



**MYERS AND  
STAUFFER** LC  
CERTIFIED PUBLIC ACCOUNTANTS

# DISPROPORTIONATE SHARE HOSPITAL (DSH) PAYMENT EXAMINATION UPDATE DSH YEAR 2012 AND UC DY1 FINAL RECONCILIATION UPDATE

DEDICATED TO GOVERNMENT HEALTH PROGRAMS





## ■ OVERVIEW

- DSH Examination Policy
- DSH Year 2012 Examination Timeline
- DSH Year 2012 Examination Impact
- Claims Data Review
- Review of DSH Year 2012 Survey and Exhibits
- 2012 Clarifications / Changes
- Recap of Prior Year Examinations (2011)
- Myers and Stauffer DSH FAQ
- UC DY1 Final Reconciliation



## ■ 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.)

- 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
- Audit/Reporting implemented in FR Vol. 79, No. 232, Wednesday, Dec. 03, 2014, Final Rule





## ■ DSH YEAR 2012 EXAMINATION TIMELINE

- Surveys emailed April 10, 2015
- Surveys returned by May 11, 2015
- Desk reviews May 11-Sept 4
- Expanded reviews June 1-Sept 18
- Draft report to the state by September 30, 2015
- Final report to CMS by December 31, 2015





## ■ DSH YEAR 2012 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 2012 examination report is the second year that may result in DSH payment recoupment.



## ■ CLAIMS DATA UPDATE FOR 2012

- Medicaid fee-for-service and Managed Care claims data
  - Will be sent to hospitals shortly.
  - Same format as last year, except that Late Filings will be incorporated instead of separated.
  - Reported based on cost report year (using adjudication date).
  - At revenue code level. Most claims will now be summarized by the original revenue code. The Medlog mapping is also available in claims detail.
  - Detailed data is available upon request (SFTP).
  - Will exclude non-Title 19 services (such as SCHIP)



## ■ CLAIMS DATA UPDATE FOR 2012

- Medicare/Medicaid cross-over paid claims data
  - This data will be in summary only, will not be at revenue code level.
  - Reported based on cost report year (using adjudication date).
  - Hospital is responsible for ensuring all Medicare payments are included in the final survey even if the payments are not reflected on the state's paid claim totals.
  - Non-Claims based Medicare payments attributable to cross-over claims should be reported by the hospital.



## ■ CLAIMS DATA UPDATE FOR 2012

- Out-of-State Medicaid paid claims data should be obtained from the state making the payment
  - If the hospital cannot obtain a paid claims listing from the state, the hospital should send in a detailed listing in Exhibit C format.
  - Must EXCLUDE SCHIP and other non-Title 19 services.
  - Should be reported based on cost report year (using adjudication when possible or discharge date if necessary).
  - In future years, request out-of-state paid claims listing at the time of your cost report filing



## ■ CLAIMS DATA UPDATE FOR 2012

- Other Medicaid Eligible (Medicaid not billed)
  - Medicaid-eligible patient services where Medicaid did not receive the claim would not have been included in the state's data. The hospital must submit these eligible services on Exhibit C for them to be eligible for inclusion in the DSH uncompensated care cost (UCC).
  - Must include all payments from all payers.
  - Must EXCLUDE SCHIP and other non-Title 19 services.
  - Should be reported based on cost report year (using adjudication date).



## ■ PAID CLAIMS DATA UPDATE FOR 2012

- Other Medicaid Eligible (cont.)
  - 2008 DSH Rule and January, 2010 CMS FAQ #33 requires that ***all*** Medicaid eligibles are reported on the DSH survey and included in the UCC calculation.
  - Exhibit C should be submitted for this population. If no “Other” Medicaid Eligibles are submitted, we will contact you to request that they be submitted.
  - Ensure that you ***separately report*** Medicaid, Medicare, third party liability (TPL, including commercial payments), and self-pay payments in Exhibit C.
  - Discussion on current federal court injunction later in the presentation.



## ■ CLAIMS DATA UPDATE FOR 2012

- Uninsured Services
  - As in years past, uninsured charges/days will be reported on Exhibit A and self pay patient payments will be reported on Exhibit B.
  - Should be reported based on cost report year (using discharge date).
  - Exhibit B patient payments will be reported based on cash basis (received during the cost report year).



## ■ DSH EXAMINATION SURVEYS

### General Instruction – Survey Files

- The survey is split into 2 separate Excel files:
  - DSH Survey Part I – DSH Year Data
    - DSH year-specific information
    - Always complete one copy
  - DSH Survey Part II – Cost Report Year Data
    - Cost report year-specific information
    - Complete a separate copy for each cost report year needed to cover the DSH year.
    - Hospitals (14) with year end changes or that are new to DSH may have to complete 2 year ends



## ■ DSH EXAMINATION SURVEYS

### General Instruction – Survey Files

- Don't complete a DSH Part II survey for a cost report year already submitted in a previous DSH exam year.
  - Example: Hospital A provided a survey for their year ending 12/31/11 with the DSH audit of MSP rate year 2011 in the prior year. In the DSH year 2012 exam, Hospital A would only need to submit a survey for their year ending 12/31/12.
- Both surveys have an Instructions tab that has been updated. Please refer to those tabs if you are unsure of what to enter in a section. If it still isn't clear, please contact Myers and Stauffer.



## ■ 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.





## ■ DSH SURVEY PART I – DSH YEAR DATA

### Section A

- DSH Year should already be filled in
- Hospital name may already be selected (if not, select from the drop-down box)
- Verify the cost report year end dates (should only include those that 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
- If Question 1 is answered yes, provide the names and license numbers of the two physicians that meet this requirement.



## ■ DSH SURVEY PART I – DSH YEAR DATA

### Section C

- Enter your total Medicaid Supplemental Payments for the DSH Year.
- Report any Medicaid supplemental payments, including UC and Non-Claim Specific payments, for the DSH state plan rate 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”.
- The DSH payment for State Hospitals is retained by the State and this is **not** a basis for answering the question “No”.
- Have CEO or CFO sign this section after completion of Part II of the survey.



State of Texas  
Disproportionate Share Hospital (DSH) Examination Survey Part I  
For State DSH Year 2011

Select Hospital Name

**A. General DSH Year Information**

	Begin	End
1. DSH Year:	10/01/2010	09/30/2011
2. Select Your Facility from the Drop-Down Menu Provided:	SELECT HOSPITAL NAME	

Identification of cost reports needed to cover the DSH Year:

	Cost Report Begin Date(s)	Cost Report End Date(s)
3. Cost Report Year 1		
4. Cost Report Year 2 (if applicable)		
5. Cost Report Year 3 (if applicable)		

Data	
6. Medicaid Provider Number:	M'caid #
7. Medicaid Subprovider Number 1 (Psychiatric or Rehab):	M'caid Sub 1 #
8. Medicaid Subprovider Number 2 (Psychiatric or Rehab):	M'caid Sub 2 #
9. Medicare Provider Number:	M'care #

Only cost report years to be submitted will show here.

Need to prepare a separate Part II DSH Survey Excel file for each cost report year listed here.

**B. DSH OB Qualifying Information**

Questions 1-3, below, should be answered in the accordance with 1 TAC 355.8065(e)(1).

During the DSH Year 10/01/2010 - 09/30/2011:

- Did the hospital have at least two licensed physicians (doctor of medicine or osteopathy) who had hospital staff privileges and who have agreed to provide non-emergency obstetrical services to individuals who are entitled to medical assistance for such services.  
If yes, please provide the two physician names and Texas Medical Board License Numbers below.  
Response should be related to the DSH Year indicated in Section A. lines 1 above

Enter Physician Name and License Number for BOTH physicians.

Physician Certification:

1) Physician Name	
1) Texas Medical Board License Number	
2) Physician Name	
2) Texas Medical Board License Number	

- Was the hospital exempt from the requirement listed under #1 above because the hospital's inpatients are predominantly under 18 years of age?
- Was the hospital exempt from the requirement listed under #1 above because it was operating but did not offer non-emergency obstetric services to the general population when federal Medicaid DSH regulations were enacted on December 22, 1987?

Answer all OB questions.

Answer



**C. Disclosure of Other Medicaid Payments Received:**

1. **Medicaid Supplemental Payments for DSH Year 07/01/2009 - 06/30/2010**  
(Should include UPL and Non-Claim Specific payments paid based on the state fiscal year. However, DSH payments should NOT be included.)

\$ 500,000

Input all supplemental payments for the DSH year (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 IGT/CPE is not a basis for answering this question "no". If your hospital was not allowed to retain 100% of its DSH payments, please explain what circumstances were present that prevented the hospital from retaining its payments.

Answer

Must answer the retain DSH question

Explanation for "No" answers:

\_\_\_\_\_

\_\_\_\_\_

Complete Certification and Contact Information

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:**

**Hospital Contact:**

Name	_____
Title	_____
Telephone Number	_____
E-Mail Address	_____
Mailing Street Address	_____
Mailing City, State, Zip	_____

**Outside Preparer:**

Name	_____
Title	_____
Firm Name	_____
Telephone Number	_____
E-Mail Address	_____

**Note: Report UC DY1 distributions on Section C. 1.**



## ■ DSH YEAR SURVEY PART II SECTION D – GENERAL INFORMATION

**Submit one copy of the part II survey for each cost report year not previously submitted.**

- Question #2 – An “X” should be shown in the column of the cost report year survey you are preparing. (if you have multiple years listed, you will need to prepare multiple surveys). If there is an error in the year ends, contact Myers and Stauffer to send out a new copy.
- Question #3 – 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

2. Select Cost Report Year Covered by this Survey (enter "X"):

1/1/2010 through 12/31/2010		
X		

3. Status of Cost Report Used for this Survey (Should be audited if available):

3 - Settled with Audit

4. Hospital Name:

5. Medicaid Provider Number:

6. Medicaid Subprovider Number 1 (Psychiatric or Rehab):

7. Medicaid Subprovider Number 2 (Psychiatric or Rehab):

8. Medicare Provider Number:

Data	Correct?	If Incorrect, Proper Information
Hospital ABC	Yes	
111111	Yes	
0	Yes	
0	Yes	
001111	Yes	

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

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

*(List additional states on a separate attachment)*

State Name	Provider No.
Kansas	0123
Illinois	1244
Iowa	1511
Arkansas	1566

Should have an "X" for the cost report year you are reporting on. Should have a separate Excel file for each year listed here.

