



# DISPROPORTIONATE SHARE HOSPITAL (DSH) PAYMENT EXAMINATION UPDATE DSH YEAR 2013

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## OVERVIEW

- DSH Examination Policy
- DSH Year 2013 Examination Timeline
- DSH Year 2013 Examination Impact
- Paid Claims Data Review
- Review of DSH Year 2013 Survey and Exhibits
- 2013 Clarifications / Changes
- Recap of Prior Year Examinations (2012)
- Myers and Stauffer DSH FAQ
- DHCFP SFY 2017 DSH Submission Requirements

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## ■ RELEVANT DSH POLICY

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

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## ■ RELEVANT DSH POLICY (CONT.)

- Allotment Reductions and Additional Reporting Requirements implemented in FR Vol. 78, No. 181, September 18, 2013, Final Rule
- CMCS Informational Bulletin Dated December 27, 2013 delaying implementation of Medicaid DSH Allotment reductions 2 years.
- April 1, 2014 – P.L. 113-93 (Protecting Access to Medicare Act) delays implementation of Medicaid DSH Allotment reductions 1 additional year.
- Additional Information of the DSH Reporting and Audit Requirements – Part 2, clarification published April 7, 2014.
- **Audit/Reporting implemented in FR Vol. 79, No. 232, Wednesday, Dec. 03, 2014, Final Rule**



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## ■ RELEVANT DSH POLICY (CONT.)

- "Medicare Access and CHIP Reauthorization Act" - Public Law, April 16, 2015, Sec. 412 Delay of Reduction to Medicaid DSH Allotments

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## ■ DSH YEAR 2013 EXAMINATION TIMELINE

- Surveys mailed 11/23/2015
- Surveys returned by 1/8/2016
- January-March - desk reviews
- April-May - on-site/expanded reviews
- Draft report to the state by June 30, 2016
- Final report to CMS by December 31, 2016



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## ■ DSH YEAR 2013 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 2013 examination report is the third year that may result in DSH payment recoupments.

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## ■ PAID CLAIMS DATA UPDATE FOR 2013

- Medicaid fee-for-service & Medicare/Medicaid cross-over paid claims data
  - Was sent via Secure FTP
  - Same format as last year.
  - Reported based on cost report year (using discharge date).
  - At revenue code level.
  - Detailed data is available upon request.
  - Will exclude non-Title 19 services (such as CHIP).

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## ■ PAID CLAIMS DATA UPDATE FOR 2013

- Medicaid managed care paid claims data
  - Was sent via Secure FTP
  - Only available in summary format
  - At revenue code level
  - Data is for State Fiscal Year (as opposed to cost report year)
  - Review the data and if it appears reasonable based on your hospital then it may be used. If you feel your internal data is more accurate you may use that instead; must submit a detailed Exhibit C if you are using your own data.

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## ■ PAID CLAIMS DATA UPDATE FOR 2013

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

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## ■ PAID CLAIMS DATA UPDATE FOR 2013

- “Other” Medicaid Eligibles
  - Medicaid-eligible patient services where Medicaid did not receive the claim or have any cost-sharing may not be included in the state’s data. The hospital must submit these eligible services on Exhibit C for them to be eligible for inclusion in the DSH uncompensated care cost (UCC).
  - Must EXCLUDE CHIP and other non-Title 19 services.
  - Should be reported based on cost report year (using discharge date).

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## ■ PAID CLAIMS DATA UPDATE FOR 2013

- “Other” Medicaid Eligibles (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. If we still do not receive the requested Exhibit C, we may have to list the hospital as non-compliant in the 2013 DSH examination report.
  - Ensure that you ***separately report*** Medicaid, Medicare, third party liability (TPL), and self-pay payments in Exhibit C.
  - Discussion on current federal court injunction later in the presentation.

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## ■ PAID CLAIMS DATA UPDATE FOR 2013

- Uninsured Services
  - As in years past, uninsured charges/days will be reported on Exhibit A and 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).

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## ■ DSH EXAMINATION SURVEYS

### **General Instruction – Survey Files**

- The survey is split into 2 separate Excel files:
  - DSH Survey Part I – DSH Year Data.
    - DSH year-specific information.
    - Always complete one copy.
  - DSH Survey Part II – Cost Report Year Data.
    - Cost report year-specific information.
    - Complete a separate copy for each cost report year needed to cover the DSH year.
    - Hospitals with year end changes or that are new to DSH may have to complete 2 or 3 year ends.

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## ■ 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 12/31/12 with the DSH audit of SFY 2012 in the prior year. In the DSH year 2013 exam, Hospital A would only need to submit a survey for their year ending 12/31/13.
- 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.

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## ■ 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.



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## ■ DSH SURVEY PART I – DSH YEAR DATA

### Section A

- DSH Year should already be filled in.
- Hospital name may already be selected (if not, select from the drop-down box).
- Verify the cost report year end dates (should only include those that 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.

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## ■ DSH SURVEY PART I – DSH YEAR DATA

### Section C

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

### Certification

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

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State of Any State  
Disproportionate Share Hospital (DSH) Audit Survey Part I  
For State DSH Year 2010

**A. General DSH Year Information**

1. DSH Year: Begin 07/01/2009 End 06/30/2010

2. Select Your Facility from the Drop-Down Menu Provided: Hospital ABC

**Identification of cost reports needed to cover the DSH Year:**

Cost Report Begin Date(s)	Cost Report End Date(s)
01/01/2010	12/31/2010

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

Data	
6. Medicaid Provider Number:	111111
7. Medicaid Subprovider Number 1 (Psychiatric or Rehab):	0
8. Medicaid Subprovider Number 2 (Psychiatric or Rehab):	0
9. Medicare Provider Number:	00-1111

**B. DSH OB Qualifying Information**  
**Questions 1-3, below, should be answered in the accordance with Sec. 1923(d) of the Social Security Act.**

During the DSH Year 07/01/2009 - 06/30/2010:

1. Did the hospital have at least two obstetricians who had staff privileges at the hospital that agreed to provide obstetric services to Medicaid-eligible individuals during the DSH year? (In the case of a hospital located in a rural area, the term "obstetrician" includes any physician with staff privileges at the hospital to perform obstetric procedures.)

2. Was the hospital exempt from the requirement listed under #1 above because the hospital's inpatients are predominantly under 18 years of age?

3. Was the hospital exempt from the requirement listed under #1 above because it did not offer non-emergency obstetric services to the general population when federal Medicaid DSH regulations were enacted on December 22, 1987?

Answer

Answer all OB questions.

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State of Any State  
Disproportionate Share Hospital (DSH) Audit Survey Part I  
For State DSH Year 2010

**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-Cash Specific payments paid based on the state fiscal year. However, DSH payments should NOT be included.)

\$ 500,000

**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 IOTCPE 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

Explanation for "No" answers: \_\_\_\_\_

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

I hereby certify that the information in Sections A, B, C, D, E, F, G, H, I, J, K, and L of the DSH Survey files are true and accurate to the best of our ability, and supported by the financial and other records of the hospital. I understand that this information will be used to determine the Medicaid program's compliance with federal Disproportionate Share Hospital (DSH) eligibility and payments provisions. Detailed support exists for all amounts reported in this 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:**

<b>Hospital Contact:</b> Name: _____ Title: _____ Telephone Number: _____ E-Mail Address: _____ Mailing Street Address: _____ Mailing City, State, Zip: _____	<b>Outside Preparer:</b> Name: _____ Title: _____ Firm Name: _____ Telephone Number: _____ E-Mail Address: _____
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Input all supplemental payments for the DSH year (UPL, etc.) should agree to the state's report.

Must answer the retain DSH question

Complete Certification and Contact Information

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

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

- **Question #2 – An “X” should be shown in the column of the cost report year survey you are preparing.**
  - If you have multiple years listed, you will need to prepare multiple surveys).
  - If there is an error in the year ends, contact Myers and Stauffer to send out a new copy.
- **Question #3 – This question may be already answered based on pre-loaded HCRIS data. If your hospital is going to update the cost report data to a more recent version of the cost report, select the status of the cost report you are using with this drop-down box.**

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State of Any State  
Disproportionate Share Hospital (DSH) Audit Survey Part II  
12/10/2015

Version 6.00

DSH Version: 6.00

1/1/2010 - 12/31/2010

### D. General Cost Report Year Information

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

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

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

4. Hospital Name:

5. Medicaid Provider Number:

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

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

8. Medicare Provider Number:

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)

**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)**

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

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

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State of Any State  
Disproportionate Share Hospital (DSH) Audit Survey Part II  
12/31/2010

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

1. Section 1011 Payment Related to Hospital Services Included in Exhibit B & B-1 (See Note 1)	\$	10,000
2. Section 1011 Payment Related to Inpatient Hospital Services NOT Included in Exhibit B & B-1 (See Note 1)	\$	0
3. Section 1011 Payment Related to Outpatient Hospital Services NOT Included in Exhibit B & B-1 (See Note 1)	\$	0
4. <b>Total Section 1011 Payments Related to Hospital Services (See Note 1)</b>	\$	10,000
5. Section 1011 Payment Related to Non-Hospital Services Included in Exhibit B & B-1 (See Note 1)	\$	0
6. Section 1011 Payment Related to Non-Hospital Services NOT Included in Exhibit B & B-1 (See Note 1)	\$	0
7. <b>Total Section 1011 Payments Related to Non-Hospital Services (See Note 1)</b>	\$	0
8. <b>Out-of-State DSH Payments (See Note 2)</b>	\$	0

	Inpatient	Outpatient	Total	
9. Total Cash Basis Patient Payments from Uninsured (On Exhibit B)	\$	250,000	\$	250,000
10. Total Cash Basis Patient Payments from All Other Patients (On Exhibit B)	\$	3,000,000	\$	3,000,000
11. Total Cash Basis Patient Payments Reported on Exhibit B (Leave in percent)	\$2,250,000	\$3,000,000	\$5,250,000	43%
12. Uninsured Cash Basis Patient Payments as a Percentage of Total Cash Basis Patient Payments	7.69%	10.00%		

Note 1: Subtitle B - Miscellaneous Provisions, 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.

