



# DISPROPORTIONATE SHARE HOSPITAL (DSH) PAYMENT EXAMINATION UPDATE DSH YEAR 2014

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## ■ OVERVIEW

- DSH Examination Policy
- DSH Year 2014 Examination Timeline
- DSH Year 2014 Examination Impact
- Paid Claims Data Review
- Review of DSH Year 2014 Survey and Exhibits
- 2014 Clarifications / Changes
- Recap of Prior Year Examinations (2013)
- Myers and Stauffer DSH FAQ
- SFY 2018 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 2014 EXAMINATION TIMELINE

- Surveys e-mailed Nov 4<sup>th</sup>, 2016
- Surveys returned by December 9<sup>th</sup>, 2016
- December – March - desk reviews
- April – May - on-site/expanded reviews
- Draft report to the state by June 30, 2017
- Final report to CMS within 90 days of draft report



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## ■ DSH YEAR 2014 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 2014 examination report is the fourth year that may result in DSH payment recoupments.

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## ■ PAID CLAIMS DATA UPDATE FOR 2014

- **Medicaid fee-for-service paid claims data**
  - Will be sent via new secure web portal.
  - 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 2014

- **Medicare/Medicaid cross-over paid claims data**
  - Will be sent via secure web portal, same format as last year.
  - Reported based on cost report year (using discharge date).
  - At revenue code level.
  - 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.
  - Detailed data is available upon request.

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## ■ PAID CLAIMS DATA UPDATE FOR 2014

- Medicaid managed care paid claims data
  - Will be sent via new secure web portal
  - 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 should 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 2014

- 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 2014

- “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 2014

- “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 or a signed statement verifying there are none to report, we may have to list the hospital as non-compliant in the 2014 DSH examination report.
  - Ensure that you ***separately report*** Medicaid, Medicaid MCO, Medicare, Medicare HMO, private insurance, 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 2014

- Uninsured Services
  - As in years past, uninsured charges/days will be reported on Exhibit A and patient payments will be reported on Exhibit B.
  - Exhibit A 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 12/31/13 with the DSH examination of SFY 2013 in the prior year. In the DSH year 2014 exam, Hospital A would only need to submit a survey for their year ending 12/31/14.
- 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) Examination Survey Part I  
For State DSH Year 2013

**A. General DSH Year Information**

1. DSH Year: 

Begin	End
07/01/2012	06/30/2013

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

Select hospital name.

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

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	01/01/2013	12/31/2013
4. Cost Report Year 2 (if applicable)		
5. Cost Report Year 3 (if applicable)		

Only cost report years to be submitted will show here.

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:


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 nonemergency 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 all OB questions.

DSH Examination Year (07/01/12 - 06/30/13)

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State of Any State  
 Disproportionate Share Hospital (DSH) Examination Survey Part I  
 For State DSH Year 2013



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

1. Medicaid Supplemental Payments for DSH Year 07/01/2012 - 06/30/2013  
(Should include UPL and Non-Claim Specific payments paid based on the state fiscal year. However, DSH payments should NOT be included.)

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

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**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/CFE 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:

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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. All Medicaid eligible patients, including those who have private insurance coverage, have been reported on the DSH survey regardless of whether the hospital received payment on the claim. 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

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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	

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L.C. CERTIFIED PUBLIC ACCOUNTANTS

## 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 New York  
Disproportionate Share Hospital (DSH) Expenditure Survey Part II  
Version 1.20

DSH Version 7.25 12/30/15

**D. General Cost Report Year Information** 1/1/2013 - 12/31/2013

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"):  
 1/01/2013 through 12/31/2013

3. Status of Cost Report Used for this Survey (choose the option that is available): X

3a. Date CMS processed the HCRRG file into the HCRRG database: 12/30/15 AM

4. Hospital Name: Hospital ABC

5. Medicaid Provider Number: 111111

6. Medicaid Subprovider Number 1 (Psychiatric or Rehab): 0

7. Medicare Subprovider Number 2 (Psychiatric or Rehab): 0

8. Medicare Provider Number: 00-1111

Date	Correct	If Incorrect, Proper Information

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

State Name	Provider No.

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)

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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 used to complete the survey (e.g., as-filled, 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 New York  
Department of Health (DOH) Disposition Survey Part II

Version 7.20

**E. Disclosure of Medicaid / Uninsured Payments Received: (01/01/2013 - 12/31/2013)**

1. Section 1011 Payment Related to Hospital Services Included in Exhibits B & B-1 (See Note 1) \$ 13,000
2. Section 1011 Payment Related to Inpatient Hospital Services NOT Included in Exhibits B & B-1 (See Note 1) \$ 1,000
3. Section 1011 Payment Related to Outpatient Hospital Services NOT Included in Exhibits B & B-1 (See Note 1) \$ 2,000
4. Total Section 1011 Payments Related to Hospital Services (See Note 1) \$ 17,000
5. Section 1011 Payment Related to Non-Hospital Services Included in Exhibits B & B-1 (See Note 1) \$ 1,000
6. Section 1011 Payment Related to Non-Hospital Services NOT Included in Exhibits B & B-1 (See Note 1) \$ 1,000
7. Total Section 1011 Payments Related to Non-Hospital Services (See Note 1) \$ 2,000
8. Out-of-State DSH Payments (See Note 2) \$ 55,000

	Inpatient	Outpatient	Total
9. Total Cash Basis Patient Payments from Uninsured (On Exhibit B)	\$ 250,000	\$ 1,000,000	\$ 1,250,000
10. Total Cash Basis Patient Payments from All Other Patients (On Exhibit B)	\$ 3,000,000	\$ 6,000,000	\$ 9,000,000
11. Total Cash Basis Patient Payments Reported on Exhibit B (Sum of 9 and 10)	\$ 3,250,000	\$ 7,000,000	\$ 10,250,000
12. Uninsured Cash Basis Patient Payments as a Percentage of Total Cash Basis Patient Payments:	7.69%	10.00%	9.43%

NOTE: Uninsured payments reported on Section H do not reconcile to uninsured payments reported on Section E. Please verify this is correct.

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. If any subsidies are directed toward non-hospital services, record the subsidies in the non-hospital cell.
- 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: 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 30 and 31 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 32 and 33 so they can be properly excluded in calculating net patient service revenue also.

