912)*

18. Do Commercial Primary with Medicaid Secondary services have to be included in the Medicaid UCC?

Yes. CMS believes the costs attributable to ALL Medicaid 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 Commercial and Medicaid payments made even if the Medicaid payment is zero.

19. 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)*

20. What is the definition of Cash Subsidies in Survey Part II Section F?

Cash Subsidies in this section are payments received from locally-only funded programs and state-only funded programs. These payments should be consistent with the definitions used on the Texas DSH payment application. Please note that cash subsidies should be accumulated on the cost report year for each Part II survey.

21. What is the definition of Charity Care in Survey Part II Section F?

Charity Care charges must be consistent with §311.031 of the *Texas Health and Safety Code* and 1 *Texas Administrative Code* §355.8065(b) and should reconcile to your Audited Financial Statements. These charges should be consistent with the definitions used on the Texas DSH payment application. Please note that charity care charges should be accumulated on the cost report year for each Part II survey.

22. Dual Eligible, do we report claims even if Medicaid made no payments?

Yes, hospitals should report dual-eligible claims even if Medicaid made no payments.

23. How do we capture upper payment limit payments (UPL)?

Myers and Stauffer will forward the UPL reported by HHSC to each applicable hospital.

24. Where do we report Primary Care Case Management (PCCM)?

PCCM claims will be included in the fee-for-services claims provided by Texas MMIS (TMHP).

25. Is there a list of non-covered Medicaid revenue codes that could be made available?

Please refer to the Texas Medicaid Provider Manual for guidance regarding non-covered Medicaid services.

26. Data transmission to Myers and Stauffer – Does the data need to be encrypted?

Please follow your hospital policies regarding the mailing of Protected Health Information.

27. What happens if we can't get out-of-state or Managed Care Organization (MCO) PS&Rs or paid claims summaries?

If PS&Rs or paid claims summaries are not available from out-of-state Medicaid agencies or MCOs please utilize the hospital's accounting records to report these claims and include with your survey submission a detailed claims listing using Exhibit C formatting.

28. We have the initial cost report but Trailblazer has posted audit adjustments to the 2009 and 2010 year end but not FINAL SETTLED yet due to the pending SSI ratio issues with CMS. Can this cost report be used for the DSH audit?

We can only accept the best available official cost report. The not final settled reports (being held for SSI ratio issues) cannot be used until they are finalized. Please use the best available report, which in this case appears to be your as-filed report.

29. Do we have to follow the formatting of Exhibit A, B and C to report patient level detail by revenue code?

Exhibits A, B and C are formatted to provide the level of detail necessary to support hospital reported claims that are summarized by revenue code for cost center grouping on Sections H, I, J and K using your Medicare crosswalk. These Exhibits are formatted specifically to allow for computerized testing of detailed claims. If your hospital system cannot report claims in this format, please contact txdsh@mslc.com to discuss a limited set of alternatives.

30. Regarding Survey Part I – Physician Certification: Are these physicians for state year 2011 or current year?

These physicians should be for Medicaid state plan rate year 2011.

31. How should a hospital report patient payments for "package plans"?

If "package plans" refers to Managed Care Organization payments, then (per CMS protocol) any managed care payments received that include payments for services other than those that qualify for inpatient or outpatient hospital services must be separated to include that portion of the payment applicable to inpatient or outpatient hospital services. If the hospital cannot separate the component parts of a managed care payment, the full amount of the payment must be counted as in IP/OP hospital managed care payment.

32. Can ambulance or air ambulance be included on the DSH survey?

Ambulance/Air Ambulance should not be included on the DSH survey. In order for a service to be included in the hospital specific DSH limit (reported on the survey) that service must be billed and reimbursed as an inpatient or outpatient hospital service and included as a Medicaid covered hospital inpatient or outpatient service in the Medicaid Provider Manual. Hospital-operated Ambulance should have an ambulance provider number and bill for those services using that number and not as a hospital service.

33. Can ESRD be included on the DSH survey?

ESRD should not be included on the DSH survey. In order for a service to be included in the hospital specific DSH limit (reported on the survey) that service must be billed and reimbursed as an inpatient or outpatient hospital service and included as a Medicaid covered hospital inpatient or outpatient service in the Medicaid Provider Manual. Hospital-operated ESRD should have a renal dialysis provider number and bill for those services using that number and not as a hospital service.