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

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

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

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

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

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

### Section F-3: **New Lines** – Reconciling Items Necessary for Proper Calculation of LIUR

- Bad debt and charity care write-offs not included on G-3, line 2 should be entered on lines 28 and 29 so they can be properly excluded in calculating net patient service revenue utilized in the LIUR.
- Medicaid DSH payments and state and local patient care cash subsidies included on G-3, line 2 should be entered on line 30 and 31 so they can be properly excluded in calculating net patient service revenue also.

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#### F. MIUR / LIUR Qualifying Data from the Cost Report (01/01/2011 - 12/31/2011)

F.1. Total Hospital Days Used in Medicaid Inpatient Utilization Ratio (MIUR)  
1. Total Hospital Days Per Cost Report Excluding Swing Bed (Col. 16, 17, 18 and 19 in Section 8.4.6)

51,626

Days per cost report.

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

2. Inpatient Hospital Subsidies
3. Outpatient Hospital Subsidies
4. Unspecified IP and OP Hospital Subsidies
5. Total Hospital Subsidies
6. Inpatient Charity Care Charges
7. Outpatient Charity Care Charges
8. Total Charity Care Charges

100,000  
100,000  
200,000  
100,000  
500,000

State or Local Govt. Subsidies

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

F.3. Calculation of Net Hospital Revenue from Patient Services (Used for LIUR (G-3, G-4 and G-5 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 CBO (B) 100 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 (Charged)			Contractual Adjustments (Formulas below call for denominator if amounts are known)			Net Hospital Revenue
	Inpatient Hospital	Outpatient Hospital	Non-Hospital	Inpatient Hospital	Outpatient Hospital	Non-Hospital	
9. Hospital	\$ 87,402,703			\$ 48,402,703			\$ 20,959,099
10. Subpayer 1 (Physic or Rehab)	\$ 1,000,000			\$ 1,000,000			\$ 568,306
11. Subpayer 2 (Physic or Rehab)							
12. Swing Bed - CDR							
13. Swing Bed - JLF							
14. Isolated Nursing Facility							
15. Nursing Facility							
16. Other Long Term Care							
17. Ancillary Services							
18. Outpatient Services		\$ 119,425,503		\$ 100,735,919	\$ 1,123,651,100		\$ 142,873,122
19. Home Health Agency		\$ 7,140,837			\$ 762,476	\$ 1,976,024	\$ 957,646
20. Ambulance			\$ 2,700,004				
21. Outpatient Ambulance							
22. ASC			\$ 2,017,843				\$ 1,207,024
23. Hospice							
24. Other		\$ 1,444,055			\$ 1,587,409		\$ 604,400
25. Total	\$ 340,902,390	\$ 182,520,364	\$ 4,937,559	\$ 240,524,369	\$ 1,225,796,028	\$ 3,403,948	\$ 1,000,000
26. Total Hospital and Non-Hospital			\$ 506,440,205			\$ 353,723,442	
27. Total Per Cost Report	Total Patient Revenues (G-3, Line 1)			Total Contractual Adj. (G-3, Line 2)			
28. Increase worksheet G-3, Line 2 for Bad Debts NOT INCLUDED on worksheet G-3, Line 2 (impact is a decrease in net patient revenue)							\$ 100,000
29. Increase worksheet G-3, Line 2 for Charity Care Write-Offs NOT INCLUDED on worksheet G-3, Line 2 (impact is a decrease in net patient revenue)							\$ 1,000,000
30. Increase worksheet G-3, Line 2 to reverse offset of Medicaid DSH Revenue INCLUDED on worksheet G-3, Line 2 (impact is a decrease in net patient revenue)							\$ 80,000
31. Increase worksheet G-3, Line 2 to reverse offset of State and Local Patient Care Cash Subsidies INCLUDED on worksheet G-3, Line 2 (impact is a decrease in net patient revenue)							\$ 100,000
32. Decrease worksheet G-3, Line 2 to remove Medicaid Provider Taxes INCLUDED on worksheet G-3, Line 2 (impact is an increase in net patient revenue)							\$ 8,000,000
33. Adjusted Contractual Adjustments							\$ 8,280,000
34. Unrecorded Difference							

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

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

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## 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

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

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

NOTE: All data in this section must be verified by the hospital. If data is already present in this section, it was compiled using CMS HCERS 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.

Line #	Cost Center Description	Total Allowable Cost	Intern & Resident Costs Reported on Cost Report	RCE and Therapy Add-Back (If Applicable)	Net Cost	IP	O/P Charges	Total Charges	Medicaid Per Diem / Cost-to-Charge Ratios
		Cost Report Worksheet B, Part I, Col. 27	Cost Report Worksheet B, Part I, Col. 28 (Intern & Resident Other ONLY)	Cost Report Worksheet C, Part I, Col. 2 and Col. 4	Calculated	Days - Cost Report Worksheet D-1, Pt. I, Line 2 for Adults & Paeds; WIS D-1, Pt. 2, Lines 42-47 for others			Calculated Per Diem
1	ROUTINE COST CENTERS (list below):								
2	0100 ADULTS & PEDIATRICS	\$ 200,000.00	\$ 50,000.00	\$ -	\$ 200,000.00	200,000		\$ 1,000.00	
3	0200 INTENSIVE CARE UNIT	\$ 14,000.00	\$ 8,500.00	\$ -	\$ 14,000.00	10,000		\$ 1,350.00	
4	0300 CORONARY CARE UNIT	\$ 7,500.00	\$ -	\$ -	\$ 7,500.00	5,000		\$ 1,500.00	
5	0400 BURN INTENSIVE CARE UNIT	\$ -	\$ -	\$ -	\$ -			\$ -	
6	0500 SURGICAL INTENSIVE CARE UNIT	\$ 12,500.00	\$ 1,500.00	\$ -	\$ 14,000.00	8,000		\$ 1,750.00	
7	0600 OTHER SPECIAL CARE UNIT	\$ -	\$ -	\$ -	\$ -			\$ -	
8	0700 SUBPROVIDER I	\$ 12,000.00	\$ 2,000.00	\$ -	\$ 14,000.00	11,000		\$ 1,272.73	
9	0800 SUBPROVIDER II	\$ 2,000.00	\$ 400.00	\$ -	\$ 2,000.00	8,000		\$ 250.00	
10	0900 NURSERY	\$ -	\$ -	\$ -	\$ -			\$ -	
11		\$ -	\$ -	\$ -	\$ -			\$ -	
12		\$ -	\$ -	\$ -	\$ -			\$ -	
13		\$ -	\$ -	\$ -	\$ -			\$ -	
14		\$ -	\$ -	\$ -	\$ -			\$ -	
15		\$ -	\$ -	\$ -	\$ -			\$ -	
16		\$ -	\$ -	\$ -	\$ -			\$ -	
17		\$ -	\$ -	\$ -	\$ -			\$ -	
18	Total Routine	\$ 248,000.00	\$ 67,040.00	\$ -	\$ 315,040.00	290,000		\$ 1,096.34	
19	Weighted Average								

Observation Data (Non-Distinct)

0600 Observation (Non-Distinct)


Hospital Observation Days - Cost Report WIS S-3, Pt. I, Line 26, Col. 6	Subprovider I Observation Days - Cost Report WIS S-3, Pt. I, Line 26.01, Col. 6	Subprovider II Observation Days - Cost Report WIS S-3, Pt. I, Line 26.02, Col. 6	Calculated / Per Diem Allow Multiplied by Days	Inpatient Charges - Cost Report Worksheet C, Pt. I, Col. 6	Outpatient Charges - Cost Report Worksheet C, Pt. I, Col. 7	Total Charges - Cost Report Worksheet C, Pt. I, Col. 8	Medicaid Calculated Cost-to-Charge Ratio
1,200	100		\$ 1,212,000	\$ 100,000	\$ 800,000	\$ 900,000	1.417879