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



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

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



**E. Disclosure of Medicaid / Uninsured Payments Received: (01/01/2010 - 12/31/2010)**

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)**
9. Total Cash Basis Patient Payments from Uninsured (On Exhibit B)
10. Total Cash Basis Patient Payments from All Other Patients (On Exhibit B)
11. Total Cash Basis Patient Payments Reported on Exhibit B(Agrees to Column (H) on Exhibit B)
12. Uninsured Cash Basis Patient Payments as a Percentage of Total Cash Basis Patient Payments:

\$	10,000		
\$	5,000		
\$	2,500		
	\$17,500		
\$	1,000		
\$	-		
	\$1,000		
\$	50,000		
	Inpatient	Outpatient	
\$	250,000	\$	1,000,000
\$	3,000,000	\$	9,000,000
	\$3,250,000		\$10,000,000
	7.69%		10.00%

Total	\$1,250,000
	\$12,000,000
	\$13,250,000
	9.43%

1011 Payment  
 (undocumented  
 patients)  
 Reconciliation

Out-of-state DSH  
 payments

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

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

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



## ■ DSH YEAR SURVEY PART II SECTION F MIUR/LIUR

- The state must report your actual MIUR and LIUR for the DSH year - data is needed to calculate the MIUR/LIUR.
- Section F-1: Total hospital days from cost report. Myers and Stauffer will pre-load CMS HCRIS cost report data into this section. If it is incorrect or 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).



## ■ DSH YEAR SURVEY PART II SECTION F, MIUR/LIUR

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

- Myers and Stauffer will pre-load CMS HCRIS cost report data into this section. If it is incorrect or 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.



**F. MIUR / LIUR Qualifying Data from the Cost Report ( - )**

**F-1. Total Hospital Days Used in Medicaid Inpatient Utilization Ratio (MIUR)**

1. Total Hospital Days Per Cost Report Excluding Swing-Bed (C/R, W/S S-3, Pt. I, Col. 8, Sum of Lns. 14, 16, 17, 18.xx less lines 5 & 6)

67,700

← Days per cost report  
(See Note in Section F-3, below)

**F-2. Cash Subsidies for Patient Services Received from State or Local Governments and Charity Care Charges (Used in Low-Income Utilization Ratio (LIUR) Calculation):**

- 2. Inpatient Hospital Subsidies
- 3. Outpatient Hospital Subsidies
- 4. Unspecified I/P and O/P Hospital Subsidies
- 5. Total Hospital Subsidies

State or Local Govt. Subsidies

← State or Local Govt. Subsidies

- 6. Inpatient Charity Care Charges
- 7. Outpatient Charity Care Charges
- 8. Total Charity Care Charges

Charity Care Charges (only used in LIUR - NOT UCC)

← Charity Care Charges (only used in LIUR - NOT UCC)

**F-3. Calculation of Net Hospital Revenue from Patient Services (Used for LIUR) (W/S G-2 and G-3 of Cost Report)**

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

	Total Patient Revenues (Charges)			Contractual Adjustments (formulas below can be overwritten if amounts are known)			Net Hospital Revenue
	Inpatient Hospital	Outpatient Hospital	Non-Hospital	Inpatient Hospital	Outpatient Hospital	Non-Hospital	
9. Hospital	\$ 52,990,359			\$ 35,004,359	\$ -	\$ -	\$ 17,986,000
10. Subprovider I (Psych or Rehab)	\$ 10,489,099			\$ 6,928,887	\$ -	\$ -	\$ 3,560,212
11. Subprovider II (Psych or Rehab)	\$ -			\$ -	\$ -	\$ -	\$ -
12. Swing Bed - SNF			\$ -			\$ -	
13. Swing Bed - NF			\$ -			\$ -	
14. Skilled Nursing Facility			\$ 6,183,620			\$ 4,084,774	
15. Nursing Facility			\$ 6,775,359			\$ 4,475,665	
16. Other Long-Term Care			\$ 6,690,449			\$ 4,419,575	
17. Ancillary Services	\$ 321,087,841	\$ 251,461,293		\$ 212,104,130	\$ 166,110,241	\$ -	\$ 194,334,763
18. Outpatient Services		\$ 99,895,911			\$ 65,989,217	\$ -	\$ 33,906,694
19. Home Health Agency			\$ 4,294,122			\$ 2,836,610	
20. Ambulance			\$ -			\$ -	
21. Outpatient Rehab Providers			\$ -			\$ -	
22. ASC	\$ -	\$ -		\$ -	\$ -	\$ -	\$ -
23. Hospice			\$ -			\$ -	
24. Other	\$ -	\$ 59,675,752	\$ -	\$ -	\$ 39,420,504	\$ -	\$ 20,255,158
25. Total	\$ 384,567,299	\$ 411,032,956	\$ 23,943,550	\$ 254,037,375	\$ 271,520,052	\$ 15,816,625	\$ 270,042,828
26. Total Hospital and Non Hospital		Total from Above	\$ 819,543,805		Total from Above	\$ 541,374,052	
27. Total Per Cost Report		Total Patient Revenues (G-3 Line 1)	\$ 819,543,805		Total Contractual Adj. (G-3 Line 2)	\$ 541,374,052	
28. Unreconciled Difference		Unreconciled Difference (Should be \$0)	\$ -		Unreconciled Difference (Should be \$0)	\$ -	

← 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



**G. Cost Report - Cost / Days / Charges**

Cost Report Year (01/01/2010-12/31/2010) Hospital ABC

Line #	Cost Center Description	Total Allowable Cost	Intern & Resident Costs Removed on Cost Report *	RCE and Therapy Add-Back (If Applicable)	Net Cost	I/P	O/P Charges	Total Charges	Medicaid Per Diem / Cost-to-Charge Ratios
		<i>Cost Report Worksheet B, Part I, Col. 27</i>	<i>Cost Report Worksheet B, Part I, Col. 26 (Intern &amp; Resident Offset ONLY)*</i>	<i>Cost Report Worksheet C, Part I, Col.2 and Col. 4</i>	<i>Swing-Bed Carve Out - Cost Report Worksheet D-1, Part I, Line 26</i>	<i>Calculated</i>	<i>Days - Cost Report W/S D-1, Pt. 1, Line 2 for Adults &amp; Peds; W/S D-1, Pt. 2, Lines 42-47 for others</i>		<i>Calculated Per Diem</i>

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

All Cost Report Data. Calculation of Routine Cost Per Diems

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

1	02500 ADULTS & PEDIATRICS	\$ 200,000,000	\$ 55,000,000	\$ -	\$ -	\$ 255,000,000	250,000		\$ 1,020.00
2	02600 INTENSIVE CARE UNIT	\$ 14,000,000	\$ 8,500,000	\$ -		\$ 22,500,000	10,000		\$ 2,250.00
3	02700 CORONARY CARE UNIT	\$ 7,500,000	\$ -	\$ -		\$ 7,500,000	5,000		\$ 1,500.00
4	02800 BURN INTENSIVE CARE UNIT	\$ -	\$ -	\$ -		\$ -	-		\$ -
5	02900 SURGICAL INTENSIVE CARE UNIT	\$ 12,500,000	\$ 1,500,000	\$ -		\$ 14,000,000	8,000		\$ 1,750.00
6	03000 OTHER SPECIAL CARE UNIT	\$ -	\$ -	\$ -		\$ -	-		\$ -
7	03100 SUBPROVIDER I	\$ 12,000,000	\$ 2,000,000	\$ -		\$ 14,000,000	11,000		\$ 1,272.73
8	03101 SUBPROVIDER II	\$ -	\$ -	\$ -		\$ -	-		\$ -
9	03300 NURSERY	\$ 2,000,000	\$ 40,000	\$ -		\$ 2,040,000	6,000		\$ 340.00
10		\$ -	\$ -	\$ -		\$ -	-		\$ -
11		\$ -	\$ -	\$ -		\$ -	-		\$ -
12		\$ -	\$ -	\$ -		\$ -	-		\$ -
13		\$ -	\$ -	\$ -		\$ -	-		\$ -
14		\$ -	\$ -	\$ -		\$ -	-		\$ -
15		\$ -	\$ -	\$ -		\$ -	-		\$ -
16		\$ -	\$ -	\$ -		\$ -	-		\$ -
17		\$ -	\$ -	\$ -		\$ -	-		\$ -
18	Total Routine	\$ 248,000,000	\$ 67,040,000	\$ -	\$ -	\$ 315,040,000	290,000		
19	Weighted Average								\$ 1,086.34

Observation Data (Non-Distinct)

20	062xx Observation (Non-Distinct)
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Hospital Observation Days - Cost Report W/S S-3, Pt. 1, Line 26, Col. 6	Subprovider I Observation Days - Cost Report W/S S-3, Pt. 1, Line 26.01, Col. 6	Subprovider II Observation Days - Cost Report W/S S-3, Pt. 1, Line 26.02, Col. 6	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	Medicaid Calculated Cost-to-Charge Ratio
1,100	150	-	\$ 1,312,910	\$ 106,000	\$ 820,000	\$ 926,000	1.417829

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 (01/01/2010-12/31/2010) Hospital ABC