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**F-1. Total Hospital Days Used in Medicaid Inpatient Utilization Ratio (MIUR)**  
 1. Total Hospital Days Per Cost Report Excluding Swing-Bed (ICR, WIS D-3, PL-1, Ch. 8, Subpart 166.14, 16, 17, 18 as well as 5 & 6) **\$1,620**

**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 IP and OIP Hospital Subsidies  
 5. Non-Hospital Subsidies  
 6. Total Hospital Subsidies  
 7. Inpatient Charity Care Charges  
 8. Outpatient Charity Care Charges  
 9. Non-Hospital Charity Care Charges  
 10. Total Charity Care Charges

**F-3. Calculation of Net Hospital Revenue from Patient Services (Used for LIUR) (2013 G-3 and G-3.1 Cost Report)**

	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	
11. Hospital	\$27,432,528.00			\$ 48,400,430	\$ -	\$ -	\$ 20,950,099
12. Subprovider (Physic or Rehab)	\$1,892,875.00			\$ 1,304,689	\$ -	\$ -	\$ 588,306
13. Subprovider (Physic or Rehab)	\$0.00			\$ -	\$ -	\$ -	\$ -
14. Swing Bed - SNF	\$0.00		\$0.00	\$ -	\$ -	\$ -	\$ -
15. Swing Bed - SNF	\$0.00		\$0.00	\$ -	\$ -	\$ -	\$ -
16. Skilled Nursing Facility	\$0.00		\$0.00	\$ -	\$ -	\$ -	\$ -
17. Nursing Facility	\$0.00		\$0.00	\$ -	\$ -	\$ -	\$ -
18. Other Long-Term Care	\$0.00		\$0.00	\$ -	\$ -	\$ -	\$ -
19. Ancillary Services	\$1,744,509.00	\$17,424,509.00		\$ 16,719,999.00	\$ 2,222,347.00	\$ -	\$ 14,271,912
20. Outpatient Services		\$1,149,822.00		\$ -	\$ 120,470	\$ -	\$ 1,170,292
21. Home Health Agency			\$2,760,004.00	\$ -	\$ -	\$ 1,918,024	\$ 841,980
22. Ambulance			\$0.00	\$ -	\$ -	\$ -	\$ -
23. Outpatient Rehab Providers	\$0.00	\$0.00	\$0.00	\$ -	\$ -	\$ -	\$ -
24. ACC	\$0.00		\$0.00	\$ -	\$ -	\$ -	\$ -
25. Hospice	\$0.00		\$2,197,004.00	\$ -	\$ -	\$ -	\$ 2,197,004
26. Other	\$0.00	\$1,944,000.00	\$0.00	\$ -	\$ 1,040,400	\$ -	\$ 903,600
27. Total	\$348,982,366	\$182,620,384	\$4,937,856	\$242,524,360	\$125,796,628	\$3,403,048	\$369,723,443
28. Total Hospital and Non-Hospital							\$369,723,443

29. Total Per Cost Report  
 Total Patient Revenues (G-3 Line 1) **\$331,442,208**  
 Total Contractual Adj. (G-3 Line 2) **\$376,533,443**

30. 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) **\$60,000**  
 31. 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**  
 32. Increase worksheet G-3, Line 2 to reverse effect of Medicaid DSH Revenue INCLUDED on worksheet G-3, Line 2 (impact is a decrease in net patient revenue) **\$0.000**  
 33. Increase worksheet G-3, Line 2 to reverse effect of State and Local Patient Care Cash Subsidies INCLUDED on worksheet G-3, Line 2 (impact is a decrease in net patient revenue) **\$0.000**  
 34. 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) **\$100,000**  
 35. Adjusted Contractual Adjustments **\$600,000**  
 36. Unreconciled Difference **\$69,723,443**

Unreconciled Difference (Should be \$0) **\$ -**  
 Unreconciled Difference (Should be \$0) **\$ -**

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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
- NF, SNF, and Swing Bed Cost for Medicaid, Medicare, and Other Payors

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G. Cost Report - Cost / Days / Charges

Cost Report Year (01/01/2013-12/31/2013) Hospital ABC

Line #	Cost Center Description	Total Allowable Cost	Intern & Resident Costs Removed on Cost Report*	RCE and Therapy Add-Back (if Applicable)	Total Cost	IP	OIP Charges	Total Charges	Medicaid Per Diem / Cost-to-Charge Ratios
			Cost Report Worksheet B, Part I, Col. 26	Cost Report Worksheet B, Part I, Col. 25 (Item & Resident Other ONLY)*	Cost Report Worksheet C, Part I, Col. 2 and Col. 4	Swing-Bed Care Cost Report Worksheet D-1, Part I, Line 26	Calculated	Days - Cost Report WIS D-1, Pt. 1, Line 2 for Adults & Peds; WIS D-1, Pt. 2, Lines 42-47 for others	Calculated Per Diem
<b>Routine Cost Centers (list below)</b>									
1	00000 ADULTS & PEDIATRICS	\$ 200,000,000	\$ 50,000,000	\$ -	\$ 150,000,000	250,000		\$ 250,000	\$ 1,000.00
2	01100 INTENSIVE CARE UNIT	\$ 14,000,000	\$ 8,500,000	\$ -	\$ 5,500,000	10,000		\$ 5,500	\$ 2,250.00
3	02000 CORONARY CARE UNIT	\$ 7,500,000	\$ -	\$ -	\$ 7,500,000	5,000		\$ 7,500	\$ 1,500.00
4	03000 BURN INTENSIVE CARE UNIT	\$ -	\$ -	\$ -	\$ -			\$ -	\$ -
5	03400 SURGICAL INTENSIVE CARE UNIT	\$ 12,500,000	\$ 1,800,000	\$ -	\$ 10,700,000	8,000		\$ 10,700	\$ 1,337.50
6	03500 OTHER SPECIAL CARE UNIT	\$ 12,000,000	\$ 2,000,000	\$ -	\$ 10,000,000	11,000		\$ 10,000	\$ 1,272.73
7	04000 SUPERVISOR I	\$ -	\$ -	\$ -	\$ -			\$ -	\$ -
8	04100 SUPERVISOR II	\$ -	\$ -	\$ -	\$ -			\$ -	\$ -
9	04200 OTHER SUPERVISOR	\$ -	\$ -	\$ -	\$ -			\$ -	\$ -
10	04300 NURSE/RY	\$ 2,000,000	\$ 400,000	\$ -	\$ 1,600,000	6,000		\$ 1,600	\$ 400.00
11		\$ -	\$ -	\$ -	\$ -			\$ -	\$ -
12		\$ -	\$ -	\$ -	\$ -			\$ -	\$ -
13		\$ -	\$ -	\$ -	\$ -			\$ -	\$ -
14		\$ -	\$ -	\$ -	\$ -			\$ -	\$ -
15		\$ -	\$ -	\$ -	\$ -			\$ -	\$ -
16		\$ -	\$ -	\$ -	\$ -			\$ -	\$ -
17		\$ -	\$ -	\$ -	\$ -			\$ -	\$ -
18	Total Routine	\$ 248,000,000	\$ 67,040,000	\$ -	\$ 180,960,000	290,000		\$ 180,960	\$ 1,096.34
19	Weighted Average								

All cost report data. Calculation of routine cost per diems.

Observation Data (Non-Distinct)	Hospital Observation Days - Cost Report WIS 3, Pt. 1, Line 28.01, Col. 8	Subprovider I Observation Days - Cost Report WIS 3, Pt. 1, Line 28.01, Col. 8	Subprovider II Observation Days - Cost Report WIS 3, Pt. 1, Line 28.02, Col. 8	Calculated (Per Diem 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
20	002= Observation (Non-Distinct)	1,100	150	\$ 1,312,410	\$108,000.00	\$80,000.00	\$ 208,000.00	1.417829

Calculation of observation CCR - uses per diems calculated in first section to carve out and calculate observation cost.