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State of New York  
 Department of Health  
 Division of Health Planning and Development  
 Hospital Survey Part II  
 12/10/2015

Version 6.00

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

Cost Report Year: 01/01/2015-12/31/2015 Hospital: ABC


Line #	Cost Center Description	Total Allowable Cost	Intern & Resident Costs Worksheet B, Part I, Col. 21	NCE and Therapy Add-Back (If Applicable)	Net Cost	IP	O/P Charges	Total Charges	Medicaid Per Diem / Cost-to-Charge Ratio
21	ANESTHESIA ROOM	10,000,000	10,000,000	-	10,000,000	174,500,000	14,000,000	209,500,000	0.393971
22	RECOVERY ROOM	25,000,000	25,000,000	-	25,000,000	23,000,000	27,000,000	42,000,000	0.416667
23	DELIVERY ROOM & LABOR ROOM	10,000,000	10,000,000	-	10,000,000	2,000,000	2,000,000	17,000,000	0.377778
24	LAWYER FEE	13,000,000	13,000,000	-	13,000,000	80,000,000	17,000,000	15,000,000	0.233333
25	RADIOLOGY DIAGNOSTIC	50,000,000	50,000,000	-	50,000,000	180,000,000	104,000,000	284,000,000	0.17281
26	RADIOLOGY THERAPEUTIC	10,000,000	10,000,000	-	10,000,000	400,000	110,000,000	110,000,000	0.264444
27	RADIOLOGY	4,000,000	4,000,000	-	4,000,000	1,000,000	11,000,000	16,000,000	0.262626
28	LABORATORY	55,000,000	55,000,000	-	55,000,000	200,000,000	179,000,000	445,000,000	0.12244
29	BLOOD TISSUE PROCESSING & TRANSFUSION	40,000,000	40,000,000	-	40,000,000	133,000,000	37,000,000	190,000,000	0.266667
30	RESPIRATORY THERAPY	17,000,000	17,000,000	-	17,000,000	60,000,000	3,000,000	63,000,000	0.269841
31	PHYSICAL THERAPY	5,000,000	5,000,000	-	5,000,000	20,000,000	20,000,000	25,000,000	0.311111
32	OCCUPATIONAL THERAPY	2,250,000	2,250,000	-	2,250,000	7,000,000	170,000	7,170,000	0.314469
33	SPEECH PATHOLOGY	1,000,000	1,000,000	-	1,000,000	2,000,000	800,000	2,800,000	0.411111
34	ELECTROCARDIOLOGY	9,000,000	9,000,000	-	9,000,000	40,000,000	65,000,000	87,000,000	0.269999
35	ELECTROENCEPHALOGRAPHY	1,000,000	1,000,000	-	1,000,000	1,500,000	700,000	6,300,000	0.360000
36	MEDICAL SUPPLY CHARGED TO PATIENT	37,000,000	37,000,000	-	37,000,000	187,000,000	20,000,000	244,000,000	0.269911
37	IMP. DRUG CHARGED TO PATIENT	120,000,000	120,000,000	-	120,000,000	180,000,000	50,000,000	238,000,000	0.511733
38	DRUGS CHARGED TO PATIENTS	150,000,000	150,000,000	-	150,000,000	270,000,000	80,000,000	350,000,000	0.333333
39	RENAL DIALYSIS	4,000,000	4,000,000	-	4,000,000	17,000,000	100,000	17,100,000	0.232626
40	CAT SCAN	10,000,000	10,000,000	-	10,000,000	30,000,000	111,000,000	141,000,000	0.052632
41	CTA / MR / PET	4,500,000	4,500,000	-	4,500,000	4,000,000	20,000,000	27,000,000	0.154444
42	CARDIAC CATHETERIZATION LABORATORY	17,500,000	17,500,000	-	17,500,000	33,000,000	23,000,000	42,000,000	0.216667
43	ENDOSCOPY	9,000,000	9,000,000	-	9,000,000	10,000,000	17,000,000	35,000,000	0.214286
44	PSYCHIATRIC/PSYCHOLOGICAL SERVICE	800,000	800,000	-	800,000	21,000	2,000,000	2,821,000	0.281166
45	CLINIC	30,000,000	30,000,000	-	30,000,000	810,000	20,000,000	20,810,000	1.026999
46	EMERGENCY	30,000,000	30,000,000	-	30,000,000	15,000,000	70,000,000	131,000,000	0.310204
101	Total Ancillary	763,050,000	58,299,000	-	821,349,000	1,719,581,000	1,216,000,000	2,935,581,000	0.298160
102	Weighted Average								
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.

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DEDICATED TO GOVERNMENT HEALTH PROGRAMS




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## 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 (*May include Medicare MCO cross-overs and other Medicaid not included elsewhere*).

DEDICATED TO GOVERNMENT HEALTH PROGRAMS



State of New York  
Department of Health (DOH) Audit Survey Part 5  
12/10/2015

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

City/County: New York City Hospital: ABC

Version: 2.00

**All Medicaid Categories**

Line #	Cost Center Description	Medicaid Per Diem Cost For Routine Care	Medicaid Cost to Charge Ratio for Routine Care	In-State Medicaid PPS Primary		In-State Medicaid Managed Care Primary		In-State Medicaid PPS Cross-Over (with Medicaid Summary)		In-State Other Medicaid Eligible (with Medicaid Summary)	
				Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient
				From PPSR Summary (Node A)	From PPSR Summary (Node A)	From PPSR Summary (Node A)	From PPSR Summary (Node A)	From PPSR Summary (Node A)	From PPSR Summary (Node A)	From PPSR Summary (Node A)	From PPSR Summary (Node A)
<b>Routine Cost Centers (Node Section G)</b>											
1	0000 - RENTALS	1	1.0000								
2	0001 - TELEPHONE	1	1.0000								
3	0002 - ELECTRICITY	1	1.0000								
4	0003 - GAS	1	1.0000								
5	0004 - WATER	1	1.0000								
6	0005 - SEWER	1	1.0000								
7	0006 - TRASH	1	1.0000								
8	0007 - JANITORY	1	1.0000								
9	0008 - SECURITY	1	1.0000								
10	0009 - MAINTENANCE	1	1.0000								
11	0010 - SUPPLIES	1	1.0000								
12	0011 - LABORATORY	1	1.0000								
13	0012 - RADIOLOGY	1	1.0000								
14	0013 - PHARMACY	1	1.0000								
15	0014 - NURSING	1	1.0000								
16	0015 - PHYSICIAN	1	1.0000								
17	0016 - OTHER	1	1.0000								
18	Total Days				10,000	10,000	10,000	10,000	10,000	10,000	10,000
19	Total Days per PPSR or Other Paid Claims Summary				10,000	10,000	10,000	10,000	10,000	10,000	10,000
20	Uninsured Days (Display Variance)										
21	Routine Charges				1,000.00	1,000.00	1,000.00	1,000.00	1,000.00	1,000.00	1,000.00
21.01	Calculated Routine Charge Per Day				100.00	100.00	100.00	100.00	100.00	100.00	100.00


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

Printed: 12/10/2015

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DEDICATED TO GOVERNMENT HEALTH PROGRAMS