Line #	Cost Center Description	Total Allowable Cost	Intern & Resident Costs Removed on Cost Report *	RCE and Therapy Add-Back (If Applicable)	Net Cost	I/P	O/P Charges	Total Charges	Medicaid Per Diem / Cost-to-Charge Ratios
		<i>Cost Report Worksheet B, Part I, Col. 27</i>	<i>Cost Report Worksheet B, Part I, Col. 26 (Intern &amp; Resident Offset ONLY)*</i>	<i>Cost Report Worksheet C, Part I, Col.2 and Col. 4</i>	<i>Calculated</i>	<i>Inpatient Charges - Cost Report Worksheet C, Pt. I, Col. 6</i>	<i>Outpatient Charges - Cost Report Worksheet C, Pt. I, Col. 7</i>	<i>Total Charges - Cost Report Worksheet C, Pt. I, Col. 8</i>	<i>Medicaid Calculated Cost-to-Charge Ratio</i>
<b>Ancillary Cost Centers (from W/S C excluding Observation) (list below):</b>									
21	03700 OPERATING ROOM	\$ 70,000,000	\$ 20,000,000	\$ -	\$ 90,000,000	\$ 154,500,000	\$ 74,000,000	\$ 228,500,000	0.393873
22	03800 RECOVERY ROOM	\$ 25,000,000	\$ -	\$ -	\$ 25,000,000	\$ 23,000,000	\$ 37,000,000	\$ 60,000,000	0.416667
23	03900 DELIVERY ROOM & LABOR ROOM	\$ 10,000,000	\$ 1,300,000	\$ -	\$ 11,300,000	\$ 9,000,000	\$ 2,000,000	\$ 11,000,000	1.027273
24	04000 ANESTHESIOLOGY	\$ 13,000,000	\$ 7,500,000	\$ -	\$ 20,500,000	\$ 40,000,000	\$ 35,000,000	\$ 75,000,000	0.273333
25	04100 RADIOLOGY-DIAGNOSTIC	\$ 50,000,000	\$ 1,000,000	\$ -	\$ 51,000,000	\$ 100,000,000	\$ 195,000,000	\$ 295,000,000	0.172881
26	04200 RADIOLOGY-THERAPEUTIC	\$ 30,000,000	\$ -	\$ -	\$ 30,000,000	\$ 7,000,000	\$ 110,000,000	\$ 117,000,000	0.256410
27	04300 RADIOISOTOPE	\$ 4,000,000	\$ 170,000	\$ -	\$ 4,170,000	\$ 5,000,000	\$ 11,000,000	\$ 16,000,000	0.260625
28	04400 LABORATORY	\$ 55,000,000	\$ 6,400,000	\$ -	\$ 61,400,000	\$ 290,000,000	\$ 175,000,000	\$ 465,000,000	0.132043
29	04700 BLOOD STORING PROCESSING & TRAN	\$ 40,000,000	\$ -	\$ -	\$ 40,000,000	\$ 115,000,000	\$ 35,000,000	\$ 150,000,000	0.266667
30	04900 RESPIRATORY THERAPY	\$ 17,000,000	\$ -	\$ -	\$ 17,000,000	\$ 60,000,000	\$ 3,000,000	\$ 63,000,000	0.269841
31	05000 PHYSICAL THERAPY	\$ 6,500,000	\$ -	\$ -	\$ 6,500,000	\$ 20,000,000	\$ 200,000	\$ 20,200,000	0.321782
32	05100 OCCUPATIONAL THERAPY	\$ 2,250,000	\$ -	\$ -	\$ 2,250,000	\$ 7,000,000	\$ 150,000	\$ 7,150,000	0.314685
33	05200 SPEECH PATHOLOGY	\$ 1,000,000	\$ -	\$ -	\$ 1,000,000	\$ 2,000,000	\$ 100,000	\$ 2,100,000	0.476190
34	05300 ELECTROCARDIOLOGY	\$ 9,000,000	\$ -	\$ -	\$ 9,000,000	\$ 46,000,000	\$ 45,000,000	\$ 91,000,000	0.098901
35	05400 ELECTROENCEPHALOGRAPHY	\$ 1,500,000	\$ 250,000	\$ -	\$ 1,750,000	\$ 5,500,000	\$ 750,000	\$ 6,250,000	0.280000
36	05500 MEDICAL SUPPLIES CHARGED TO PATI	\$ 97,000,000	\$ -	\$ -	\$ 97,000,000	\$ 185,000,000	\$ 60,000,000	\$ 245,000,000	0.395918
37	05530 IMPL. DEV. CHARGED TO PATIENT	\$ 120,000,000	\$ -	\$ -	\$ 120,000,000	\$ 180,000,000	\$ 50,000,000	\$ 230,000,000	0.521739
38	05600 DRUGS CHARGED TO PATIENTS	\$ 120,000,000	\$ -	\$ -	\$ 120,000,000	\$ 270,000,000	\$ 90,000,000	\$ 360,000,000	0.333333
39	05700 RENAL DIALYSIS	\$ 4,000,000	\$ -	\$ -	\$ 4,000,000	\$ 17,000,000	\$ 180,000	\$ 17,180,000	0.232829
40	05900 CAT SCAN	\$ 10,000,000	\$ -	\$ -	\$ 10,000,000	\$ 75,000,000	\$ 115,000,000	\$ 190,000,000	0.052632
41	05901 ULTRASOUND	\$ 4,500,000	\$ 75,000	\$ -	\$ 4,575,000	\$ 7,000,000	\$ 20,000,000	\$ 27,000,000	0.169444
42	05902 CARDIAC CATHETERIZATION LABORATO	\$ 12,500,000	\$ 500,000	\$ -	\$ 13,000,000	\$ 35,000,000	\$ 25,000,000	\$ 60,000,000	0.216667
43	05903 ENDOSCOPY	\$ 9,500,000	\$ -	\$ -	\$ 9,500,000	\$ 10,000,000	\$ 25,000,000	\$ 35,000,000	0.271429
44	05907 PSYCHIATRIC/PSYCHOLOGICAL SERVIC	\$ 800,000	\$ -	\$ -	\$ 800,000	\$ 25,000	\$ 2,800,000	\$ 2,825,000	0.283186
45	06000 CLINIC	\$ 20,000,000	\$ 10,600,000	\$ -	\$ 30,600,000	\$ 950,000	\$ 28,000,000	\$ 28,950,000	1.056995
46	06100 EMERGENCY	\$ 30,500,000	\$ 10,300,000	\$ -	\$ 40,800,000	\$ 55,500,000	\$ 76,000,000	\$ 131,500,000	0.310266
101	Total Ancillary	\$ 763,050,000	\$ 58,095,000	\$ -	\$ 821,145,000	\$ 1,719,581,000	\$ 1,216,000,000	\$ 2,935,581,000	
102	Weighted Average								0.280169
103	Grand Totals	\$ 1,011,050,000	\$ 125,135,000	\$ -					

\* Note A - Final cost-to-charge ratios should include teaching cost. Only enter Intern & Resident costs if it was removed in Column 26 of Worksheet B, Pt. I of the cost report you are using.

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



## ■ DSH SURVEY PART II SECTION H, IN-STATE MEDICAID

- Enter inpatient (routine) days, I/P and O/P charges, and payments. The form will calculate cost and shortfall / long-fall for:
  - In-State FFS Medicaid Primary (*Traditional Medicaid*)
  - 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 (*Medicaid not included elsewhere including Commercial Primary/Medicaid Secondary claims*)



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

Cost Report Year (01/01/2010-12/31/2010) Hospital ABC

**All Medicaid Categories**

Line #	Cost Center Description	Medicaid Per Diem Cost for Routine Cost Centers <i>From Section G</i>	Medicaid Cost to Charge Ratio for Ancillary Cost Centers <i>From Section G</i>	In-State Medicaid FFS Primary		In-State Medicaid Managed Care Primary		In-State Medicare FFS Cross-Over (with Medicaid Secondary)		In-State Other Medicaid Eligibles (Not Included Elsewhere)		
				Inpatient <i>From PS&amp;R Summary (Note A)</i>	Outpatient <i>From PS&amp;R Summary (Note A)</i>	Inpatient <i>From PS&amp;R Summary (Note A)</i>	Outpatient <i>From PS&amp;R Summary (Note A)</i>	Inpatient <i>From PS&amp;R Summary (Note A)</i>	Outpatient <i>From PS&amp;R Summary (Note A)</i>	Inpatient <i>From PS&amp;R Summary (Note A)</i>	Outpatient <i>From PS&amp;R Summary (Note A)</i>	
<b>Routine Cost Centers (from Section G):</b>				<b>Days</b>		<b>Days</b>		<b>Days</b>		<b>Days</b>		
1	02500 ADULTS & PEDIATRICS	\$ 1,020.00		29,500		11,000		22,000		5		
2	02600 INTENSIVE CARE UNIT	\$ 2,250.00		1,800		40		1,500				
3	02700 CORONARY CARE UNIT	\$ 1,500.00		500		15		800				
4	02800 BURN INTENSIVE CARE UNIT	\$ -										
5	02900 SURGICAL INTENSIVE CARE UNIT	\$ 1,750.00		1,100		140		600				
6	03000 OTHER SPECIAL CARE UNIT	\$ -										
7	03100 SUBPROVIDER I	\$ 1,272.73		3,000		250		2,800				
8	03101 SUBPROVIDER II	\$ -										
9	03300 NURSERY	\$ 340.00		1,255		4,000						
10		\$ -										
11		\$ -										
12		\$ -										
13		\$ -										
14		\$ -										
15		\$ -										
16		\$ -										
17		\$ -										
18		\$ -										
				<b>Total Days</b>		<b>36,955</b>		<b>15,445</b>		<b>27,500</b>		<b>5</b>
19	Total Days per PS&R or Other Paid Claims Summary											
20	Unreconciled Days (Explain Variance)					<b>36,955</b>		<b>15,445</b>		<b>27,500</b>		<b>5</b>
				<b>Routine Charges</b>		<b>\$ 35,500,000</b>		<b>\$ 10,405,000</b>		<b>\$ 26,800,000</b>		<b>\$ 3,500</b>
21	Routine Charges											
21.01	Calculated Routine Charge Per Diem					\$ 960.63		\$ 673.68		\$ 974.55		\$ 700.00

Enter in Medicaid days and total routine charges. Per diem cost amounts carry over from Section G cost report data.