DEDICATED TO GOVERNMENT HEALTH PROGRAMS



G. Cost Report - Cost / Days / Charges

Cost Report Year (01/01/2013-12/31/2013) Hospital ABC

Line #	Cost Center Description	Total Allowable Cost	Intern & Resident Costs Removed on Cost Report*	RCE and Therapy Add-Back (if Applicable)	Total Cost	IP	OIP Charges	Total Charges	Medicaid Per Diem / Cost-to-Charge Ratios
			Cost Report Worksheet B, Part I, Col. 26	Cost Report Worksheet B, Part I, Col. 25 (Item & Resident Other ONLY)*	Cost Report Worksheet C, Part I, Col. 2 and Col. 4	Calculated	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
<b>Ancillary Cost Centers (from WIS C excluding Observation) (list below)</b>									
21	01000 OPERATING ROOM	\$ 70,000,000	\$ -	\$ -	\$ 70,000,000	154,000,000	\$ 74,000,000	\$ 238,000,000	\$ 1,552.63
22	38000 RECOVERY ROOM	\$ 25,000,000	\$ -	\$ -	\$ 25,000,000	30,000,000	\$ 37,000,000	\$ 60,000,000	\$ 4,166.67
23	39000 DELIVER ROOM & LABOR ROOM	\$ 10,000,000	\$ 1,300,000	\$ -	\$ 8,700,000	11,000,000	\$ 9,000,000	\$ 2,000,000	\$ 1,818.18
24	40000 ANESTHESIOLOGY	\$ 13,000,000	\$ 7,500,000	\$ -	\$ 5,500,000	20,000,000	\$ 40,000,000	\$ 35,000,000	\$ 2,750.00
25	41000 RADIOLOGY - DIAGNOSTIC	\$ 50,000,000	\$ 1,600,000	\$ -	\$ 48,400,000	51,000,000	\$ 180,000,000	\$ 195,000,000	\$ 3,728.11
26	42000 RADIOLOGY - THERAPEUTIC	\$ 20,000,000	\$ -	\$ -	\$ 20,000,000	30,000,000	\$ 3,000,000	\$ 110,000,000	\$ 3,666.67
27	43000 RADIOISOTOPE	\$ 4,000,000	\$ 170,000	\$ -	\$ 3,830,000	5,000,000	\$ 11,000,000	\$ 16,000,000	\$ 3,200.00
28	44000 LABORATORY	\$ 50,000,000	\$ 6,400,000	\$ -	\$ 43,600,000	290,000,000	\$ 175,000,000	\$ 465,000,000	\$ 1,320.43
29	47000 BLOOD STORING PROCESSING & TRAN	\$ 40,000,000	\$ -	\$ -	\$ 40,000,000	110,000,000	\$ 95,000,000	\$ 150,000,000	\$ 1,363.64
30	48000 RESPIRATORY THERAPY	\$ 17,000,000	\$ -	\$ -	\$ 17,000,000	60,000,000	\$ 3,000,000	\$ 63,000,000	\$ 1,050.00
31	50000 PHYSICAL THERAPY	\$ 5,000,000	\$ -	\$ -	\$ 5,000,000	20,000,000	\$ 200,000	\$ 20,200,000	\$ 3,533.33
32	51000 OCCUPATIONAL THERAPY	\$ 2,500,000	\$ -	\$ -	\$ 2,500,000	10,000,000	\$ 100,000	\$ 1,100,000	\$ 1,100.00
33	52000 SPEECH PATHOLOGY	\$ 1,500,000	\$ -	\$ -	\$ 1,500,000	2,000,000	\$ 100,000	\$ 2,100,000	\$ 1,050.00
34	53000 ELECTROENCEPHALOGRAPHY	\$ 9,000,000	\$ -	\$ -	\$ 9,000,000	40,000,000	\$ 48,000,000	\$ 81,000,000	\$ 2,025.00
35	54000 ULTRASOUND	\$ 1,500,000	\$ 280,000	\$ -	\$ 1,220,000	7,000,000	\$ 780,000	\$ 2,380,000	\$ 3,400.00
36	55000 MEDICAL SUPPLIES CHARGED TO PATIENT	\$ 7,000,000	\$ -	\$ -	\$ 7,000,000	180,000,000	\$ 80,000,000	\$ 240,000,000	\$ 1,333.33
37	56000 NPI - DAY CHARGES TO PATIENT	\$ 120,000,000	\$ -	\$ -	\$ 120,000,000	180,000,000	\$ 50,000,000	\$ 250,000,000	\$ 1,388.89
38	59000 DRUGS CHARGED TO PATIENTS	\$ 120,000,000	\$ -	\$ -	\$ 120,000,000	270,000,000	\$ 90,000,000	\$ 360,000,000	\$ 1,333.33
39	67000 RENTAL ANALYSES	\$ 4,000,000	\$ -	\$ -	\$ 4,000,000	17,000,000	\$ 180,000	\$ 17,180,000	\$ 1,010.53
40	68000 CAT SCAN	\$ 10,000,000	\$ -	\$ -	\$ 10,000,000	78,000,000	\$ 118,000,000	\$ 190,000,000	\$ 2,437.50
41	69000 ULTRASOUND	\$ 4,500,000	\$ 75,000	\$ -	\$ 4,425,000	7,000,000	\$ 20,000,000	\$ 27,000,000	\$ 6,136.36
42	70000 CHEMICAL SYNTHESIZATION LABORATORY	\$ 12,500,000	\$ 500,000	\$ -	\$ 12,000,000	35,000,000	\$ 25,000,000	\$ 60,000,000	\$ 1,714.29
43	80000 ENDOSCOPY	\$ 8,500,000	\$ -	\$ -	\$ 8,500,000	10,000,000	\$ 35,000,000	\$ 38,000,000	\$ 4,588.24
44	82000 PSYCHIATRY/PSYCHOLOGICAL SERVICE	\$ 500,000	\$ -	\$ -	\$ 500,000	25,000	\$ 2,500,000	\$ 2,500,000	\$ 100.00
45	83000 CLINIC	\$ 20,000,000	\$ 10,800,000	\$ -	\$ 9,200,000	950,000	\$ 28,000,000	\$ 28,950,000	\$ 1,586.05
46	91000 EMERGENCY	\$ 30,500,000	\$ 10,300,000	\$ -	\$ 20,200,000	40,000,000	\$ 95,000,000	\$ 76,000,000	\$ 1,310.26
128	Total Ancillary	\$ 793,050,000	\$ 58,065,000	\$ -	\$ 734,985,000	621,145,000	\$ 1,718,585,000	\$ 2,995,581,000	\$ 2,280.60
129	Sub Totals	\$ 1,011,050,000	\$ 125,105,000	\$ -	\$ 885,945,000	1,136,185,000			
130	NF, SNF, and Swing Bed Cost for Medicaid (Sum of applicable Cost Report Worksheet D-3, Title 19, Column 3, Line 200 and Worksheet D, Part V, Title 19, Column 5-7, Line 200)				\$ 90.00				
131	NF, SNF, and Swing Bed Cost for Medicare (Sum of applicable Cost Report Worksheet D-3, Title 18, Column 3, Line 200 and Worksheet D, Part V, Title 18, Column 5-7, Line 200)				\$ 90.00				
132	NF, SNF, and Swing Bed Cost for Other Payers (Hospital must calculate. Submit support for calculation of cost.)				\$ 1,136,185,000				
133	Grand Totals				\$ 1,136,185,000				
134	Total Intern/Resident Cost as a Percent of Other Allowable Cost				12.38%				

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

Enter NF, SNF, and Swing bed costs for Medicaid and Medicare per cost report. Enter data for other payors per hospital internal records.

DEDICATED TO GOVERNMENT HEALTH PROGRAMS



## 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 Apr State  
Disproportionate Share Hospital (DSH) Expenditure Survey Part 2  
12/31/2013

All Medicaid categories.