State of New York  
Department of Health (DOH) Audit Survey Part 5  
12/10/2015

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

City/County: New York City Hospital: ABC

Version: 2.00

Line #	Cost Center Description	Medicaid Per Diem Cost For Routine Care	Medicaid Cost to Charge Ratio for Routine Care	In-State Medicaid PPS Primary		In-State Medicaid Managed Care Primary		In-State Medicaid PPS Cross-Over (with Medicaid Summary)		In-State Other Medicaid Eligible (with Medicaid Summary)	
				Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient
				From PPSR Summary (Node A)	From PPSR Summary (Node A)	From PPSR Summary (Node A)	From PPSR Summary (Node A)	From PPSR Summary (Node A)	From PPSR Summary (Node A)	From PPSR Summary (Node A)	From PPSR Summary (Node A)
<b>Ancillary Cost Centers (Node Section G)</b>											
22	0017 - ALCOHOL AND TOBACCO	1	1.0000								
23	0018 - PRESCRIPTION DRUGS	1	1.0000								
24	0019 - PHYSICIAN SERVICES	1	1.0000								
25	0020 - NURSING SERVICES	1	1.0000								
26	0021 - LABORATORY SERVICES	1	1.0000								
27	0022 - RADIOLOGY SERVICES	1	1.0000								
28	0023 - PHARMACY SERVICES	1	1.0000								
29	0024 - JANITORY SERVICES	1	1.0000								
30	0025 - SECURITY SERVICES	1	1.0000								
31	0026 - MAINTENANCE SERVICES	1	1.0000								
32	0027 - SUPPLIES	1	1.0000								
33	0028 - LABORATORY SERVICES	1	1.0000								
34	0029 - RADIOLOGY SERVICES	1	1.0000								
35	0030 - PHARMACY SERVICES	1	1.0000								
36	0031 - NURSING SERVICES	1	1.0000								
37	0032 - PHYSICIAN SERVICES	1	1.0000								
38	0033 - ALCOHOL AND TOBACCO	1	1.0000								
39	0034 - PRESCRIPTION DRUGS	1	1.0000								
40	0035 - PHYSICIAN SERVICES	1	1.0000								
41	0036 - NURSING SERVICES	1	1.0000								
42	0037 - LABORATORY SERVICES	1	1.0000								
43	0038 - RADIOLOGY SERVICES	1	1.0000								
44	0039 - PHARMACY SERVICES	1	1.0000								
45	0040 - JANITORY SERVICES	1	1.0000								
46	0041 - SECURITY SERVICES	1	1.0000								
47	0042 - MAINTENANCE SERVICES	1	1.0000								
48	0043 - SUPPLIES	1	1.0000								
49	0044 - LABORATORY SERVICES	1	1.0000								
50	0045 - RADIOLOGY SERVICES	1	1.0000								
51	0046 - PHARMACY SERVICES	1	1.0000								
52	0047 - NURSING SERVICES	1	1.0000								
53	0048 - PHYSICIAN SERVICES	1	1.0000								
54	0049 - ALCOHOL AND TOBACCO	1	1.0000								
55	0050 - PRESCRIPTION DRUGS	1	1.0000								
56	0051 - PHYSICIAN SERVICES	1	1.0000								
57	0052 - NURSING SERVICES	1	1.0000								
58	0053 - LABORATORY SERVICES	1	1.0000								
59	0054 - RADIOLOGY SERVICES	1	1.0000								
60	0055 - PHARMACY SERVICES	1	1.0000								
61	0056 - JANITORY SERVICES	1	1.0000								
62	0057 - SECURITY SERVICES	1	1.0000								
63	0058 - MAINTENANCE SERVICES	1	1.0000								
64	0059 - SUPPLIES	1	1.0000								
65	0060 - LABORATORY SERVICES	1	1.0000								
66	0061 - RADIOLOGY SERVICES	1	1.0000								
67	0062 - PHARMACY SERVICES	1	1.0000								
68	0063 - NURSING SERVICES	1	1.0000								
69	0064 - PHYSICIAN SERVICES	1	1.0000								
70	0065 - ALCOHOL AND TOBACCO	1	1.0000								
71	0066 - PRESCRIPTION DRUGS	1	1.0000								
72	0067 - PHYSICIAN SERVICES	1	1.0000								
73	0068 - NURSING SERVICES	1	1.0000								
74	0069 - LABORATORY SERVICES	1	1.0000								
75	0070 - RADIOLOGY SERVICES	1	1.0000								
76	0071 - PHARMACY SERVICES	1	1.0000								
77	0072 - JANITORY SERVICES	1	1.0000								
78	0073 - SECURITY SERVICES	1	1.0000								
79	0074 - MAINTENANCE SERVICES	1	1.0000								
80	0075 - SUPPLIES	1	1.0000								
81	0076 - LABORATORY SERVICES	1	1.0000								
82	0077 - RADIOLOGY SERVICES	1	1.0000								
83	0078 - PHARMACY SERVICES	1	1.0000								
84	0079 - NURSING SERVICES	1	1.0000								
85	0080 - PHYSICIAN SERVICES	1	1.0000								
86	0081 - ALCOHOL AND TOBACCO	1	1.0000								
87	0082 - PRESCRIPTION DRUGS	1	1.0000								
88	0083 - PHYSICIAN SERVICES	1	1.0000								
89	0084 - NURSING SERVICES	1	1.0000								
90	0085 - LABORATORY SERVICES	1	1.0000								
91	0086 - RADIOLOGY SERVICES	1	1.0000								
92	0087 - PHARMACY SERVICES	1	1.0000								
93	0088 - JANITORY SERVICES	1	1.0000								
94	0089 - SECURITY SERVICES	1	1.0000								
95	0090 - MAINTENANCE SERVICES	1	1.0000								
96	0091 - SUPPLIES	1	1.0000								
97	0092 - LABORATORY SERVICES	1	1.0000								
98	0093 - RADIOLOGY SERVICES	1	1.0000								
99	0094 - PHARMACY SERVICES	1	1.0000								
100	0095 - NURSING SERVICES	1	1.0000								
101	0096 - PHYSICIAN SERVICES	1	1.0000								
102	0097 - ALCOHOL AND TOBACCO	1	1.0000								
103	0098 - PRESCRIPTION DRUGS	1	1.0000								
104	0099 - PHYSICIAN SERVICES	1	1.0000								
105	0100 - NURSING SERVICES	1	1.0000								
106	0101 - LABORATORY SERVICES	1	1.0000								
107	0102 - RADIOLOGY SERVICES	1	1.0000								
108	0103 - PHARMACY SERVICES	1	1.0000								
109	0104 - JANITORY SERVICES	1	1.0000								
110	0105 - SECURITY SERVICES	1	1.0000								
111	0106 - MAINTENANCE SERVICES	1	1.0000								
112	0107 - SUPPLIES	1	1.0000								
113	0108 - LABORATORY SERVICES	1	1.0000								
114	0109 - RADIOLOGY SERVICES	1	1.0000								
115	0110 - PHARMACY SERVICES	1	1.0000								
116	0111 - NURSING SERVICES	1	1.0000								
117	0112 - PHYSICIAN SERVICES	1	1.0000								
118	0113 - ALCOHOL AND TOBACCO	1	1.0000								
119	0114 - PRESCRIPTION DRUGS	1	1.0000								
120	0115 - PHYSICIAN SERVICES	1	1.0000								
121	0116 - NURSING SERVICES	1	1.0000								
122	0117 - LABORATORY SERVICES	1	1.0000				</				



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

- Medicaid Payments Include:
  - Claim payments.
  - Medicaid cost report settlements.
  - Medicare bad debt payments (cross-overs).
  - Medicare cost report settlement payments (cross-overs).
  - Other third party payments (TPL).

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

Cost Report Year: 10/1/13-9/30/14 Hospital ABC

	In-State Medicaid FFS Primary	In-State Medicaid Managed Care Primary	In-State Medicaid FFS Cross-Over (if Medicaid Secondary)	In-State Medicaid Managed Care Cross-Over (if Medicaid Secondary)
133 Total Payments				
134 Total Charges (includes organ acquisition from Section B)	\$ 185,891,000	\$ 89,890,000	\$ 37,725,000	\$ 185,725,000
135 Total Charges per FFS or Other Paid Claims Summary	\$ 185,891,000	\$ 89,890,000	\$ 37,725,000	\$ 185,725,000
136 Total Charges per FFS or Other Paid Claims Summary (Excludes Organ Acquisition)	\$ 185,891,000	\$ 89,890,000	\$ 37,725,000	\$ 185,725,000
137 Total Medicaid Paid Amount (includes TPL, Co-Pay and Spend-Down)	\$ 22,875,000	\$ 22,875,000	\$ 22,875,000	\$ 22,875,000
138 Other Total Third Party Liability (including Co-Pay and Spend-Down but excluding Medicare cross-overs)	\$ 22,875,000	\$ 22,875,000	\$ 22,875,000	\$ 22,875,000
139 Total Allowed Amount from Medicaid FFS or MCO (All Payments)	\$ 22,875,000	\$ 22,875,000	\$ 22,875,000	\$ 22,875,000
140 Medicaid Cost Settlement Payments (See Note B)	\$ 22,875,000	\$ 22,875,000	\$ 22,875,000	\$ 22,875,000
141 Other Medicaid Payments Reported on Cost Report Year (See Note C)	\$ 22,875,000	\$ 22,875,000	\$ 22,875,000	\$ 22,875,000
142 Medicaid Paid Amount (includes cross-over contributions)	\$ 22,875,000	\$ 22,875,000	\$ 22,875,000	\$ 22,875,000
143 Medicare Cross-Over Bad Debt Payments	\$ 22,875,000	\$ 22,875,000	\$ 22,875,000	\$ 22,875,000
144 Other Medicare Cross-Over Payments (See Note D)	\$ 22,875,000	\$ 22,875,000	\$ 22,875,000	\$ 22,875,000
145 Payments from Hospital Uninsured During Cost Report Year (Cash Basis)	\$ 22,875,000	\$ 22,875,000	\$ 22,875,000	\$ 22,875,000
146 Section 1311 Payments (Related to Inpatient Hospital Services NOT Included in Exhibits B & C (from Section E))	\$ 22,875,000	\$ 22,875,000	\$ 22,875,000	\$ 22,875,000
147 Calculated Payment Shortfall (Length)	\$ 37,725,000	\$ 37,725,000	\$ 37,725,000	\$ 37,725,000
148 Calculated Payments as a Percentage of Cost	55%	75%	85%	100%

Enter in all Medicaid, TPL, and Medicare crossover payments.