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

Cost Report Year (01/01/2010-12/31/2010) Hospital ABC

Ancillary Cost Centers (from W/S C) (from Section G):			In-State Medicaid FFS Primary		In-State Medicaid Managed Care Primary		In-State Medicare FFS Cross-Overs (with Medicaid Secondary)		In-State Other Medicaid Eligibles (Not Included Elsewhere)	
			Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges
22	062xx	Observation (Non-Distinct)	1.417829	30,000	130,000	-	50,000	-	90,000	-
23	03700	OPERATING ROOM	0.393873	10,930,000	3,690,000	1,450,000	1,320,000	8,010,000	3,200,000	2,000
24	03800	RECOVERY ROOM	0.416667	1,850,000	2,170,000	290,000	730,000	1,340,000	1,890,000	600
25	03900	DELIVERY ROOM & LABOR ROOM	1.027273	940,000	260,000	3,630,000	1,040,000	110,000	20,000	-
26	04000	ANESTHESIOLOGY	0.273333	2,850,000	1,360,000	480,000	570,000	1,860,000	1,070,000	500
27	04100	RADIOLOGY-DIAGNOSTIC	0.172881	11,930,000	13,170,000	1,260,000	3,110,000	8,860,000	10,390,000	10,000
28	04200	RADIOLOGY-THERAPEUTIC	0.256410	750,000	10,540,000	60,000	1,390,000	520,000	4,790,000	-
29	04300	RADIOISOTOPE	0.260625	650,000	850,000	50,000	160,000	690,000	730,000	-
30	04400	LABORATORY	0.132043	31,920,000	15,920,000	6,140,000	6,340,000	25,430,000	10,180,000	1,500
31	04700	BLOOD STORING PROCESSING & TRAN	0.266667	11,340,000	3,030,000	2,410,000	590,000	7,800,000	2,070,000	3,000
32	04900	RESPIRATORY THERAPY	0.269841	6,360,000	220,000	480,000	70,000	6,530,000	180,000	-
33	05000	PHYSICAL THERAPY	0.321782	1,070,000	20,000	120,000	-	990,000	10,000	-
34	05100	OCCUPATIONAL THERAPY	0.314685	650,000	20,000	100,000	-	620,000	20,000	-
35	05200	SPEECH PATHOLOGY	0.476190	240,000	20,000	30,000	-	170,000	20,000	-
36	05300	ELECTROCARDIOLOGY	0.098901	4,780,000	3,240,000	350,000	540,000	4,740,000	2,850,000	2,000
37	05400	ELECTROENCEPHALOGRAPHY	0.280000	530,000	90,000	70,000	20,000	530,000	60,000	-
38	05500	MEDICAL SUPPLIES CHARGED TO PATI	0.395918	23,630,000	5,400,000	3,680,000	1,120,000	20,900,000	5,120,000	500
39	05530	IMPL. DEV. CHARGED TO PATIENT	0.521739	-	-	-	-	-	-	800
40	05600	DRUGS CHARGED TO PATIENTS	0.333333	30,140,000	5,780,000	5,160,000	1,030,000	22,330,000	5,010,000	400
41	05700	RENAL DIALYSIS	0.232829	1,440,000	20,000	20,000	-	3,890,000	100,000	1,800
42	05900	CAT SCAN	0.052632	9,460,000	10,040,000	1,070,000	2,140,000	7,020,000	5,870,000	-
43	05901	ULTRASOUND	0.169444	950,000	2,000,000	190,000	2,050,000	680,000	670,000	900
44	05902	CARDIAC CATHETERIZATION LABORATO	0.216667	2,260,000	1,110,000	200,000	70,000	2,850,000	1,130,000	-
45	05903	ENDOSCOPY	0.271429	1,060,000	2,110,000	70,000	200,000	930,000	1,500,000	-
46	05907	PSYCHIATRIC/PSYCHOLOGICAL SERVIC	0.283186	-	360,000	-	10,000	10,000	1,340,000	-
47	06000	CLINIC	1.056995	50,000	4,460,000	60,000	2,690,000	70,000	2,430,000	-
48	06100	EMERGENCY	0.310266	8,670,000	10,940,000	1,210,000	6,530,000	7,050,000	4,630,000	-

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



## ■ DSH SURVEY PART II SECTION H, IN-STATE MEDICAID

Allocation of Days and Charges to the appropriate Cost Center

- We will accept many allocation methods as long as they are supported with detailed documentation and do not appear improperly shift cost.
  - Revenue code; as 1:1 or 1:many
  - Revenue and Usage Report (% to total)
  - Total days and charges from the Medicare Cost Report
  - Medicare days and charges from the Medicare Cost Report on cross-overs



## ■ 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 Medicare Payments (IME/GME on crossovers)
  - Other third party payments (TPL)



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

Cost Report Year (01/01/2010-12/31/2010) Hospital ABC

		In-State Medicaid FFS Primary		In-State Medicaid Managed Care Primary		In-State Medicare FFS Cross-Overs (with Medicaid Secondary)		In-State Other Medicaid Eligibles (Not Included Elsewhere)	
<b>Totals / Payments</b>									
103	<b>Total Charges (includes organ acquisition from Section J)</b>	\$ 199,580,000	\$ 96,950,000	\$ 38,985,000	\$ 31,770,000	\$ 160,730,000	\$ 65,170,000	\$ 11,100	\$ 22,390
104	Total Charges per PS&R or Other Paid Claims Summary	\$ 199,580,000	\$ 96,950,000	\$ 38,985,000	\$ 31,770,000	\$ 160,730,000	\$ 65,170,000	\$ 11,100	\$ 22,390
105	Unreconciled Charges (Explain Variance)	-	-	-	-	-	-	-	-
106	<b>Total Calculated Cost (includes organ acquisition from Section J)</b>	\$ 83,914,981	\$ 25,679,281	\$ 23,546,916	\$ 10,315,678	\$ 66,162,462	\$ 17,125,232	\$ 6,982	\$ 4,414
107	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)	\$ 46,300,000	\$ 20,000,000	\$ 15,500,000	\$ 9,000,000	\$ 2,100,000	\$ 3,000,000	\$ -	\$ -
108	Other Total Third Party Liability (including Co-Pay and Spend-Down but excluding Medicare on crossovers)	\$ 16,000	\$ 100,000	\$ 600,000	\$ 300,000	\$ 15,000	\$ 10,000	\$ -	\$ 156
109	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)	\$ 46,316,000	\$ 20,100,000	\$ 16,100,000	\$ 9,300,000				
110	Medicaid Cost Settlement Payments (See Note B)								
111	Other Medicaid Payments Reported on Cost Report Year (See Note C)								
112	Medicare Paid Amount (excludes coinsurance/deductibles)					\$ 60,000,000	\$ 10,500,000	\$ 5,000	\$ 1,900
113	Medicare Cross-Over Bad Debt Payments					\$ 2,000,000	\$ 7,000		
114	Other Medicare Cross-Over Payments (See Note D)					\$ 8,200,000	\$ 1,200,000	\$ 300	\$ 400
115	Payment from Hospital Uninsured During Cost Report Year (Cash Basis)								
116	Section 1011 Payment Related to Inpatient Hospital Services NOT Included in Exhibits B & B-1 (from Section E)								
117	<b>Calculated Payment Shortfall / (Longfall)</b>	\$ 37,598,981	\$ 5,579,281	\$ 7,446,916	\$ 1,015,678	\$ (6,152,538)	\$ 2,408,232	\$ 1,682	\$ 1,958
118	<b>Calculated Payments as a Percentage of Cost</b>	55%	78%	68%	90%	109%	86%	76%	56%

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.



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

Cost Report Year (01/01/2010-12/31/2010) Hospital ABC

Line #	Cost Center Description	Medicaid Per Diem Cost for Routine Cost Centers <i>From Section G</i>	Medicaid Cost to Charge Ratio for Ancillary Cost Centers <i>From Section G</i>	Uninsured	
				Inpatient (See Exhibit A) <i>From Hospital's Own Internal Analysis</i>	Outpatient (See Exhibit A) <i>From Hospital's Own Internal Analysis</i>
<b>Routine Cost Centers (from Section G):</b>					
				<b>Days</b>	
1	02500 ADULTS & PEDIATRICS	\$ 1,020.00		1,000	
2	02800 INTENSIVE CARE UNIT	\$ 2,250.00		80	
3	02700 CORONARY CARE UNIT	\$ 1,500.00		60	
4	02800 BURN INTENSIVE CARE UNIT	\$ -			
5	02900 SURGICAL INTENSIVE CARE UNIT	\$ 1,750.00		120	
6	03000 OTHER SPECIAL CARE UNIT	\$ -			
7	03100 SUBPROVIDER I	\$ 1,272.73		400	
8	03101 SUBPROVIDER II	\$ -			
9	03300 NURSERY	\$ 340.00		60	
10		\$ -			
11		\$ -			
12		\$ -			
13		\$ -			
14		\$ -			
15		\$ -			
16		\$ -			
17		\$ -			
18		\$ -			
			<b>Total Days</b>	1,720	

Uninsured days - should agree to Exhibit A

19 Total Days per PS&R or Other Paid Claims Summary  
20 Unreconciled Days (Explain Variance)

Routine Charges	Routine Charges
21 \$ 1,650,000	\$ 1,650,000
21.01 Calculated Routine Charge Per Diem	\$ 959.30