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


Client Report Year (01/01/2013-12/31/2013) Hospital ABC

Line #	Cost Center Description	Medicaid Per Diem Cost for Routine Cost Centers	Medicaid Cost to Charge Ratio for Ancillary Cost Centers	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)	
				Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient
				From PSGR Summary (Note A)	From PSGR Summary (Note A)	From PSGR Summary (Note A)	From PSGR Summary (Note A)	From PSGR Summary (Note A)	From PSGR Summary (Note A)	From PSGR Summary (Note A)	From PSGR Summary (Note A)
<b>Routine Cost Centers (from Section G)</b>				<b>Days</b>							
1	010000 ADULT & PEDIATRIC	\$ 1,000.00				11,000					
2	011000 INTENSIVE CARE UNIT	\$ 2,000.00				20					
3	012000 CORONARY CARE UNIT	\$ 1,000.00				500					
4	013000 BURN INTENSIVE CARE UNIT	\$ 1,000.00				100					
5	014000 SURGICAL INTENSIVE CARE UNIT	\$ 1,750.00				140					
6	015000 CHEST SPECIAL CARE UNIT	\$ 1,000.00				200					
7	04000 SUBPROVIDER	\$ 1,212.73				3,000					
8	04100 SUBPROVIDER I	\$ ---				---					
9	04200 OTHER SUBPROVIDER	\$ ---				---					
10	04300 NURSE	\$ 340.00				1,213					
19				<b>Total Days</b>		<b>13,443</b>		<b>27,580</b>			
20	<b>Total Days per PSGR or Other Paid Claims Summary (Unreconciled Days (Begin Variance))</b>					<b>13,443</b>		<b>27,580</b>			
21				<b>Routine Charges</b>		<b>\$ 13,443,000</b>		<b>\$ 27,580,000</b>			
21.01	<b>Calculated Routine Charge Per Day:</b>					<b>\$ 1,000</b>		<b>\$ 1,000</b>			

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

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Property of Myers and Stauffer, L.C.
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DEDICATED TO GOVERNMENT HEALTH PROGRAMS



State of New York  
Department of Health (DOH) Division of Health Planning and Services  
13010313

Version 7.00

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

Cost Report Year (01/01/2015 - 12/31/2015) Hospital ABC

	Ancillary Cost Centers (from WS-CJ from Section G)	In-State Medicaid FFS Inpatient		In-State Medicaid Managed Care Inpatient		In-State Medicaid FFS Cross-Over (with Commercial Insurance)		In-State Other Medicaid Eligible (Not Commercial Insurance)	
		Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges
22	33001 CONSUMABLES, INDO-CHEMIST	1,417,992.00	133,000.00	1,417,992.00	133,000.00	1,417,992.00	133,000.00	1,417,992.00	133,000.00
23	33002 OPERATING ROOM	2,339,773.00	3,400,000.00	2,339,773.00	3,400,000.00	2,339,773.00	3,400,000.00	2,339,773.00	3,400,000.00
24	33003 RECOVERY ROOM	8,146,627.00	1,800,000.00	8,146,627.00	1,800,000.00	8,146,627.00	1,800,000.00	8,146,627.00	1,800,000.00
25	33004 FLEET ROOM & LABOR ROOM	1,827,773.00	700,000.00	1,827,773.00	700,000.00	1,827,773.00	700,000.00	1,827,773.00	700,000.00
26	4000 ANESTHESIOLOGY	2,373,333.00	1,900,000.00	2,373,333.00	1,900,000.00	2,373,333.00	1,900,000.00	2,373,333.00	1,900,000.00
27	4100 RADIOLOGY - DIAGNOSTIC	2,728,811.00	11,710,000.00	2,728,811.00	11,710,000.00	2,728,811.00	11,710,000.00	2,728,811.00	11,710,000.00
28	4200 RADIOLOGY - THERAPEUTIC	2,254,110.00	10,540,000.00	2,254,110.00	10,540,000.00	2,254,110.00	10,540,000.00	2,254,110.00	10,540,000.00
29	4300 RADIOGRAPHY	2,254,110.00	10,540,000.00	2,254,110.00	10,540,000.00	2,254,110.00	10,540,000.00	2,254,110.00	10,540,000.00
30	4400 LABORATORY	6,132,021.00	18,320,000.00	6,132,021.00	18,320,000.00	6,132,021.00	18,320,000.00	6,132,021.00	18,320,000.00
31	4500 X-RAY WORKING PROCESSING & TRAN	2,244,444.00	3,330,000.00	2,244,444.00	3,330,000.00	2,244,444.00	3,330,000.00	2,244,444.00	3,330,000.00
32	4600 RESPIRATORY THERAPY	2,244,444.00	3,330,000.00	2,244,444.00	3,330,000.00	2,244,444.00	3,330,000.00	2,244,444.00	3,330,000.00
33	4700 PHYSICAL THERAPY	2,244,444.00	3,330,000.00	2,244,444.00	3,330,000.00	2,244,444.00	3,330,000.00	2,244,444.00	3,330,000.00
34	4800 OCCUPATIONAL THERAPY	2,244,444.00	3,330,000.00	2,244,444.00	3,330,000.00	2,244,444.00	3,330,000.00	2,244,444.00	3,330,000.00
35	5000 SPEECH PATHOLOGY	2,244,444.00	3,330,000.00	2,244,444.00	3,330,000.00	2,244,444.00	3,330,000.00	2,244,444.00	3,330,000.00
36	5100 EYE OPTOMETROLOGY	2,244,444.00	3,330,000.00	2,244,444.00	3,330,000.00	2,244,444.00	3,330,000.00	2,244,444.00	3,330,000.00
37	5200 ELECTRODIAGNOSTIC EXAMINAT	2,244,444.00	3,330,000.00	2,244,444.00	3,330,000.00	2,244,444.00	3,330,000.00	2,244,444.00	3,330,000.00
38	5300 MEDICAL SUPPLIES CHARGED TO PATIENT	2,244,444.00	3,330,000.00	2,244,444.00	3,330,000.00	2,244,444.00	3,330,000.00	2,244,444.00	3,330,000.00
39	6000 SUPPLIES CHARGED TO PATIENT	2,244,444.00	3,330,000.00	2,244,444.00	3,330,000.00	2,244,444.00	3,330,000.00	2,244,444.00	3,330,000.00
40	6100 SUPPLIES CHARGED TO PATIENT	2,244,444.00	3,330,000.00	2,244,444.00	3,330,000.00	2,244,444.00	3,330,000.00	2,244,444.00	3,330,000.00
41	6200 CAT SCAN	2,244,444.00	3,330,000.00	2,244,444.00	3,330,000.00	2,244,444.00	3,330,000.00	2,244,444.00	3,330,000.00
42	6300 MRI	2,244,444.00	3,330,000.00	2,244,444.00	3,330,000.00	2,244,444.00	3,330,000.00	2,244,444.00	3,330,000.00
43	6400 PET/CT	2,244,444.00	3,330,000.00	2,244,444.00	3,330,000.00	2,244,444.00	3,330,000.00	2,244,444.00	3,330,000.00
44	6500 CARDIAC CATHETERIZATION LABORATORY	2,244,444.00	3,330,000.00	2,244,444.00	3,330,000.00	2,244,444.00	3,330,000.00	2,244,444.00	3,330,000.00
45	6600 RADIOLOGY	2,244,444.00	3,330,000.00	2,244,444.00	3,330,000.00	2,244,444.00	3,330,000.00	2,244,444.00	3,330,000.00
46	6700 PATHOLOGY-CYTOLOGICAL SERVICE	2,244,444.00	3,330,000.00	2,244,444.00	3,330,000.00	2,244,444.00	3,330,000.00	2,244,444.00	3,330,000.00
47	6800 ENDOSCOPY	2,244,444.00	3,330,000.00	2,244,444.00	3,330,000.00	2,244,444.00	3,330,000.00	2,244,444.00	3,330,000.00
48	6900 EMERGENCY	2,244,444.00	3,330,000.00	2,244,444.00	3,330,000.00	2,244,444.00	3,330,000.00	2,244,444.00	3,330,000.00
		<b>164,584,000.00</b>	<b>68,980,000.00</b>	<b>164,584,000.00</b>	<b>68,980,000.00</b>	<b>164,584,000.00</b>	<b>68,980,000.00</b>	<b>164,584,000.00</b>	<b>68,980,000.00</b>