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DEDICATED TO GOVERNMENT HEALTH PROGRAMS



**MYERS AND STAUFFER** LLC  
CERTIFIED PUBLIC ACCOUNTANTS

## DSH SURVEY PART II SECTION H, UNINSURED

- Report uninsured services, patient days (by routine cost center) and ancillary charges by cost center.
- Survey form Exhibit A shows the data elements that need to be collected and provided to Myers and Stauffer.
- For uninsured payments, enter the uninsured hospital patient payment totals from your Survey form Exhibit B. Do NOT pick up the non-hospital or insured patient payments in Section H even though they are reported in Exhibit B.

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

**H. Indicate Medicaid and All Uninsured Inpatient and Outpatient Hospital Data.**

**Uninsured Days**

Cost Center Description	Medicaid Part - Inpatient Days	Medicaid Part - Outpatient Days	Uninsured Days - Inpatient	Uninsured Days - Outpatient
01 - Inpatient - General	1,234	567	890	123
02 - Inpatient - Special	567	123	456	789
03 - Outpatient - General	123	456	789	123
04 - Outpatient - Special	456	789	123	456
<b>Total Days</b>	<b>2,345</b>	<b>1,475</b>	<b>1,458</b>	<b>1,461</b>

**Uninsured Charges**

Cost Center Description	Medicaid Part - Inpatient Charges	Medicaid Part - Outpatient Charges	Uninsured Charges - Inpatient	Uninsured Charges - Outpatient
01 - Inpatient - General	\$12,345	\$6,789	\$8,901	\$1,234
02 - Inpatient - Special	\$6,789	\$1,234	\$4,567	\$7,890
03 - Outpatient - General	\$1,234	\$4,567	\$7,890	\$1,234
04 - Outpatient - Special	\$4,567	\$7,890	\$1,234	\$4,567
<b>Total Charges</b>	<b>\$25,935</b>	<b>\$20,480</b>	<b>\$22,592</b>	<b>\$14,925</b>

**Uninsured Payments**

Cost Center Description	Medicaid Part - Inpatient Payments	Medicaid Part - Outpatient Payments	Uninsured Payments - Inpatient	Uninsured Payments - Outpatient
01 - Inpatient - General	\$12,345	\$6,789	\$8,901	\$1,234
02 - Inpatient - Special	\$6,789	\$1,234	\$4,567	\$7,890
03 - Outpatient - General	\$1,234	\$4,567	\$7,890	\$1,234
04 - Outpatient - Special	\$4,567	\$7,890	\$1,234	\$4,567
<b>Total Payments</b>	<b>\$25,935</b>	<b>\$20,480</b>	<b>\$22,592</b>	<b>\$14,925</b>

**Uninsured Cash-Basis Payments**

Cost Center Description	Medicaid Part - Inpatient Cash-Basis Payments	Medicaid Part - Outpatient Cash-Basis Payments	Uninsured Cash-Basis Payments - Inpatient	Uninsured Cash-Basis Payments - Outpatient
01 - Inpatient - General	\$12,345	\$6,789	\$8,901	\$1,234
02 - Inpatient - Special	\$6,789	\$1,234	\$4,567	\$7,890
03 - Outpatient - General	\$1,234	\$4,567	\$7,890	\$1,234
04 - Outpatient - Special	\$4,567	\$7,890	\$1,234	\$4,567
<b>Total Cash-Basis Payments</b>	<b>\$25,935</b>	<b>\$20,480</b>	<b>\$22,592</b>	<b>\$14,925</b>

**Uninsured Payments as a Percentage of Total**

Cost Center Description	Medicaid Part - Inpatient %	Medicaid Part - Outpatient %	Uninsured % - Inpatient	Uninsured % - Outpatient
01 - Inpatient - General	47.6%	44.6%	61.3%	8.4%
02 - Inpatient - Special	25.8%	8.1%	30.7%	53.2%
03 - Outpatient - General	4.7%	22.3%	30.7%	8.2%
04 - Outpatient - Special	18.0%	38.3%	8.2%	30.6%
<b>Total</b>	<b>24.3%</b>	<b>28.7%</b>	<b>24.3%</b>	<b>24.3%</b>

DEDICATED TO GOVERNMENT HEALTH PROGRAMS



## ■ DSH SURVEY PART II SECTION H, UNINSURED

- If BOTH of the following conditions are met, a hospital is NOT required to submit any uninsured data on the survey nor Exhibits A and B:
  1. The hospital Medicaid shortfall is greater than the hospital's total Medicaid DSH payments for the year.
    - The shortfall is equal to all Medicaid (FFS, MCO, cross-over, In-State, Out-of-State) cost less all applicable payments in the survey and non-claim payments such as UPL, GME, outlier, and supplemental payments.
  2. The hospital provides a certification that it incurred additional uncompensated care costs serving uninsured individuals.

DEDICATED TO GOVERNMENT HEALTH PROGRAMS



## ■ DSH SURVEY PART II SECTION H, UNINSURED

**NOTE:** It is important to remember that if you are not required to submit uninsured data that it may still be to the advantage of the hospital to submit it.

1. Your hospital's total UCC may be used to redistribute overpayments from other hospitals (to your hospital).
2. Your hospital's total UCC may be used to establish future DSH payments.
3. CMS DSH allotment reductions are partially based on states targeting DSH payments to hospitals with high uninsured and Medicaid populations.

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

- Additional Edits
  - In the far right column, you will see an edit message if your total charges or days by cost center exceed those reported from the cost report in Section G of the survey. Please clear these edits prior to filing the survey.
  - Calculated payments as a percentage of cost by payor (at bottom).
    - Review percentage for reasonableness.

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## ■ DSH SURVEY PART II SECTION I, OUT OF STATE MEDICAID

- Report Out-of-State Medicaid days, ancillary charges and payments.
- Report in the same format as Section H. Days, charges and payments received must agree to the other state's PS&R (or similar) claim payment summary. If no summary is available, submit Exhibit C (hospital data) as support.
- If your hospital provided services to several other states, please consolidate your data and provide support for your survey responses.

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## ■ DSH SURVEY PART II – SECTIONS J & K, ORGAN ACQUISITION

- Total organ acquisition cost and total useable organs 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.

DEDICATED TO GOVERNMENT HEALTH PROGRAMS



## ■ DSH SURVEY PART II - SECTIONS J & K, ORGAN ACQUISITION

- All organ acquisition charges should be reported in Sections J & K of the survey and should be **EXCLUDED** from Section H & I of the survey. (days should also be excluded from H & I)
- Medicaid and uninsured charges/days included in the cost report D-4 series as part of the total organ acquisition charges/days, must be excluded from Sections H & I of the survey.