Line #	Ancillary Cost Centers (from W/S C) (from Section G):			Ancillary Charges	
				Ancillary Charges	Ancillary Charges
22	062xx Observation (Non-Distinct)	1.417829		-	80,000
23	03700 OPERATING ROOM	0.393873		3,640,000	2,000,000
24	03800 RECOVERY ROOM	0.416667		1,180,000	1,250,000
25	03900 DELIVERY ROOM & LABOR ROOM	1.027273		100,000	30,000
26	04000 ANESTHESIOLOGY	0.273333		1,840,000	980,000
27	04100 RADIOLOGY-DIAGNOSTIC	0.172881		2,000,000	4,000,000
28	04200 RADIOLOGY-THERAPEUTIC	0.256410		140,000	1,990,000
29	04300 RADIOISOTOPE	0.260625		220,000	300,000
30	04400 LABORATORY	0.132043		5,000,000	6,000,000
31	04700 BLOOD STORING PROCESSING & TRAN	0.286867		2,000,000	870,000
32	04900 RESPIRATORY THERAPY	0.289841		1,030,000	250,000
33	05000 PHYSICAL THERAPY	0.321782		300,000	10,000
34	05100 OCCUPATIONAL THERAPY	0.314665		210,000	10,000
35	05200 SPEECH PATHOLOGY	0.476190		40,000	-
36	05300 ELECTROCARDIOLOGY	0.098901		580,000	550,000
37	05400 ELECTROENCEPHALOGRAPHY	0.280000		110,000	40,000
38	05500 MEDICAL SUPPLIES CHARGED TO PATI	0.395918		3,000,000	2,000,000
39	05530 IMPL. DEV. CHARGED TO PATIENT	0.521739		-	-
40	05600 DRUGS CHARGED TO PATIENTS	0.333333		1,800,000	1,300,000
41	05700 RENAL DIALYSIS	0.232829		90,000	2,900,000
42	05900 CAT SCAN	0.052632		3,000,000	720,000
43	05901 ULTRASOUND	0.169444		290,000	290,000
44	05902 CARDIAC CATHETERIZATION LABORATO	0.216667		1,150,000	710,000
45	05903 ENDOSCOPY	0.271429		400,000	10,000
46	05907 PSYCHIATRIC/PSYCHOLOGICAL SERVIC	0.283186		-	-
47	06000 CLINIC	1.056995		10,000	1,870,000
48	06100 EMERGENCY	0.310266		2,100,000	7,000,000

Uninsured Charges must agree to Exhibit A

Totals / Payments	Total Charges (includes organ acquisition from Section J)	Total Charges
103	\$ 31,860,000	\$ 35,240,000
	(Agrees to Exhibit A)	(Agrees to Exhibit A)

104 Total Charges per PS&R or Other Paid Claims Summary  
105 Unreconciled Charges (Explain Variance)

Total Calculated Cost (includes organ acquisition from Section J)	Total Calculated Cost	Total Calculated Cost
106	\$ 9,713,438	\$ 10,477,934

Medicaid Cost Settlement Payments (See Note B)	Medicaid Cost Settlement Payments	Medicaid Cost Settlement Payments
107 Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)		
108 Other Total Third Party Liability (including Co-Pay and Spend-Down but excluding Medicare on crossovers)		
109 Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)		
110 Medicare Paid Amount (excludes coinsurance/deductibles)		
111 Medicare Cross-Over Bad Debt Payments		
112 Other Medicare Cross-Over Payments (See Note D)		
113 Payment from Hospital Uninsured During Cost Report Year (Cash Basis)	\$ 250,000	\$ 1,000,000
114 Section 1011 Payment Related to Inpatient Hospital Services NOT Included in Exhibits B & B-1 (from Section J)	\$ 5,000	\$ 2,500
115		
116		

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

Calculated Payment Shortfall / (Longfall)	Calculated Payment Shortfall / (Longfall)	Calculated Payment Shortfall / (Longfall)
117	\$ 9,458,438	\$ 9,475,434
118	3%	10%



## ■ 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 confirm that this message is the result of use of adjudication date and not improper mapping.
  - 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 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.



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

Cost Report Year (-) #N/A

In-state organ acquisitions

	Total Organ Acquisition Cost	Revenue for Medicaid/ Uninsured Organs Sold	Total Useable Organs (Count)	In-State Medicaid FFS Primary		In-State Medicaid Managed Care Primary		In-State Medicare FFS Cross-Overs (with Medicaid Secondary)		In-State Other Medicaid Eligibles (Not Included Elsewhere)		Uninsured	
				Charges	Useable Organs (Count)	Charges	Useable Organs (Count)	Charges	Useable Organs (Count)	Charges	Useable Organs (Count)	Charges	Useable Organs (Count)
	Cost Report Worksheet D-6, Pt. III, Col. 1, Ln 53	Similar to Instructions from Cost Report W/S D-6, Pt. III, Col. 1, Ln 58 (substitute Medicare with Medicaid/ uninsured). See Note C below.	Cost Report Worksheet D-6, Pt. III, Line 54	From Paid Claims Data or Provider Logs (Note A)	From Paid Claims Data or Provider Logs (Note A)	From Paid Claims Data or Provider Logs (Note A)	From Paid Claims Data or Provider Logs (Note A)	From Paid Claims Data or Provider Logs (Note A)	From Paid Claims Data or Provider Logs (Note A)	From Paid Claims Data or Provider Logs (Note A)	From Paid Claims Data or Provider Logs (Note A)	From Hospital's Own Internal Analysis	From Hospital's Own Internal Analysis
<b>Organ Acquisition Cost Centers (list below):</b>													
1	Lung Acquisition	\$ -	0										
2	Kidney Acquisition	\$ -	0										
3	Liver Acquisition	\$ -	0										
4	Heart Acquisition	\$ -	0										
5	Pancreas Acquisition	\$ -	0										
6	Intestinal Acquisition	\$ -	0										
7	Islet Acquisition	\$ -	0										
8													
9	<b>Totals</b>	\$ -	-	\$ -	-	\$ -	-	\$ -	-	\$ -	-	\$ -	-
10	<b>Total Cost</b>												

Note A - These amounts must agree to your inpatient and outpatient Medicaid paid claims summary, if available (if not, use hospital's logs and submit with survey).  
 Note B - Enter Organ Acquisition Payments in Section H as part of your In-State Medicaid total payments.  
 Note C - Enter the total revenue applicable to organs furnished to other providers, to organ procurement organizations and others, and for organs transplanted into non-Medicaid / non-Uninsured patients (but where organs were included in the Medicaid and Uninsured organ counts above). Such revenues must be determined under the accrual method of accounting. If organs are transplanted into non-Medicaid/non-Uninsured patients who are not liable for payment on a charge basis, and as such there is no revenue applicable to the related organ acquisitions, the amount entered must also include an amount representing the acquisition cost of the organs transplanted into such patients.

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

Cost Report Year (-) #N/A

Out-of-state organ acquisitions

	Total Organ Acquisition Cost	Revenue for Medicaid/ Uninsured Organs Sold	Total Useable Organs (Count)	Out-of-State Medicaid FFS Primary		Out-of-State Medicaid Managed Care Primary		Out-of-State Medicare FFS Cross-Overs (with Medicaid Secondary)		Out-of-State Other Medicaid Eligibles (Not Included Elsewhere)	
				Charges	Useable Organs (Count)	Charges	Useable Organs (Count)	Charges	Useable Organs (Count)	Charges	Useable Organs (Count)
	Cost Report Worksheet D-6, Pt. III, Col. 1, Ln 53	Similar to Instructions from Cost Report W/S D-6, Pt. III, Col. 1, Ln 58 (substitute Medicare with Medicaid/ uninsured). See Note C below.	Cost Report Worksheet D-6, Pt. III, Line 54	From Paid Claims Data or Provider Logs (Note A)	From Paid Claims Data or Provider Logs (Note A)	From Paid Claims Data or Provider Logs (Note A)	From Paid Claims Data or Provider Logs (Note A)	From Paid Claims Data or Provider Logs (Note A)	From Paid Claims Data or Provider Logs (Note A)	From Paid Claims Data or Provider Logs (Note A)	
<b>Organ Acquisition Cost Centers (list below):</b>											
11	Lung Acquisition	\$ -	0								
12	Kidney Acquisition	\$ -	0								
13	Liver Acquisition	\$ -	0								
14	Heart Acquisition	\$ -	0								
15	Pancreas Acquisition	\$ -	0								
16	Intestinal Acquisition	\$ -	0								
17	Islet Acquisition	\$ -	0								
18											
19	<b>Totals</b>	\$ -	-	\$ -	-	\$ -	-	\$ -	-	\$ -	-
20	<b>Total Cost</b>										

Note A - These amounts must agree to your inpatient and outpatient Medicaid paid claims summary, if available (if not, use hospital's logs and submit with survey).  
 Note B - Enter Organ Acquisition Payments in Section I as part of your Out-of-State Medicaid total payments.



## ■ **DSH SURVEY PART II SECTION L, PROVIDER TAXES**

- Hospitals in Cameron, Webb and Hidalgo Counties began participating in a Provider Participation Fund in July of 2013.
- Federally, this mechanism is considered a provider tax or provider assessment and portions of the hospital's cost of funding this program are allowable for DSH purposes.



## ■ **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)



## ■ DSH SURVEY PART II SECTION L, PROVIDER TAXES

"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)



## ■ DSH SURVEY PART II SECTION L, PROVIDER TAXES

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



## ■ DSH SURVEY PART II SECTION L, PROVIDER TAXES

- The Medicaid DSH audit rule clearly indicates that the portion of permissible provider taxes applicable to Medicaid and uninsured is an allowable cost for the Medicaid DSH UCC. (FR Vol. 73, No. 245, Friday, Dec. 19, 2008, page 77923)
- By "permissible", they are referring to a "valid" tax in accordance with 42 CFR §433.68(b).



## ■ 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 (Quality Assurance Fund).
- 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.