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

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DEDICATED TO GOVERNMENT HEALTH PROGRAMS



**MYERS AND STAUFFER L.C.**  
CERTIFIED PUBLIC ACCOUNTANTS



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

- Medicaid Payments Include:
  - Claim payments.
  - NEW PAYMENT LINES – Payments should be broken out between payor sources
  - Payment lines added for Medicaid Managed Care payments, Medicare HMO payments, Private Insurance, and Self-Pay
- Medicaid cost report settlements.
- Medicare bad debt payments (cross-overs).
- Medicare cost report settlement payments (cross-overs).

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

State of New York  
 Disproportionate Share Hospital (DSH) Reconciliation Survey Part II  
 12/31/2013

Version 7.20

**H. In-State Medicaid and All Uninsured Inpatient and Outpatient Hospital Data:**  
 Cost Report Year (01/01/2013-12/31/2013) Hospital ABC

	In-State Medicaid PFS Primary	In-State Medicaid Managed Care Primary	In-State Medicaid PFS Cross-Over (with Medicaid Secondary)	In-State Medicaid Managed Care Cross-Over (with Medicaid Secondary)	In-State Medicaid PFS Other Medicaid Eligible (Not Included Cross-Over)	In-State Medicaid Managed Care Other Medicaid Eligible (Not Included Cross-Over)	In-State Medicaid PFS Other Medicaid Eligible (Not Included Cross-Over)
129 Total Charges per PFSAR or Other Paid Claims Summary (Unreconciled Charges (Credit) Variance)	\$ 199,890,000	\$ 96,950,000	\$ 38,985,000	\$ 31,770,000	\$ 187,730,000	\$ 89,175,000	\$ 11,100
130 Total Charges per PFSAR or Other Paid Claims Summary (Unreconciled Charges (Credit) Variance)	\$ 199,890,000	\$ 96,950,000	\$ 38,985,000	\$ 31,770,000	\$ 187,730,000	\$ 89,175,000	\$ 11,100
131 Total Calculated Cost (includes organ acquisition from Section J)	\$ 64,964,981	\$ 25,679,281	\$ 23,548,918	\$ 10,318,878	\$ 63,262,481	\$ 17,125,232	\$ 1,892
132 Total Medicaid Paid Amount (includes TPL, Co-Pay and Spend-Down)	\$ 49,300,000	\$ 20,000,000	\$ -	\$ -	\$ 1,000,000	\$ 2,000,000	\$ -
133 Total Medicaid Managed Care Paid Amount (includes TPL, Co-Pay and Spend-Down)	\$ 10,000,000	\$ 1,000,000	\$ 18,000,000	\$ 9,000,000	\$ 500,000	\$ 1,180,000	\$ -
134 Private Insurance (including primary and their party liability)	\$ 10,000	\$ 400,000	\$ 600,000	\$ 200,000	\$ 10,000	\$ 7,000	\$ -
135 Self-Pay (including Co-Pay and Spend-Down)	\$ 6,000	\$ 10,000	\$ 20,000	\$ 60,000	\$ 6,000	\$ 3,000	\$ -
136 Total Allowed Amount from Medicaid PFSAR or PA Detail (All Payments)	\$ 65,316,000	\$ 21,910,000	\$ 18,100,000	\$ 9,300,000			
137 Medicaid Cost Settlement Payments (See Note B)							
138 Other Medicaid Payments Reported on Cost Report Year (See Note C)							
139 Medicare Transitional (Pre-ACO) Paid Amount (includes concurrent beneficiaries)					\$ 60,000,000	\$ 10,000,000	\$ 1,000
140 Medicare Managed Care (pre-ACO) Paid Amount (includes concurrent beneficiaries)					\$ 10,000,000	\$ 800,000	\$ -
141 Medicare Cross-Over Bad Debt Payments					\$ 2,000,000	\$ 7,000	\$ 300
142 Other Medicare Cross-Over Payments (See Note D)					\$ 8,200,000	\$ 1,200,000	\$ -
143 Payment from Hospital Uninsured During Cost Report Year (Cash Basis)							
144 Section 1011 Payment Related to Inpatient Hospital Services NOT included in Exhibits B & B-1 (from Section E)							
145 Calculated Payment Shortfall (Longevity)	\$ 28,048,981	\$ 3,769,281	\$ 7,448,918	\$ 1,018,878	\$ 8,302,530	\$ 2,289,232	\$ 892
146 Calculated Payments as a Percentage of Cost	65%	92%	85%	90%	113%	87%	89%

Enter in all Medicaid, Medicare, Private Insurance, Self-Pay, Cost Settlement, and Medicare Crossover payments. **NEW LINES** to split out Medicaid Managed Care, Medicare Managed Care, and Private Insurance Payments.

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DEDICATED TO GOVERNMENT HEALTH PROGRAMS

**MYERS AND STAUFFER L.C.**  
 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



# DSH SURVEY PART II SECTION H, UNINSURED

- State-only claims with no Medicare or private insurance liability can be included in Exhibit A.
- Exception: State-only indigent care programs delivered by a private Managed Care Organization (MCO) should be submitted on Exhibit C to ensure proper reporting of payments received from the MCO. Cost and payments should still be included in uninsured columns of DSH Survey Part II.
- See Additional Information of the DSH Reporting and Audit Requirements – Part 2, clarification published April 7, 2014, item # 12.