DEDICATED TO GOVERNMENT HEALTH PROGRAMS



Rev. of May 2014  
Hospitals: Sun Region (2015) Revenue Survey Form

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

**In-State organ acquisitions**

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

Total Organ Acquisition Cost	Additional Average Fee Paid to Third-Party Supplier	Total Hospital Charge	Total Hospital Charge (Net of Add-On Cost)	In-State Medicaid		Out-of-State Medicaid		In-State Medicaid (Net of Add-On Cost)		Out-of-State Medicaid (Net of Add-On Cost)		Uninsured	
				Charges	Net Charges	Charges	Net Charges	Charges	Net Charges	Charges	Net Charges		
Cost Report Worksheet (A, B, C, D, E, F, G, H, I, J, K, L, M, N, O, P, Q, R, S, T, U, V, W, X, Y, Z, AA, AB, AC, AD, AE, AF, AG, AH, AI, AJ, AK, AL, AM, AN, AO, AP, AQ, AR, AS, AT, AU, AV, AW, AX, AY, AZ, BA, BB, BC, BD, BE, BF, BG, BH, BI, BJ, BK, BL, BM, BN, BO, BP, BQ, BR, BS, BT, BU, BV, BW, BX, BY, BZ, CA, CB, CC, CD, CE, CF, CG, CH, CI, CJ, CK, CL, CM, CN, CO, CP, CQ, CR, CS, CT, CU, CV, CW, CX, CY, CZ, DA, DB, DC, DD, DE, DF, DG, DH, DI, DJ, DK, DL, DM, DN, DO, DP, DQ, DR, DS, DT, DU, DV, DW, DX, DY, DZ, EA, EB, EC, ED, EE, EF, EG, EH, EI, EJ, EK, EL, EM, EN, EO, EP, EQ, ER, ES, ET, EU, EV, EW, EX, EY, EZ, FA, FB, FC, FD, FE, FF, FG, FH, FI, FJ, FK, FL, FM, FN, FO, FP, FQ, FR, FS, FT, FU, FV, FW, FX, FY, FZ, GA, GB, GC, GD, GE, GF, GG, GH, GI, GJ, GK, GL, GM, GN, GO, GP, GQ, GR, GS, GT, GU, GV, GW, GX, GY, GZ, HA, HB, HC, HD, HE, HF, HG, HH, HI, HJ, HK, HL, HM, HN, HO, HP, HQ, HR, HS, HT, HU, HV, HW, HX, HY, HZ, IA, IB, IC, ID, IE, IF, IG, IH, II, IJ, IK, IL, IM, IN, IO, IP, IQ, IR, IS, IT, IU, IV, IW, IX, IY, IZ, JA, JB, JC, JD, JE, JF, JG, JH, JI, JJ, JK, JL, JM, JN, JO, JP, JQ, JR, JS, JT, JU, JV, JW, JX, JY, JZ, KA, KB, KC, KD, KE, KF, KG, KH, KI, KJ, KK, KL, KM, KN, KO, KP, KQ, KR, KS, KT, KU, KV, KW, KX, KY, KZ, LA, LB, LC, LD, LE, LF, LG, LH, LI, LJ, LK, LL, LM, LN, LO, LP, LQ, LR, LS, LT, LU, LV, LW, LX, LY, LZ, MA, MB, MC, MD, ME, MF, MG, MH, MI, MJ, MK, ML, MM, MN, MO, MP, MQ, MR, MS, MT, MU, MV, MW, MX, MY, MZ, NA, NB, NC, ND, NE, NF, NG, NH, NI, NJ, NK, NL, NM, NN, NO, NP, NQ, NR, NS, NT, NU, NV, NW, NX, NY, NZ, OA, OB, OC, OD, OE, OF, OG, OH, OI, OJ, OK, OL, OM, ON, OO, OP, OQ, OR, OS, OT, OU, OV, OW, OX, OY, OZ, PA, PB, PC, PD, PE, PF, PG, PH, PI, PJ, PK, PL, PM, PN, PO, PP, PQ, PR, PS, PT, PU, PV, PW, PX, PY, PZ, QA, QB, QC, QD, QE, QF, QG, QH, QI, QJ, QK, QL, QM, QN, QO, QP, QQ, QR, QS, QT, QU, QV, QW, QX, QY, QZ, RA, RB, RC, RD, RE, RF, RG, RH, RI, RJ, RK, RL, RM, RN, RO, RP, RQ, RR, RS, RT, RU, RV, RW, RX, RY, RZ, SA, SB, SC, SD, SE, SF, SG, SH, SI, SJ, SK, SL, SM, SN, SO, SP, SQ, SR, SS, ST, SU, SV, SW, SX, SY, SZ, TA, TB, TC, TD, TE, TF, TG, TH, TI, TJ, TK, TL, TM, TN, TO, TP, TQ, TR, TS, TT, TU, TV, TW, TX, TY, TZ, UA, UB, UC, UD, UE, UF, UG, UH, UI, UJ, UK, UL, UM, UN, UO, UP, UQ, UR, US, UT, UU, UV, UW, UX, UY, UZ, VA, VB, VC, VD, VE, VF, VG, VH, VI, VJ, VK, VL, VM, VN, VO, VP, VQ, VR, VS, VT, VU, VW, VX, VY, VZ, WA, WB, WC, WD, WE, WF, WG, WH, WI, WJ, WK, WL, WM, WN, WO, WP, WQ, WR, WS, WT, WU, WV, WW, WX, WY, WZ, XA, XB, XC, XD, XE, XF, XG, XH, XI, XJ, XK, XL, XM, XN, XO, XP, XQ, XR, XS, XT, XU, XV, XW, XX, XY, XZ, YA, YB, YC, YD, YE, YF, YG, YH, YI, YJ, YK, YL, YM, YN, YO, YP, YQ, YR, YS, YT, YU, YV, YW, YX, YY, YZ, ZA, ZB, ZC, ZD, ZE, ZF, ZG, ZH, ZI, ZJ, ZK, ZL, ZM, ZN, ZO, ZP, ZQ, ZR, ZS, ZT, ZU, ZV, ZW, ZX, ZY, ZZ													

**K. Transplant Facilities Only: Organ Acquisition Cost by State Medicaid**

**Out-of-State organ acquisitions**

Total Organ Acquisition Cost	Additional Average Fee Paid to Third-Party Supplier	Total Hospital Charge	Total Hospital Charge (Net of Add-On Cost)	In-State Medicaid		Out-of-State Medicaid		In-State Medicaid (Net of Add-On Cost)		Out-of-State Medicaid (Net of Add-On Cost)		Uninsured	
				Charges	Net Charges	Charges	Net Charges	Charges	Net Charges	Charges	Net Charges		
Cost Report Worksheet (A, B, C, D, E, F, G, H, I, J, K, L, M, N, O, P, Q, R, S, T, U, V, W, X, Y, Z, AA, AB, AC, AD, AE, AF, AG, AH, AI, AJ, AK, AL, AM, AN, AO, AP, AQ, AR, AS, AT, AU, AV, AW, AX, AY, AZ, BA, BB, BC, BD, BE, BF, BG, BH, BI, BJ, BK, BL, BM, BN, BO, BP, BQ, BR, BS, BT, BU, BV, BW, BX, BY, BZ, CA, CB, CC, CD, CE, CF, CG, CH, CI, CJ, CK, CL, CM, CN, CO, CP, CQ, CR, CS, CT, CU, CV, CW, CX, CY, CZ, DA, DB, DC, DD, DE, DF, DG, DH, DI, DJ, DK, DL, DM, DN, DO, DP, DQ, DR, DS, DT, DU, DV, DW, DX, DY, DZ, EA, EB, EC, ED, EE, EF, EG, EH, EI, EJ, EK, EL, EM, EN, EO, EP, EQ, ER, ES, ET, EU, EV, EW, EX, EY, EZ, FA, FB, FC, FD, FE, FF, FG, FH, FI, FJ, FK, FL, FM, FN, FO, FP, FQ, FR, FS, FT, FU, FV, FW, FX, FY, FZ, GA, GB, GC, GD, GE, GF, GG, GH, GI, GJ, GK, GL, GM, GN, GO, GP, GQ, GR, GS, GT, GU, GV, GW, GX, GY, GZ, HA, HB, HC, HD, HE, HF, HG, HH, HI, HJ, HK, HL, HM, HN, HO, HP, HQ, HR, HS, HT, HU, HV, HW, HX, HY, HZ, IA, IB, IC, ID, IE, IF, IG, IH, II, IJ, IK, IL, IM, IN, IO, IP, IQ, IR, IS, IT, IU, IV, IW, IX, IY, IZ, JA, JB, JC, JD, JE, JF, JG, JH, JI, JJ, JK, JL, JM, JN, JO, JP, JQ, JR, JS, JT, JU, JV, JW, JX, JY, JZ, KA, KB, KC, KD, KE, KF, KG, KH, KI, KJ, KK, KL, KM, KN, KO, KP, KQ, KR, KS, KT, KU, KV, KW, KX, KY, KZ, LA, LB, LC, LD, LE, LF, LG, LH, LI, LJ, LK, LL, LM, LN, LO, LP, LQ, LR, LS, LT, LU, LV, LW, LX, LY, LZ, MA, MB, MC, MD, ME, MF, MG, MH, MI, MJ, MK, ML, MM, MN, MO, MP, MQ, MR, MS, MT, MU, MV, MW, MX, MY, MZ, NA, NB, NC, ND, NE, NF, NG, NH, NI, NJ, NK, NL, NM, NN, NO, NP, NQ, NR, NS, NT, NU, NV, NW, NX, NY, NZ, OA, OB, OC, OD, OE, OF, OG, OH, OI, OJ, OK, OL, OM, ON, OO, OP, OQ, OR, OS, OT, OU, OV, OW, OX, OY, OZ, PA, PB, PC, PD, PE, PF, PG, PH, PI, PJ, PK, PL, PM, PN, PO, PP, PQ, PR, PS, PT, PU, PV, PW, PX, PY, PZ, QA, QB, QC, QD, QE, QF, QG, QH, QI, QJ, QK, QL, QM, QN, QO, QP, QQ, QR, QS, QT, QU, QV, QW, QX, QY, QZ, RA, RB, RC, RD, RE, RF, RG, RH, RI, RJ, RK, RL, RM, RN, RO, RP, RQ, RR, RS, RT, RU, RV, RW, RX, RY, RZ, SA, SB, SC, SD, SE, SF, SG, SH, SI, SJ, SK, SL, SM, SN, SO, SP, SQ, SR, SS, ST, SU, SV, SW, SX, SY, SZ, TA, TB, TC, TD, TE, TF, TG, TH, TI, TJ, TK, TL, TM, TN, TO, TP, TQ, TR, TS, TT, TU, TV, TW, TX, TY, TZ, UA, UB, UC, UD, UE, UF, UG, UH, UI, UJ, UK, UL, UM, UN, UO, UP, UQ, UR, US, UT, UU, UV, UW, UX, UY, UZ, VA, VB, VC, VD, VE, VF, VG, VH, VI, VJ, VK, VL, VM, VN, VO, VP, VQ, VR, VS, VT, VU, VW, VX, VY, VZ, WA, WB, WC, WD, WE, WF, WG, WH, WI, WJ, WK, WL, WM, WN, WO, WP, WQ, WR, WS, WT, WU, WV, WW, WX, WY, WZ, XA, XB, XC, XD, XE, XF, XG, XH, XI, XJ, XK, XL, XM, XN, XO, XP, XQ, XR, XS, XT, XU, XV, XW, XX, XY, XZ, YA, YB, YC, YD, YE, YF, YG, YH, YI, YJ, YK, YL, YM, YN, YO, YP, YQ, YR, YS, YT, YU, YV, YW, YX, YY, YZ, ZA, ZB, ZC, ZD, ZE, ZF, ZG, ZH, ZI, ZJ, ZK, ZL, ZM, ZN, ZO, ZP, ZQ, ZR, ZS, ZT, ZU, ZV, ZW, ZX, ZY, ZZ													

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

- Survey form Exhibit A has been designed to assist hospitals in collecting and reporting all uninsured charges and routine days needed to cost out the uninsured services.
  - Total hospital charges / routine days from Exhibit A must agree to the total entered in Section H of the survey.
  - Must be for 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.