## ■ DSH SURVEY PART II SECTION L, PROVIDER TAXES

- All permissible provider tax not included in allowable cost on the cost report will be added back and allocated to the Medicaid and uninsured UCC on a reasonable basis (e.g., charges).
- 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 cost is properly reflected in determining your hospital-specific DSH limit. For instance, if your hospital removed part or all of the provider tax assessment on the Medicare cost report, the full amount of the provider tax assessment would not have been apportioned to the various payers through the step down allocation process, resulting in the Medicaid and uninsured share being understated in determining the hospital-specific DSH limit. If your hospital needs to make an adjustment for the Medicaid and uninsured share of the provider tax assessment, please fill out the reconciliation below, and submit the supporting general ledger entries and other supporting documentation to Myers and Stauffer, LC along with your hospital's DSH audit surveys.

Cost Report Year (01/01/2010-12/31/2010) Hospital ABC

#### Worksheet A Provider Tax Assessment Reconciliation:

	Dollar Amount	W/S A Cost Center Line
1 Hospital Gross Provider Tax Assessment (from general ledger)*	\$ 10,000,000	
2 Hospital Gross Provider Tax Assessment Included in Expense on the Cost Report (W/S A, Col. 2)	\$ 10,000,000	6.00 (Where is the cost included on w/s A?)
3 Difference (Explain Here ----->)	\$ -	
<b>Provider Tax Assessment Reclassifications (from w/s A-6 of the Medicare cost report)</b>		
4 Reclassification Code		(Reclassified to / (from))
5 Reclassification Code		(Reclassified to / (from))
6 Reclassification Code		(Reclassified to / (from))
7 Reclassification Code		(Reclassified to / (from))
<b>DSH UCC ALLOWABLE - Provider Tax Assessment Adjustments (from w/s A-8 of the Medicare cost report)</b>		
8 Reason for adjustment	Recovery offset for Medicare rules	\$ (5,000,000) 6.00 (Adjusted to / (from))
9 Reason for adjustment		(Adjusted to / (from))
10 Reason for adjustment		(Adjusted to / (from))
11 Reason for adjustment		(Adjusted to / (from))
<b>DSH UCC NON-ALLOWABLE Provider Tax Assessment Adjustments (from w/s A-8 of the Medicare cost report)</b>		
12 Reason for adjustment	Payment to association "pool"	\$ (50,000) 6.00
13 Reason for adjustment	Payment of association fees	\$ (35,000) 6.00
14 Reason for adjustment	Nursing Home provider taxes	\$ (500,000) 6.00
15 Reason for adjustment		
16 Total Net Provider Tax Assessment Expense Included in the Cost Report	\$ 4,415,000	

Enter in G/L and Cost report total tax amounts

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

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

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

#### DSH UCC Provider Tax Assessment Adjustment:

17 Gross Allowable Assessment Not Included in the Cost Report**	\$ 5,000,000
<b>Apportionment of Provider Tax Assessment Adjustment to Medicaid &amp; Uninsured:</b>	
18 Medicaid Hospital Charges	593,218,490
19 Uninsured Hospital Charges	66,900,000
20 Total Hospital Charges	2,959,000,000
21 Percentage of Provider Tax Assessment Adjustment to include in DSH Medicaid UCC	20.05%
22 Percentage of Provider Tax Assessment Adjustment to include in DSH Uninsured UCC	2.26%
23 Medicaid Provider Tax Assessment Adjustment to DSH UCC	\$ 1,002,397
24 Uninsured Provider Tax Assessment Adjustment to DSH UCC	\$ 113,045
25 Provider Tax Assessment Adjustment to DSH UCC	\$ 1,115,442 (May change after examination of analysis at audit)

Tax allocation to UCC is estimated here but is subject to audit

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

\*\* The Gross Allowable Assessment Not Included in the Cost Report (line 17, above) will be apportioned to Medicaid and Uninsured based on Charges unless the hospital provides a revised cost report to include the amount in the cost-to-charge ratios and per diems used in the survey.



## ■ EXHIBIT A – UNINSURED CHARGES/DAYS BY REVENUE CODE

- Survey form Exhibit A has been designed to assist hospitals in collecting and reporting all uninsured charges and routine days needed to cost out the uninsured services.
  - Total hospital charges / routine days from Exhibit A must agree to the total entered in Section H of the survey.
  - Must be for dates of service in the cost report fiscal year.
  - Line item data must be at patient date of service level with multiple lines showing revenue code level charges



## ■ EXHIBIT A - UNINSURED

- Exhibit A:
  - Include *Primary Payor Plan, Secondary Payor Plan, Provider #, PCN, Birth Date, SSN, Gender, 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) is the same as the prior year – need to indicate if Exhausted / Non-Covered Insurance claims are being included under the December 3, 2014 final rule.
  - If exhausted / non-covered insurance services are included on Exhibit A, then they must also be included on Exhibit B for patient payments
- Submit Exhibit A in the format shown either in Excel or a CSV file using the tab or | (pipe symbol above the enter key).



Claim Type (A)	Primary Payor Plan (B)	Secondary Payor Plan (C)	Hospital's Medicaid Provider # (D)	Patient Identifier Number (PCN) (E)	Patient's Birth Date (F)	Patient's Social Security Number (G)	Patient's Gender (H)	Name (I)	Admit Date (J)	Discharge Date (K)	Service Indicator (Inpatient / Outpatient) (L)	Revenue Code (M)	Total Charges for Services Provided (N)	Routine Days of Care (O)	Total Patient Payments for Services Provided (P)	Total Third Party Payments for Services Provided (Q)	Claim Status (Exhausted or Non-Covered Service, if applicable) (R)
Uninsured Charges	Charity	Self-Pay	12345	2222222	1/1/1960	999-99-999	Female	Doe, Jane	3/1/2010	3/11/2010	Inpatient	110	\$ 4,000.00	7			
Uninsured Charges	Charity	Self-Pay	12345	2222222	1/1/1960	999-99-999	Female	Doe, Jane	3/1/2010	3/11/2010	Inpatient	200	\$ 4,500.00	3			
Uninsured Charges	Charity	Self-Pay	12345	2222222	1/1/1960	999-99-999	Female	Doe, Jane	3/1/2010	3/11/2010	Inpatient	250	\$ 5,200.25				
Uninsured Charges	Charity	Self-Pay	12345	2222222	1/1/1960	999-99-999	Female	Doe, Jane	3/1/2010	3/11/2010	Inpatient	300	\$ 2,700.00				
Uninsured Charges	Charity	Self-Pay	12345	2222222	1/1/1960	999-99-999	Female	Doe, Jane	3/1/2010	3/11/2010	Inpatient	360	\$ 15,000.75				
Uninsured Charges	Charity	Self-Pay	12345	2222222	1/1/1960	999-99-999	Female	Doe, Jane	3/1/2010	3/11/2010	Inpatient	450	\$ 1,000.25				
Uninsured Charges	Medicare		12345	4444444	7/12/1985	999-99-999	Male	Jones, James	6/15/2010	6/15/2010	Outpatient	250	\$ 150.00		\$ 500.00		Exhausted
Uninsured Charges	Medicare		12345	4444444	7/12/1985	999-99-999	Male	Jones, James	6/15/2010	6/15/2010	Outpatient	450	\$ 750.00		\$ 500.00		Exhausted
Uninsured Charges	Blue Cross		12345	1111111	3/5/2000	999-99-999	Male	Smith, Mike	8/10/2010	8/10/2010	Outpatient	450	\$ 1,100.00			\$ 100.00	Non-Covered Service

EXHIBIT A - UNINSURED CHARGES / DAYS



## ■ EXHIBIT B – ALL PATIENT PAYMENTS (SELF-PAY) ON A CASH BASIS

- Survey form Exhibit B has been designed to assist hospitals in collecting and reporting all patient payments received on a cash basis.
  - Exhibit B should include all patient payments regardless of their insurance status.
  - Total patient payments from this exhibit are entered in Section E of the survey.
  - Insurance status should be noted on each patient payment so you can sub-total the uninsured hospital patient payments and enter them in Section H of the survey.



## ■ EXHIBIT B – ALL PATIENT PAYMENTS (SELF-PAY) ON A CASH BASIS

- Patient payments received for uninsured services need to be reported on a cash basis.
- For example, a cash payment received during the '11 cost report year that relates to a service provided in the '05 cost report year, must be used to reduce uninsured cost for the '11 cost report year.



## ■ EXHIBIT B – ALL PATIENT PAYMENTS (SELF-PAY) ON A CASH BASIS

- Exhibit B
  - Include *Primary Payor Plan, Secondary Payor Plan, Payment Transaction Code, Provider #, PCN, Birth Date, SSN, and Gender, Admit, Discharge, Date of Collection, Amount of Collection, 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).