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

State of New York  
Department of Health - Office of Health Planning and Standards  
1/15/2015

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

Client Agency: ABC

Line #	Code Center Description	Medicaid Fee Charge Rates by Center		Uninsured	
		From Section G	From Medicaid's Case Internal Analysis	Inpatient (See Exhibit A)	Outpatient (See Exhibit A)
				Days	
1	ADULT INPATIENT	1,200.00		10	
2	ADULT OUTPATIENT	2,500.00		5	
3	CHILD INPATIENT	1,000.00		10	
4	CHILD OUTPATIENT	1,500.00		5	
5	OBSTETRIC INPATIENT	1,500.00		10	
6	OBSTETRIC OUTPATIENT	1,000.00		5	
7	PSYCHIATRY INPATIENT	1,000.00		10	
8	PSYCHIATRY OUTPATIENT	1,000.00		5	
9	SKILLED NURSING INPATIENT	1,000.00		10	
10	SKILLED NURSING OUTPATIENT	1,000.00		5	
11	WOUND HEALING INPATIENT	1,000.00		10	
12	WOUND HEALING OUTPATIENT	1,000.00		5	
13	OTHER INPATIENT	1,000.00		10	
14	OTHER OUTPATIENT	1,000.00		5	
15	TOTAL DAYS PER FTE/FULL OR OTHER FTE/DAYS SUMMARY				
16	UNINSURED DAYS (EXHIBIT A)				

Line #	Code Center Description	Medicaid Fee Charge Rates by Center	Uninsured
		From Section G	From Medicaid's Case Internal Analysis
17	ADULT INPATIENT	1,200.00	10
18	ADULT OUTPATIENT	2,500.00	5
19	CHILD INPATIENT	1,000.00	10
20	CHILD OUTPATIENT	1,500.00	5
21	OBSTETRIC INPATIENT	1,500.00	10
22	OBSTETRIC OUTPATIENT	1,000.00	5
23	PSYCHIATRY INPATIENT	1,000.00	10
24	PSYCHIATRY OUTPATIENT	1,000.00	5
25	SKILLED NURSING INPATIENT	1,000.00	10
26	SKILLED NURSING OUTPATIENT	1,000.00	5
27	WOUND HEALING INPATIENT	1,000.00	10
28	WOUND HEALING OUTPATIENT	1,000.00	5
29	OTHER INPATIENT	1,000.00	10
30	OTHER OUTPATIENT	1,000.00	5
31	TOTAL CHARGES (INCLUDES ORGAN ACQUISITION FROM SECTION J)		
32	TOTAL CHARGES PER FTE/FULL OR OTHER FTE/DAYS SUMMARY		
33	UNINSURED CHARGES (EXHIBIT A)		

Line #	Code Center Description	Medicaid Fee Charge Rates by Center	Uninsured
		From Section G	From Medicaid's Case Internal Analysis
34	ADULT INPATIENT	1,200.00	10
35	ADULT OUTPATIENT	2,500.00	5
36	CHILD INPATIENT	1,000.00	10
37	CHILD OUTPATIENT	1,500.00	5
38	OBSTETRIC INPATIENT	1,500.00	10
39	OBSTETRIC OUTPATIENT	1,000.00	5
40	PSYCHIATRY INPATIENT	1,000.00	10
41	PSYCHIATRY OUTPATIENT	1,000.00	5
42	SKILLED NURSING INPATIENT	1,000.00	10
43	SKILLED NURSING OUTPATIENT	1,000.00	5
44	WOUND HEALING INPATIENT	1,000.00	10
45	WOUND HEALING OUTPATIENT	1,000.00	5
46	OTHER INPATIENT	1,000.00	10
47	OTHER OUTPATIENT	1,000.00	5
48	TOTAL CHARGES (INCLUDES ORGAN ACQUISITION FROM SECTION J)		
49	TOTAL CHARGES PER FTE/FULL OR OTHER FTE/DAYS SUMMARY		
50	UNINSURED CHARGES (EXHIBIT A)		

Line #	Code Center Description	Medicaid Fee Charge Rates by Center	Uninsured
		From Section G	From Medicaid's Case Internal Analysis
51	ADULT INPATIENT	1,200.00	10
52	ADULT OUTPATIENT	2,500.00	5
53	CHILD INPATIENT	1,000.00	10
54	CHILD OUTPATIENT	1,500.00	5
55	OBSTETRIC INPATIENT	1,500.00	10
56	OBSTETRIC OUTPATIENT	1,000.00	5
57	PSYCHIATRY INPATIENT	1,000.00	10
58	PSYCHIATRY OUTPATIENT	1,000.00	5
59	SKILLED NURSING INPATIENT	1,000.00	10
60	SKILLED NURSING OUTPATIENT	1,000.00	5
61	WOUND HEALING INPATIENT	1,000.00	10
62	WOUND HEALING OUTPATIENT	1,000.00	5
63	OTHER INPATIENT	1,000.00	10
64	OTHER OUTPATIENT	1,000.00	5
65	TOTAL CHARGES (INCLUDES ORGAN ACQUISITION FROM SECTION J)		
66	TOTAL CHARGES PER FTE/FULL OR OTHER FTE/DAYS SUMMARY		
67	UNINSURED CHARGES (EXHIBIT A)		

Line #	Code Center Description	Medicaid Fee Charge Rates by Center	Uninsured
		From Section G	From Medicaid's Case Internal Analysis
68	ADULT INPATIENT	1,200.00	10
69	ADULT OUTPATIENT	2,500.00	5
70	CHILD INPATIENT	1,000.00	10
71	CHILD OUTPATIENT	1,500.00	5
72	OBSTETRIC INPATIENT	1,500.00	10
73	OBSTETRIC OUTPATIENT	1,000.00	5
74	PSYCHIATRY INPATIENT	1,000.00	10
75	PSYCHIATRY OUTPATIENT	1,000.00	5
76	SKILLED NURSING INPATIENT	1,000.00	10
77	SKILLED NURSING OUTPATIENT	1,000.00	5
78	WOUND HEALING INPATIENT	1,000.00	10
79	WOUND HEALING OUTPATIENT	1,000.00	5
80	OTHER INPATIENT	1,000.00	10
81	OTHER OUTPATIENT	1,000.00	5
82	TOTAL CHARGES (INCLUDES ORGAN ACQUISITION FROM SECTION J)		
83	TOTAL CHARGES PER FTE/FULL OR OTHER FTE/DAYS SUMMARY		
84	UNINSURED CHARGES (EXHIBIT A)		

Line #	Code Center Description	Medicaid Fee Charge Rates by Center	Uninsured
		From Section G	From Medicaid's Case Internal Analysis
85	ADULT INPATIENT	1,200.00	10
86	ADULT OUTPATIENT	2,500.00	5
87	CHILD INPATIENT	1,000.00	10
88	CHILD OUTPATIENT	1,500.00	5
89	OBSTETRIC INPATIENT	1,500.00	10
90	OBSTETRIC OUTPATIENT	1,000.00	5
91	PSYCHIATRY INPATIENT	1,000.00	10
92	PSYCHIATRY OUTPATIENT	1,000.00	5
93	SKILLED NURSING INPATIENT	1,000.00	10
94	SKILLED NURSING OUTPATIENT	1,000.00	5
95	WOUND HEALING INPATIENT	1,000.00	10
96	WOUND HEALING OUTPATIENT	1,000.00	5
97	OTHER INPATIENT	1,000.00	10
98	OTHER OUTPATIENT	1,000.00	5
99	TOTAL CHARGES (INCLUDES ORGAN ACQUISITION FROM SECTION J)		
100	TOTAL CHARGES PER FTE/FULL OR OTHER FTE/DAYS SUMMARY		
101	UNINSURED CHARGES (EXHIBIT A)		