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## ■ 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.

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## ■ EXHIBIT A - UNINSURED

- Claim Status (Column R) is the same as the prior year – need to indicate if Exhausted / Non-Covered Insurance claims are being included under the [December 3, 2014 final DSH rule](#).
- If exhausted / non-covered insurance services are included on Exhibit A, then they must also be included on Exhibit B for patient payments.
- Submit Exhibit A in the format shown either in Excel or a CSV file using the tab or | (pipe symbol above the enter key).

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

- Patient payments received for uninsured services need to be reported on a cash basis.
- For example, a cash payment received during the 2013 cost report year that relates to a service provided in the 2005 cost report year, must be used to reduce uninsured cost for the 2013 cost report year.

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

- Exhibit B
  - Include *Primary Payor Plan, Secondary Payor Plan, Payment Transaction Code, Provider #, PCN, Birth Date, SSN, Gender, Admit, Discharge, Date of Collection, Amount of Collection, 1011 Indicator, Service Indicator, Hospital Charges, Physician Charges, Non-Hospital Charges, Insurance Status, Claim Status and Calculated Collection* fields.
  - A separate “key” for all payment transaction codes should be submitted with the survey.
- Submit Exhibit B in the format shown using Excel or a CSV file using the tab or | (pipe symbol above the enter key).

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## ■ EXHIBIT C – HOSPITAL-PROVIDED MEDICAID DATA

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

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## ■ EXHIBIT C – HOSPITAL-PROVIDED MEDICAID DATA

- Types of data that may require an Exhibit C are as follows:
  - Self-reported Medicaid MCO data (Section H).
  - Self-reported “Other” Medicaid eligibles (Section H).
  - All self-reported Out-of-State Medicaid categories (Section I).

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## ■ EXHIBIT C – HOSPITAL-PROVIDED MEDICAID DATA

- Exhibit C
  - Include *Primary Payor Plan, Secondary Payor Plan, Hospital MCD #, PCN, Patient's MCD Recipient #, 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.
  - Submit Exhibit C in the format shown using Excel or a CSV file using the tab or | (pipe symbol above the enter key).

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EXHIBIT C - MANAGED CARE

DPR Survey Exhibits A-C Hospital-Provided Claims Database

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## ■ DSH SURVEY PART I – DSH YEAR DATA

- Separate tab in Part I of the survey.
- Should be completed after Part I and Part II surveys are prepared.
- Includes list of all supporting documentation that needs to be submitted with the survey for audit.
- Includes Myers and Stauffer address and phone numbers.

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## ■ DSH SURVEY PART I – DSH YEAR DATA

### Submission Checklist

1. Electronic copy of the DSH Survey Part I – DSH Year Data.
2. Electronic copy of the DSH Survey Part II – Cost Report Year Data.
3. Electronic Copy of Exhibit A – Uninsured Charges/Days.
  - *Must be in Excel (.xls or .xlsx) or CSV (.csv) using either a TAB or | (pipe symbol above the ENTER key).*
4. Description of logic used to compile Exhibit A. Include a copy of all financial classes and payor plan codes utilized during the cost report period and a description of which codes were included or excluded if applicable.

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## ■ DSH SURVEY PART I – DSH YEAR DATA

### Submission Checklist (cont.)

5. Electronic Copy of Exhibit B – Self-Pay Payments.
  - *Must be in Excel (.xls or .xlsx) or CSV (.csv) using either a TAB or | (pipe symbol above the ENTER key).*
6. Description of logic used to compile Exhibit B. Include a copy of all transaction codes utilized to post payments during the cost reporting period and a description of which codes were included or excluded if applicable.

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## ■ DSH SURVEY PART I – DSH YEAR DATA

### Submission Checklist (cont.)

7. Electronic copy of Exhibit C for hospital-generated data (includes Medicaid eligibles, Medicaid MCO, or Out-Of-State Medicaid data that isn't supported by a state-provided or MCO-provided report).
  - *Must be in Excel (.xls or .xlsx) or CSV (.csv) using either a TAB or | (pipe symbol above the ENTER key).*
8. Description of logic used to compile each Exhibit C. Include a copy of all financial classes and payor plan codes utilized during the cost report period and a description of which codes were included or excluded if applicable.

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## ■ DSH SURVEY PART I – DSH YEAR DATA

### Submission Checklist (cont.)

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

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## ■ DSH SURVEY PART I – DSH YEAR DATA

### **Submission Checklist (cont.)**

12. Support for Section 1011 (Undocumented Alien) payments if not applied at patient level in Exhibit B.
13. Documentation supporting out-of-state DSH payments received. Examples may include remittances, detailed general ledgers, or add-on rates.
14. Financial statements to support total charity care charges and state / local govt. cash subsidies reported.
15. Revenue code cross-walk used to prepare cost report.

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## ■ DSH SURVEY PART I – DSH YEAR DATA

### **Submission Checklist (cont.)**

16. A detailed working trial balance used to prepare each cost report (including revenues).
17. A detailed revenue working trial balance by payor/contract. The schedule should show charges, contractual adjustments, and revenues by payor plan and contract (e.g., Medicare, each Medicaid agency payor, each Medicaid Managed care contract).
18. Electronic copy of all cost reports used to prepare each DSH Survey Part II.
19. Documentation supporting cost report payments calculated for Medicaid/Medicare cross-overs (dual eligibles).

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## ■ 2013 CLARIFICATIONS

- *DSH Allotments*
  - Allotment reduction has been delayed even further until federal fiscal year 2018, through the Medicare Access and CHIP Reauthorization Act of 2015. The total reduction amount was increased to \$2,000,000,000 for 2018.



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## ■ 2013 CLARIFICATIONS

- *State-Specific Annual DSH Allotment Reduction Factors*
  - High Volume of Medicaid Inpatients Factor (HMF).
    - Imposes larger percentage reductions on states that do not target their DSH payments on hospitals with high volumes of Medicaid inpatients.
  - High Level of Uncompensated Care Factor (HUF).
    - Imposes larger percentage reductions on states that do not target their DSH payments on hospitals with high levels of uncompensated care.

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## ■ 2013 CLARIFICATIONS / CHANGES

- *Labor and delivery days and costs associated with L&D equivalent days must be properly matched in the Medicaid version of the cost report for accurate calculation of costs.*
  - In some states, hospitals are adding labor and delivery days from line 32 of S-3 to total adults and peds days on line 1 of S-3 in the Medicaid version of their cost reports. However, the costs associated with these days are not reclassified from labor and delivery to adults and peds.
  - This understates the A&P per diem for the calculation of the DSH UCC.
  - If L&D day costs are included in adults and peds in the cost report, it is proper to add the L&D days to A&P days in calculating the per diem.

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## ■ 2013 CLARIFICATIONS / CHANGES

- *Labor and delivery days and costs (Continued)*
  - The methodology used to capture labor and delivery cost and days is also dependent on whether labor and delivery days are counted in the hospital census and whether they are billed as an inpatient day.
    - *According to Medicare guidelines, a labor and delivery day is defined as a day during which a maternity patient is in the labor/delivery room ancillary area at midnight at the time of census taking and is not included in the census of the inpatient routine care area because the patient has not occupied an inpatient routine bed at some time before admission. In the case where the maternity patient is in a single multipurpose labor, delivery and postpartum room, hospital must determine the proportion of each inpatient stay that is associated with ancillary services versus routine adult and pediatric services and report the days associated with the labor and delivery portion of the stay on line 32 of S-3.*
  - If the L&D days are billed as inpatient days, the days should also be included in total days.