Claim Type (A)	Primary Payor Plan (B)	Secondary Payor Plan (C)	Transaction Code (D)	Hospital's Medicaid Provider # (E)	Patient Identifier Number (PCN) (F)	Patient's Birth Date (G)	Patient's Social Security Number (H)	Patient's Gender (I)	Name (J)	Admit Date (K)	Discharge Date (L)	Date of Cash Collection (M)	Amount of Cash Collections (N)	Indicate if Collection is a 1011 Payment (O)	Service Indicator (Inpatient/Outpatient) (P)	Total Hospital Charges for Services Provided (Q)	Total Physician Charges for Services Provided (R)	Total Other Non-Hospital Charges for Services Provided (S)	Insurance Status When Services Were Provided (Insured or Uninsured) (T)	Claim Status (Exhausted or Non-Covered Service, if applicable) (U)	Calculated Hospital Uninsured Collections If (T)="Uninsured" or (U)="Exhausted" or "Non-Covered Service", (Q)/((Q)+(R)+(S))* (N), 0
Self Pay Payments	Medicare	Medicaid	500	12345	3333333	2/7/2025	999-99-999	Male	Jones, Anthony	7/12/1995	7/14/1995	1/1/2010	\$ 50	No	Inpatient	\$ 10,000	\$ 900	\$ -	Insured		\$ -
Self Pay Payments	Medicare	Medicaid	500	12345	3333333	2/7/2025	999-99-999	Male	Jones, Anthony	7/12/1995	7/14/1995	2/1/2010	\$ 50	No	Inpatient	\$ 10,000	\$ 900	\$ -	Insured		\$ -
Self Pay Payments	Medicare	Medicaid	500	12345	3333333	2/7/2025	999-99-999	Male	Jones, Anthony	7/12/1995	7/14/1995	3/1/2010	\$ 50	No	Inpatient	\$ 10,000	\$ 900	\$ -	Insured		\$ -
Self Pay Payments	Medicare	Medicaid	500	12345	3333333	2/7/2025	999-99-999	Male	Jones, Anthony	7/12/1995	7/14/1995	4/1/2010	\$ 50	No	Inpatient	\$ 10,000	\$ 900	\$ -	Insured		\$ -
Self Pay Payments	Blue Cross		150	12345	9999999	9/25/1979	999-99-999	Male	Smith, John	9/21/2000	9/21/2000	9/30/2009	\$ 150	No	Outpatient	\$ 2,000	\$ -	\$ 50	Insured	Exhausted	\$ 146
Self Pay Payments	Blue Cross		150	12345	9999999	9/25/1979	999-99-999	Male	Smith, John	9/21/2000	9/21/2000	10/31/2009	\$ 150	No	Outpatient	\$ 2,000	\$ -	\$ 50	Insured	Exhausted	\$ 146
Self Pay Payments	Blue Cross		150	12345	9999999	9/25/1979	999-99-999	Male	Smith, John	9/21/2000	9/21/2000	11/30/2009	\$ 150	No	Outpatient	\$ 2,000	\$ -	\$ 50	Insured	Exhausted	\$ 146
Self Pay Payments	Self-Pay		500	12345	7777777	7/9/2000	999-99-999	Male	Cliff, Heath	12/31/2009	1/1/2010	5/15/2010	\$ 90	No	Inpatient	\$ 15,000	\$ 1,000	\$ -	Uninsured		\$ 84
Self Pay Payments	Self-Pay		500	12345	7777777	7/9/2000	999-99-999	Male	Cliff, Heath	12/31/2009	1/1/2010	5/31/2010	\$ 90	No	Inpatient	\$ 15,000	\$ 1,000	\$ -	Uninsured		\$ 84
Self Pay Payments	United Healthcare		500	12345	5555555	2/15/1960	999-99-999	Male	Johnson, Joe	9/1/2005	9/3/2005	11/12/2010	\$ 130	No	Inpatient	\$ 14,000	\$ 400	\$ 50	Insured	Non-Covered Service	\$ 126

Exhibit B - Cash Basis Patient Payments



## ■ EXHIBIT C – HOSPITAL-PROVIDED MEDICAID DATA

- Medicaid data reported on the survey must be supported by a third-party paid claims summary such as a PS&R, Managed Care Plan provided report, or state-run paid claims report.
- If not available, the hospital must submit the detail behind the reported survey data in the Exhibit C format. Otherwise, the data may not be allowed in the final UCC.



## ■ EXHIBIT C – HOSPITAL-PROVIDED MEDICAID DATA

- Types of data that may require an Exhibit C are as follows:
  - Self-reported Commercial/Medicaid data (Section H)
  - All self-reported Out-of-State Medicaid categories (Section I)



## ■ EXHIBIT C – HOSPITAL-PROVIDED MEDICAID DATA

- Exhibit C
  - Include *Primary Payor Plan, Secondary Payor Plan, Hospital MCD #, PCN, Patient's MCD Recipient #, DOB, Social, Gender, 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.



## ■ EXHIBIT C – HOSPITAL-PROVIDED MEDICAID DATA

- Exhibit C
  - Include *Birth Date, Social Security Number, and Gender* fields
    - Necessary to match to state's Medicaid eligibility files if the patient's Medicaid number is not provided or incorrect
- Submit Exhibit C in the format shown using Excel or a CSV file using the tab or | (pipe symbol above the enter key).



# MYERS AND STAUFFER<sup>LC</sup>

CERTIFIED PUBLIC ACCOUNTANTS

Example of Exhibit C (Out-of-State Medicaid example)

Claim Type (A) **	Primary Payor Plan (B)	Secondary Payor Plan (C)	Hospital's Medicaid Provider # (D)	Patient Identifier Number (PCN) (E)	Patient's Medicaid Recipient # (F)	Patient's Birth Date (G)	Patient's Social Security Number (H)	Patient's Gender (I)	Name (J)	Admit Date (K)	Discharge Date (L)	Service Indicator (Inpatient / Outpatient) (M)	Revenue Code (N)	Total Charges for Services Provided (O) *	Routine Days of Care (P)	Total Medicare Payments for Services Provided (Q)	Total Medicaid Payments for Services Provided (R)	Total Third Party Liability Payments for Services Provided (S)	Self-Pay Payments (T)	Sum of All Payments Received on Claim (Q)+(R)+(S)+(T)	Adjudication Date (V)
Out-of-State Medicaid	Arkansas Medicaid		12345	888888	123456789	1/1/1980	999-99-999	Male	James, Samuel	9/1/2009	9/4/2009	Inpatient	120	\$ 1,200	3	\$ -	\$ 1,500	\$ 50	\$ -	\$ 1,550	9/14/2009
Out-of-State Medicaid	Arkansas Medicaid		12345	888888	123456789	1/1/1980	999-99-999	Male	James, Samuel	9/1/2009	9/4/2009	Inpatient	206	\$ 1,500	1	\$ -	\$ 1,500	\$ 50	\$ -	\$ 1,550	9/14/2009
Out-of-State Medicaid	Arkansas Medicaid		12345	888888	123456789	1/1/1980	999-99-999	Male	James, Samuel	9/1/2009	9/4/2009	Inpatient	250	\$ 100	-	\$ -	\$ 1,500	\$ 50	\$ -	\$ 1,550	9/14/2009
Out-of-State Medicaid	Arkansas Medicaid		12345	888888	123456789	1/1/1980	999-99-999	Male	James, Samuel	9/1/2009	9/4/2009	Inpatient	300	\$ 375	-	\$ -	\$ 1,500	\$ 50	\$ -	\$ 1,550	9/14/2009
Out-of-State Medicaid	Arkansas Medicaid		12345	888888	123456789	1/1/1980	999-99-999	Male	James, Samuel	9/1/2009	9/4/2009	Inpatient	450	\$ 1,500	-	\$ -	\$ 1,500	\$ 50	\$ -	\$ 1,550	9/14/2009
Out-of-State Medicaid	Oklahoma Medicaid		12345	666666	978854321	7/12/1985	999-99-999	Female	Johnson, Sandy	6/30/2010	6/30/2010	Outpatient	250	\$ 100	-	\$ -	\$ 900	\$ -	\$ 75	\$ 975	7/15/2010
Out-of-State Medicaid	Oklahoma Medicaid		12345	666666	978854321	7/12/1985	999-99-999	Female	Johnson, Sandy	6/30/2010	6/30/2010	Outpatient	300	\$ 375	-	\$ -	\$ 900	\$ -	\$ 75	\$ 975	7/15/2010
Out-of-State Medicaid	Oklahoma Medicaid		12345	666666	978854321	7/12/1985	999-99-999	Female	Johnson, Sandy	6/30/2010	6/30/2010	Outpatient	450	\$ 1,500	-	\$ -	\$ 900	\$ -	\$ 75	\$ 975	7/15/2010
Out-of-State Medicaid	Oklahoma Medicaid		12345	555555	654321978	3/5/2000	999-99-999	Female	Jeffery, Susan	2/28/2010	2/28/2010	Outpatient	300	\$ 375	-	\$ -	\$ 1,000	\$ 100	\$ -	\$ 1,100	3/15/2010
Out-of-State Medicaid	Oklahoma Medicaid		12345	555555	654321978	3/5/2000	999-99-999	Female	Jeffery, Susan	2/28/2010	2/28/2010	Outpatient	450	\$ 1,500	-	\$ -	\$ 1,000	\$ 100	\$ -	\$ 1,100	3/15/2010

Exhibit C Out-of-State Medicaid claims



## ■ 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.
- HCPCS cross-walk request added for 2012
- Includes Myers and Stauffer address and phone numbers.



## ■ 2012 CLARIFICATIONS / CHANGES

- *December 3, 2014 Final Rule*
  - Definitions of uninsured as laid out in the January 2012 proposed rule have been finalized.
  - If the individual has no source of third-party coverage for the specific inpatient hospital or outpatient hospital service, hospitals should classify the individual as uninsured and include all costs and revenues associated with that particular service
  - Individuals who have exhausted benefits before obtaining services will be considered uninsured.
  - All Medicaid eligible services should be reported as Medicaid and not uninsured



## ■ 2012 CLARIFICATIONS / CHANGES

- *December 3, 2014 Final Rule (cont.)*
  - Individuals who exhaust covered benefits during the course of a service will not be considered uninsured for that particular service. If the individual is not Medicaid eligible and has a **source of third party coverage for all or a portion of the single inpatient stay** for a particular service, the costs and revenues of that service **cannot be included** in the hospital-specific DSH limit.
  - Individuals with **high deductible or catastrophic plans** are considered insured for the service even in instances when the policy requires the individual to satisfy a deductible and/or share in the overall cost of the hospital service. The cost and revenues associated with these claims **cannot be included** in the hospital-specific DSH limit.
  - For details and examples of the definition of uninsured based on the December 3, 2014 Final Rule, see the “Uninsured Definitions” tab of DSH Survey Part II. Also See Myers and Stauffer FAQ #4-9.