Line #	Code Center Description	Medicaid Fee Charge Rates by Center	Uninsured
		From Section G	From Medicaid's Case Internal Analysis
102	ADULT INPATIENT	1,200.00	10
103	ADULT OUTPATIENT	2,500.00	5
104	CHILD INPATIENT	1,000.00	10
105	CHILD OUTPATIENT	1,500.00	5
106	OBSTETRIC INPATIENT	1,500.00	10
107	OBSTETRIC OUTPATIENT	1,000.00	5
108	PSYCHIATRY INPATIENT	1,000.00	10
109	PSYCHIATRY OUTPATIENT	1,000.00	5
110	SKILLED NURSING INPATIENT	1,000.00	10
111	SKILLED NURSING OUTPATIENT	1,000.00	5
112	WOUND HEALING INPATIENT	1,000.00	10
113	WOUND HEALING OUTPATIENT	1,000.00	5
114	OTHER INPATIENT	1,000.00	10
115	OTHER OUTPATIENT	1,000.00	5
116	TOTAL CHARGES (INCLUDES ORGAN ACQUISITION FROM SECTION J)		
117	TOTAL CHARGES PER FTE/FULL OR OTHER FTE/DAYS SUMMARY		
118	UNINSURED CHARGES (EXHIBIT A)		

Line #	Code Center Description	Medicaid Fee Charge Rates by Center	Uninsured
		From Section G	From Medicaid's Case Internal Analysis
119	ADULT INPATIENT	1,200.00	10
120	ADULT OUTPATIENT	2,500.00	5
121	CHILD INPATIENT	1,000.00	10
122	CHILD OUTPATIENT	1,500.00	5
123	OBSTETRIC INPATIENT	1,500.00	10
124	OBSTETRIC OUTPATIENT	1,000.00	5
125	PSYCHIATRY INPATIENT	1,000.00	10
126	PSYCHIATRY OUTPATIENT	1,000.00	5
127	SKILLED NURSING INPATIENT	1,000.00	10
128	SKILLED NURSING OUTPATIENT	1,000.00	5
129	WOUND HEALING INPATIENT	1,000.00	10
130	WOUND HEALING OUTPATIENT	1,000.00	5
131	OTHER INPATIENT	1,000.00	10
132	OTHER OUTPATIENT	1,000.00	5
133	TOTAL CHARGES (INCLUDES ORGAN ACQUISITION FROM SECTION J)		
134	TOTAL CHARGES PER FTE/FULL OR OTHER FTE/DAYS SUMMARY		
135	UNINSURED CHARGES (EXHIBIT A)		

Line #	Code Center Description	Medicaid Fee Charge Rates by Center	Uninsured
		From Section G	From Medicaid's Case Internal Analysis
136	ADULT INPATIENT	1,200.00	10
137	ADULT OUTPATIENT	2,500.00	5
138	CHILD INPATIENT	1,000.00	10
139	CHILD OUTPATIENT	1,500.00	5
140	OBSTETRIC INPATIENT	1,500.00	10
141	OBSTETRIC OUTPATIENT	1,000.00	5
142	PSYCHIATRY INPATIENT	1,000.00	10
143	PSYCHIATRY OUTPATIENT	1,000.00	5
144	SKILLED NURSING INPATIENT	1,000.00	10
145	SKILLED NURSING OUTPATIENT	1,000.00	5
146	WOUND HEALING INPATIENT	1,000.00	10
147	WOUND HEALING OUTPATIENT	1,000.00	5
148	OTHER INPATIENT	1,000.00	10
149	OTHER OUTPATIENT	1,000.00	5
150	TOTAL CHARGES (INCLUDES ORGAN ACQUISITION FROM SECTION J)		
151	TOTAL CHARGES PER FTE/FULL OR OTHER FTE/DAYS SUMMARY		
152	UNINSURED CHARGES (EXHIBIT A)		

Line #	Code Center Description	Medicaid Fee Charge Rates by Center	Uninsured
		From Section G	From Medicaid's Case Internal Analysis
153	ADULT INPATIENT	1,200.00	10
154	ADULT OUTPATIENT	2,500.00	5
155	CHILD INPATIENT	1,000.00	10
156	CHILD OUTPATIENT	1,500.00	5
157	OBSTETRIC INPATIENT	1,500.00	10
158	OBSTETRIC OUTPATIENT	1,000.00	5
159	PSYCHIATRY INPATIENT	1,000.00	10
160	PSYCHIATRY OUTPATIENT	1,000.00	5
161	SKILLED NURSING INPATIENT	1,000.00	10
162	SKILLED NURSING OUTPATIENT	1,000.00	5
163	WOUND HEALING INPATIENT	1,000.00	10
164	WOUND HEALING OUTPATIENT	1,000.00	5
165	OTHER INPATIENT	1,000.00	10
166	OTHER OUTPATIENT	1,000.00	5
167	TOTAL CHARGES (INCLUDES ORGAN ACQUISITION FROM SECTION J)		
168	TOTAL CHARGES PER FTE/FULL OR OTHER FTE/DAYS SUMMARY		
169	UNINSURED CHARGES (EXHIBIT A)		

Line #	Code Center Description	Medicaid Fee Charge Rates by Center	Uninsured
		From Section G	From Medicaid's Case Internal Analysis
170	ADULT INPATIENT	1,200.00	10
171	ADULT OUTPATIENT	2,500.00	5
172	CHILD INPATIENT	1,000.00	10
173	CHILD OUTPATIENT	1,500.00	5
174	OBSTETRIC INPATIENT	1,500.00	10
175	OBSTETRIC OUTPATIENT	1,000.00	5
176	PSYCHIATRY INPATIENT	1,000.00	10
177	PSYCHIATRY OUTPATIENT	1,000.00	5
178	SKILLED NURSING INPATIENT	1,000.00	10
179	SKILLED NURSING OUTPATIENT	1,000.00	5
180	WOUND HEALING INPATIENT	1,000.00	10
181	WOUND HEALING OUTPATIENT	1,000.00	5
182	OTHER INPATIENT	1,000.00	10
183	OTHER OUTPATIENT	1,000.00	5
184	TOTAL CHARGES (INCLUDES ORGAN ACQUISITION FROM SECTION J)		
185	TOTAL CHARGES PER FTE/FULL OR OTHER FTE/DAYS SUMMARY		
186	UNINSURED CHARGES (EXHIBIT A)		

Form 101 (2015)

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## ■ 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 a UPL, GME, outlier, and supplemental payments.
  2. The hospital provides a certification that it incurred additional uncompensated care costs serving uninsured individuals.

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## ■ 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 may be partially based on states targeting DSH payments to hospitals with high uninsured and Medicaid populations.

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## ■ 2014 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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## ■ 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.

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## 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.