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## ■ 2013 CLARIFICATIONS / CHANGES

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

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## ■ 2013 CLARIFICATIONS / CHANGES

### • OB Requirements

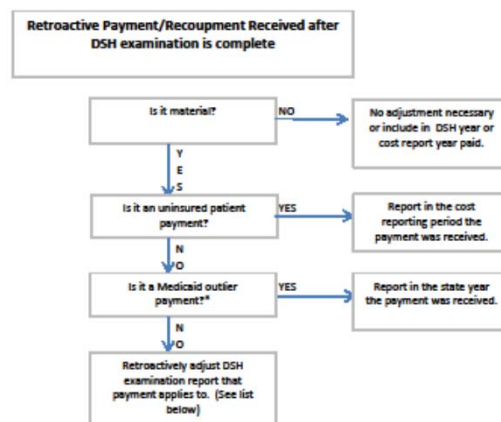
- Section 1923(d) of the SSA includes exceptions to OB service requirements. One exception is that hospitals that did not offer emergency OB services to the general population as of December 22, 1987 are not required to meet the two-OB rule for DSH payment eligibility.
- CMS issued a clarification titled *Additional Information on the DSH Reporting and Auditing Requirements* on April 7, 2014.
- "The law does not contemplate a grandfathering clause or otherwise make exception to the obstetrician requirement for hospitals that came into existence after December 22, 1987; therefore, such hospitals would not be considered exempt from the obstetrician requirement at section 1923(d) of the act."

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## ■ 2013 CLARIFICATIONS / CHANGES

### • Retroactive Payments/Recoupments



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## ■ 2013 CLARIFICATIONS / CHANGES

### • *Retroactive Payments/Recoupments*

#### Types of payments resulting in retroactive adjustment:

Medicaid paid claims payments  
Medicare paid claims payments  
TPL paid claims payments  
Direct Medicaid payments  
UPL payments  
Trauma add-on and trauma outlier payments  
Quarterly & enhanced GME payments  
Cost settlement payments

#### Types of recoupments retroactive adjustment:

Recoupment of Medicaid paid claims payments  
Recoupment of Medicare paid claims payments  
Recoupment of TPL paid claims payments  
Recoupment of Direct Medicaid payments  
Recoupment of UPL payments  
Recoupment of Trauma add-on and trauma outlier payments  
Recoupment of Quarterly & enhanced GME payments  
Recoupment of Medicaid outlier payments\*  
Recoupment of Cost settlement payments

\* Medicaid outlier payments are included for DSH purposes based on the date paid by the state regardless of the DOS.  
Recoupments of Medicaid outlier payments will be included for DSH purposes based on the original date of the payment—not the DOS.

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## ■ 2013 CLARIFICATIONS / CHANGES

- *December 3, 2014 Final Rule*
  - Definitions of uninsured as laid out in the January 2012 proposed rule have been finalized.
  - Myers and Stauffer has been utilizing the definitions of uninsured as stated in the January 2012 proposed rule since the 2009 DSH examinations.
  - Now that the proposed rule has been finalized, Myers and Stauffer will continue to utilize those definitions as they have been since the 2009 DSH examinations.
  - 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.

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## ■ 2013 CLARIFICATIONS

- 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.)*
- Seattle Children's and Texas Children's Hospitals have sued to stop recoupments of their DSH overpayments that have resulted from the inclusion of these private insurance claims in their DSH UCC. On December 29, 2014, a federal court ordered an injunction against Washington and Texas state Medicaid agencies and CMS preventing the state and/or CMS from recouping the overpayments as included in the DSH examination report.

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## ■ 2013 CLARIFICATIONS

- This does **not** change how Myers and Stauffer or any other independent CPA firm must calculate a hospital's uncompensated care cost for the 2013 DSH examinations at this time.
- Until new CMS audit guidance is issued, we must continue to calculate each hospital's UCC including all Other Medicaid Eligibles (including those with private insurance).
- However, 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 that was provided on your FTP site.

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## ■ PRIOR YEAR DSH EXAMINATION (2012)

### Significant Data Issues in Final Report

- Reporting self-pay payments (Exhibit B) on an accrual basis rather than a cash basis
- Some hospitals were unable to provide Uninsured and Medicaid days and charges (Exhibits A and C) by revenue code

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## ■ PRIOR YEAR DSH EXAMINATION (2012)

### 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, and non-Medicaid untimely filings as uninsured patient claims.

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## ■ PRIOR YEAR DSH EXAMINATION (2012)

### Common Issues Noted During Examination

- Charges and days reported on survey exceeded total charges and days reported on the cost report (by cost center).
- Inclusion of patients in the uninsured charges listing (Exhibit A) that are concurrently listed as insured in the payments listing (Exhibit B).
- Patients listed as both insured and uninsured in Exhibit B for the same dates of service.

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## ■ PRIOR YEAR DSH EXAMINATION (2012)

### Common Issues Noted During Examination

- Patient-level documentation on uninsured Exhibit A and uninsured patient payments from Exhibit B didn't agree to totals on the survey.
- [Under the December 3, 2014 final DSH rule](#), hospitals reported "Exhausted" / "Insurance Non-Covered" on Exhibit A (Uninsured) but did not report the payments on Exhibit B.

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## ■ PRIOR YEAR DSH EXAMINATION (2012)

### 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.

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## ■ PRIOR YEAR DSH EXAMINATION (2012)

### 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.

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## ■ PRIOR YEAR DSH EXAMINATION (2012)

### Common Issues Noted During Examination

- Medicare cross-over payments didn't include all Medicare payments (outlier, cost report settlements, lump-sum/pass-through, payments received after year end, etc.).
- Only uninsured payments are to be on cash basis – all other payor payments must include all payments made for the dates of service as of the audit date.

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## ■ PRIOR YEAR DSH EXAMINATION (2012)

### 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.

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## ■ FAQ

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

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

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

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## ■ FAQ

### 1. What is the definition of uninsured for Medicaid DSH purposes? (Continued from previous slide)

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

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

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## ■ FAQ

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

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

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## ■ FAQ

### 3. What categories of services can be included in uninsured on the DSH survey?

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

- There has been some confusion with this issue. CMS attempts to clarify this in #24 of their FAQ titled "Additional Information on the DSH Reporting and Audit Requirements". It basically says if a service is a hospital service it can be included even if Medicaid only covered a specific group of individuals for that service.
- EXAMPLE : A state Medicaid program covers speech therapy for beneficiaries under 18 at a hospital. However, a hospital provides speech therapy to an uninsured individual over the age of 18. Can they include it in uninsured? The answer is "Yes" since speech therapy is a Medicaid hospital service even though they wouldn't cover beneficiaries over 18.

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## ■ FAQ

### 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)

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## ■ FAQ

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

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

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

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

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## ■ FAQ

### 7. Can bad debts be considered uninsured?

Bad debts cannot be considered uninsured if the patient has third party coverage. The exception would be if they qualify as uninsured under the 2014 final DSH rule as an exhausted or insurance non-covered service (but those must be separately identified).

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## ■ FAQ

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

- Many states remove individuals between the ages of 22 and 64 from Medicaid eligibility rolls; if so these costs should be reported as uncompensated care for the uninsured. If these individuals are reported on the Medicaid eligibility rolls, they should be reported as uncompensated care for the Medicaid population. *(Reporting pg. 77929 and CMS Feb. 2010 FAQ #28 – Additional Information on the DSH Reporting and Audit Requirements)*
- Per CMS FAQ, if the state removes a patient from the Medicaid rolls and they have Medicare, they cannot be included in the DSH UCC.
- Under the 2014 final DSH rule, these patients may be included in the DSH UCC if Medicare is exhausted.

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## ■ FAQ

### 9. 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)*

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## ■ FAQ

### 10. How are patient payments to be reported on Exhibit B?

Cash-basis! Exhibit B should include patient payments collected during the cost report period (cash-basis). Under the DSH rules, uninsured cost must be offset by uninsured cash-basis payments.

### 11. Does Exhibit B include only uninsured patient payments or ALL patient payments?

ALL patient payments. Exhibit B includes all cash-basis patient payments so that testing can be done to ensure no payments were left off of the uninsured. The total patient payments on Exhibit B should reconcile to your total self-pay payments collected during the cost report year.

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## ■ FAQ

### 12. Should we include state and local government payments for indigent in uninsured on Exhibit B?

Uninsured payments do not include payments made by State-only or local only government programs for services provided to indigent patients (no Federal share or match).  
(Reporting pg. 77914)

### 13. Can physician services be included in the DSH survey?

Physician costs that are billed as physician professional services and reimbursed as such should not be considered in calculating the hospital-specific DSH limit. (Reporting pg. 77924)

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## ■ FAQ

### 14. Do dual eligibles (Medicare/Medicaid) have to be included in the Medicaid UCC?

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

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

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

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## ■ FAQ

### 16. 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")

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## ■ FAQ

### 16. 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")

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## ■ OTHER INFORMATION

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

Upload survey and other data to the Secure FTP site:

<https://transfer.mslc.com>

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

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