## ■ 2012 CLARIFICATIONS / CHANGES

- The 2008 DSH rule and January, 2010 CMS FAQ #33 both require that a hospital's DSH uncompensated care cost include all Other Medicaid Eligibles.
- The 2008 DSH rule specifically states that the UCC calculation must include "regular Medicaid payments, Medicaid managed care organization payments, supplemental/enhanced Medicaid payments, uninsured revenues, and 1011 payments." *FR Vol. 73, No. 245, Friday, Dec. 19, 2008, Final Rule, 77904*
- January, 2010 CMS FAQ #33 was issued on January 10, 2010, and clarified that the Other Medicaid Eligible population includes patients with private insurance who are dually eligible for Medicaid, and that any payments from private insurance must be included in the UCC calculation. *(See question and answers at the end of this presentation.)*
- On December 29, 2014, a federal court ordered a temporary injunction against CMS from enforcing, applying, or implementing FAQ #33. The order also enjoined Washington and Texas state Medicaid agencies and CMS from recouping the overpayments attributable to FAQ #33 in the DSH examination report.



## ■ 2012 CLARIFICATIONS / CHANGES

- This does **not** change how Myers and Stauffer or any other independent CPA firm must calculate a hospital's uncompensated care cost for the 2012 DSH examinations at this time.
- Until new CMS audit guidance is issued, we must continue to calculate each hospital's UCC including ALL Medicaid Eligibles (including those with private insurance).
- Myers and Stauffer will continue to include "Other Insurance" payments in our DSH Examination Reports, however, HHSC will not recoup DSH overpayments applicable to "Other Insurance".
- We do recommend that you submit your Other Medicaid Eligibles exactly as requested in Exhibit C. Specifically, ensure that you **separately identify** each claims Medicaid, Medicare, Third Party Liability (TPL), and Self-Pay payments into their individual columns as laid out in the Exhibit A-C template.



## ■ PRIOR YEAR DSH EXAMINATION (2011)

### Significant Findings in Final Report

- 26 Hospitals had DSH payments greater than their UCC. (23 when other insurance payments are excluded)
- Six hospitals couldn't document their uninsured cost and payments.
- Fifteen additional hospitals couldn't document their uninsured payments.
- Three hospitals did not complete a Survey, one of which was out of business.



## ■ PRIOR YEAR DSH EXAMINATION (2011)

### Significant Findings in Final Report (cont.)

- One hospital did not sign the requested attestation statements related to the data they provided.
- Hospitals couldn't obtain out-of-state Medicaid Paid Claims Summaries (PS&Rs).
- Some hospitals couldn't document all payments received on all Medicaid eligible services.



## ■ PRIOR YEAR DSH EXAMINATION (2011)

### Common Issues Noted During Examination

- 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 as uninsured patient claims.



## ■ PRIOR YEAR DSH EXAMINATION (2011)

### Common Issues Noted During Examination

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



## ■ PRIOR YEAR DSH EXAMINATION (2011)

### Common Issues Noted During Examination

- 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 for the services received.
- Only uninsured payments are to be on cash basis.



## ■ PRIOR YEAR DSH EXAMINATION (2011)

### Common Issues Noted During Examination

- 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.



## ■ PRIOR YEAR DSH EXAMINATION (2011)

### Common Issues Noted During Examination

- “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.



## ■ MOST COMMON QUESTIONS

### 1. **What is the definition of uninsured for Medicaid DSH purposes?**

Uninsured patients are individuals with no source of third party health care coverage (insurance) for the specific inpatient or outpatient hospital service provided. Prisoners must be excluded.

- On December 3, 2014, CMS finalized the proposed rule published on January 18, 2012 Federal Register to clarify the definition of uninsured and prisoners.
- Under this final DSH rule, the DSH examination looks at whether a patient is uninsured using a “service-specific” approach.
- Based on the 2014 final DSH rule, the survey allows for hospitals to report “fully exhausted” and “insurance non-covered” services as uninsured.



## ■ MOST COMMON QUESTIONS

### 1. What is the definition of uninsured for Medicaid DSH purposes? (cont.)

Excluded prisoners were defined in the 2014 final DSH rule as:

- Individuals who are inmates in a public institution or are otherwise involuntarily held in secure custody as a result of criminal charges. These individuals are considered to have a source of third party coverage.
  - Prisoner Exception
    - If a person has been released from secure custody and is referred to the hospital by law enforcement or correction authorities, they can be included.
    - The individual must be admitted as a patient rather than an inmate to the hospital.
    - The individual cannot be in restraints or seclusion.



## ■ MOST COMMON QUESTIONS

### 2. **What is meant by “Exhausted” and “Non-Covered” in the uninsured Exhibits A and B?**

Under the December 3, 2014 final DSH rule, hospitals can report services if insurance is “fully exhausted” or if the service provided was “not covered” by insurance. The service must still be a hospital service that would normally be covered by Medicaid.



## ■ MOST COMMON QUESTIONS

### 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.



## ■ MOST COMMON QUESTIONS

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*)



## ■ MOST COMMON QUESTIONS

### 5. **Can unpaid co-pays or deductibles be considered uninsured?**

No. The presence of a co-pay or deductible indicates the patient has insurance and none of the co-pay or deductible is allowable even under the 2014 final DSH rule. (*Reporting pg. 77911*)

### 6. **Can a hospital report their charity charges as uninsured?**

Typically a hospital's charity care will meet the definition of uninsured but since charity care policies vary there may be exceptions. If charity includes unpaid co-pays or deductibles, those cannot be included. Each hospital will have to review their charity care policy and compare it to the DSH rules for uninsured.



## ■ FAQ

### **7. 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.

### **8. 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.



## ■ MOST COMMON QUESTIONS

### **9. 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)*

### **10. 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)*



## ■ MOST COMMON QUESTIONS

### **11. 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)*

### **12. 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)*



## ■ MOST COMMON QUESTIONS

### **13. Do Other Medicaid Eligibles (Private Insurance/Medicaid) have to be included in the Medicaid UCC?**

Days, costs, and revenues associated with patients that are dually eligible for Medicaid and private insurance should be included in the calculation of the Medicaid inpatient utilization rate (MIUR) for the purposes of determining a hospital eligible to receive DSH payments. Section 1923(g)(1) does not contain an exclusion for individuals eligible for Medicaid and also enrolled in private health insurance. Therefore, days, costs and revenues associated with patients that are eligible for Medicaid and also have private insurance should be included in the calculation of the hospital-specific DSH limit. *(January, 2010 CMS FAQ 33 titled, "Additional Information on the DSH Reporting and Audit Requirements")*

Update: Myers and Stauffer will continue to include all payments on Medicaid eligible hospital services. Under the temporary injunction HHSC will not recoup DSH overpayments applicable to "other insurance" payments.



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## ■ MOST COMMON QUESTIONS

**See the FAQ emailed with your DSH Surveys for more. We will update the FAQ as needed based on feedback from these webinar sessions.**



## ■ UC DY1 FINAL RECONCILIATIONS

Myers and Stauffer is in process of contracting with HHSC to perform Final Reconciliations

- Those hospitals where CMS has finalized their Medicare Cost Reports that span the FFY 2012 by December 31, 2014 require a Final Reconciliation of UC DY1 distributions by December 31, 2015. Myers and Stauffer will notify hospitals that meet this criteria shortly.
- Final Reconciliation of TXHUC Schedule 1, 2 and 3 will be based on the actual cost of services for DY1.
- For hospitals that received both a DSH 2012 payment and a UC DY1 Distribution, the results of the DSH examination will represent the Schedule 3 final HSL



## ■ UC DY1 FINAL RECONCILIATIONS

- UC DY1 limits include costs that are not allowable under the DSH rules.
  - Schedule 1 – Physicians and Mid-Level Professionals
  - Schedule 2 – Pharmacy Costs Related to the Texas Vendor Drug Program
- Schedule 1 and Schedule 2 costs will be calculated in a matter as closely resembling the TXHUC schedules as possible.
- Schedule 1 and Schedule 2 surveys will be sent to applicable DSH hospitals shortly.
- IMDs will also receive supplemental schedules to accurately segregate the IMD 22-64 population.



## ■ UC DY1 FINAL RECONCILIATIONS

- For those hospitals that received a UC DY1 distribution but did not receive a 2012 DSH payment, a notification of Final Reconciliation will be transmitted within the next few weeks. This will include:
  - DSH-like surveys for Schedule 3 HSL
  - Schedule 1 surveys for Physicians and Mid-Level Professionals
  - Schedule 2 surveys for Pharmacy Costs Related to the Texas Vendor Drug Program
  - Similar supporting instructions and checklists as DSH hospital notifications
- Separate webinars will be scheduled for these hospitals (UC DY1 non-DSH).



## ■ OTHER INFORMATION

- HHSC needs to be contacted as soon as possible of any business transaction or process that has a potential impact on a hospital's eligibility and/or payments for DSH or UC.
- If you are contemplating or have just entered into:
  - Change of ownership, merger, change of operating entity (including public operator to private operator or vice versa, filing bankruptcy, split a single hospital into multiple hospitals, changing licensee or license type (e.g., to or from a specialty hospital)



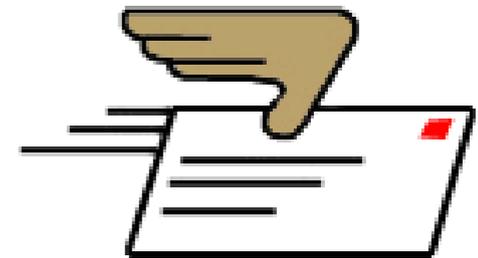
## ■ OTHER INFORMATION

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 by setting up a secure FTP account with us -or- please mail to:

Myers and Stauffer LC  
Attn: TX DSH Examination  
700 W. 47 Street, Suite 1100  
Kansas City, MO 64112  
(800) 374-6858

[txdsh@mslc.com](mailto:txdsh@mslc.com)



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