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

Version 1.00

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

Enter the following information for each organ type:

Organ Acquisition Cost	Additional Add-on Administrative Cost	Total Adjusted Organ Acquisition Cost	Revenue for Total Organ Acquisition Cost (Uninsured/Other Payers)	Total Medicare Organ Charges	In-State Medicaid PPS Primary		In-State Medicaid Managed Care Primary		In-State Medicaid PPS Case Rates (All Medicaid Services)		In-State Other Medicaid Eligible But Not Medicaid Services		Uninsured	
					Charges	Medicare Payers (Count)	Charges	Medicare Payers (Count)	Charges	Medicare Payers (Count)	Charges	Medicare Payers (Count)	Charges	Medicare Payers (Count)
Cost Report Worksheet (D-4) (R, W, Col. 1, Ltr. A)	Medi-Cal Cost Factor (W, Section 2, Col. 1, Ltr. A) (R, W, Col. 1, Ltr. A)	Sum of Col. 1 and Col. 2 (R, W, Col. 1, Ltr. A)	Enter in Institution from Cost Report (R, W, Section 2, Col. 1, Ltr. A) (R, W, Col. 1, Ltr. A)	Cost Report Worksheet (D-4) (R, W, Col. 1, Ltr. A)	From Paid Claims (Col. of Provider Log: (R) (W) (A))	From Paid Claims (Col. of Provider Log: (R) (W) (A))	From Paid Claims (Col. of Provider Log: (R) (W) (A))	From Paid Claims (Col. of Provider Log: (R) (W) (A))	From Paid Claims (Col. of Provider Log: (R) (W) (A))	From Paid Claims (Col. of Provider Log: (R) (W) (A))	From Paid Claims (Col. of Provider Log: (R) (W) (A))	From Medicaid's Cost Internal Analysis	From Medicaid's Cost Internal Analysis	
1	0.00	0.00												
2	0.00	0.00												
3	0.00	0.00												
4	0.00	0.00												
5	0.00	0.00												
6	0.00	0.00												
7	0.00	0.00												
8	0.00	0.00												
9	0.00	0.00												
10	0.00	0.00												

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

Enter the following information for each organ type:

Organ Acquisition Cost	Additional Add-on Administrative Cost	Total Adjusted Organ Acquisition Cost	Revenue for Total Organ Acquisition Cost (Uninsured/Other Payers)	Total Medicare Organ Charges	Out-of-State Medicaid PPS Primary		Out-of-State Medicaid Managed Care Primary		Out-of-State Medicaid PPS Case Rates (All Medicaid Services)		Out-of-State Other Medicaid Eligible But Not Medicaid Services		Uninsured	
					Charges	Medicare Payers (Count)	Charges	Medicare Payers (Count)	Charges	Medicare Payers (Count)	Charges	Medicare Payers (Count)		
Cost Report Worksheet (D-4) (R, W, Col. 1, Ltr. A)	Medi-Cal Cost Factor (W, Section 2, Col. 1, Ltr. A) (R, W, Col. 1, Ltr. A)	Sum of Col. 1 and Col. 2 (R, W, Col. 1, Ltr. A)	Enter in Institution from Cost Report (R, W, Section 2, Col. 1, Ltr. A) (R, W, Col. 1, Ltr. A)	Cost Report Worksheet (D-4) (R, W, Col. 1, Ltr. A)	From Paid Claims (Col. of Provider Log: (R) (W) (A))	From Paid Claims (Col. of Provider Log: (R) (W) (A))	From Paid Claims (Col. of Provider Log: (R) (W) (A))	From Paid Claims (Col. of Provider Log: (R) (W) (A))	From Paid Claims (Col. of Provider Log: (R) (W) (A))	From Paid Claims (Col. of Provider Log: (R) (W) (A))	From Paid Claims (Col. of Provider Log: (R) (W) (A))	From Medicaid's Cost Internal Analysis	From Medicaid's Cost Internal Analysis	
11	0.00	0.00												
12	0.00	0.00												
13	0.00	0.00												
14	0.00	0.00												
15	0.00	0.00												
16	0.00	0.00												
17	0.00	0.00												
18	0.00	0.00												
19	0.00	0.00												
20	0.00	0.00												

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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 discharges 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, Name, Admit, Discharge, Service Indicator, Revenue Code, Total Charges, Days, Patient Payments, Private Insurance Payments, 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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BABA A - Uninsured Charges

Claim Type (A)	Plan (B)	Primary Payer	Secondary Payer Plan (C)	Hospital's Medicaid Provider # (D)	Patient Identifier # (E)	Patient's Birth Date (F)	Patient's Social Security Number (G)	Patient's Gender (H)	Patient's Name (I)	Admit Date (J)	Discharge Date (K)	Service Indicator (L)	Revenue Code (M)	Total Charges Provided (N)	Revenue Days of Date (O)	1099-INTEN Payments for Services Provided (P)	1099-INTEN Insurance Payments for Services Provided (Q)	Claim Status Exhausted or Non-Covered Service, if applicable (R)
Uninsured Charges - Charity	Self-Pay			12345	000000	1/1/1980	999-99-9999	Female	Doc, Jane	3/1/2010	3/1/2010	Inpatient	100	\$ 4,000.00				
Uninsured Charges - Charity	Self-Pay			12345	000000	1/1/1980	999-99-9999	Female	Doc, Jane	3/1/2010	3/1/2010	Inpatient	200	\$ 4,000.00				
Uninsured Charges - Charity	Self-Pay			12345	000000	1/1/1980	999-99-9999	Female	Doc, Jane	3/1/2010	3/1/2010	Inpatient	300	\$ 2,000.00				
Uninsured Charges - Charity	Self-Pay			12345	000000	1/1/1980	999-99-9999	Female	Doc, Jane	3/1/2010	3/1/2010	Inpatient	400	\$ 2,000.00				
Uninsured Charges - Charity	Self-Pay			12345	000000	1/1/1980	999-99-9999	Female	Doc, Jane	3/1/2010	3/1/2010	Inpatient	500	\$ 10,000.00				
Uninsured Charges - Charity	Self-Pay			12345	000000	1/1/1980	999-99-9999	Female	Doc, Jane	3/1/2010	3/1/2010	Inpatient	400	\$ 1,000.00				
Uninsured Charges - Medicare				12345	444444	7/1/1980	999-99-9999	Male	Jones, James	6/15/2010	6/15/2010	Outpatient	200	\$ 100.00	\$ 500.00			Exhausted
Uninsured Charges - Medicare				12345	444444	7/1/1980	999-99-9999	Male	Jones, James	6/15/2010	6/15/2010	Outpatient	400	\$ 700.00	\$ 500.00			Exhausted
Uninsured Charges - Blue Cross				12345	111111	3/1/2000	999-99-9999	Male	Smith, Mike	8/1/2010	8/1/2010	Outpatient	400	\$ 1,000.00			\$ 100.00	Non-Covered Service

Exhibit A - Uninsured charges/days

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## ■ 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.

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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 2014 cost report year that relates to a service provided in the 2008 cost report year, must be used to reduce uninsured cost for the 2014 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, 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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Primary Payor Plan	Secondary Payor Plan	Transaction Code	Hospital's Medical Record #	Patient's Medical Record #	Patient's Birth Date	Patient's Social Security Number	Patient's Name	Admit Date	Discharge Date	Date of Cash Collection	Amount of Cash Collection	Indicator if Collection is a 1011 Payment	Service Indicator (Hospital/Physician/Non-Hospital)	Total Hospital Charges for Service Provided	Total Physician Charges for Service Provided	Total Other Non-Hospital Charges	Insurance Status	Claim Status	Calculated Collection
Self Pay Payments	Medicaid	Medicaid	000000	000000	01/01/00	000-00-0000	John, Anthony	01/01/00	01/01/00	01/01/00	100	No	Hospital	10000	0	0	Medicaid	Unpaid	10000
Self Pay Payments	Medicaid	Medicaid	000000	000000	01/01/00	000-00-0000	John, Anthony	01/01/00	01/01/00	01/01/00	100	No	Physician	0	10000	0	Medicaid	Unpaid	10000
Self Pay Payments	Blue Cross	Blue Cross	000000	000000	01/01/00	000-00-0000	John, Anthony	01/01/00	01/01/00	01/01/00	100	No	Hospital	10000	0	0	Blue Cross	Unpaid	10000
Self Pay Payments	Blue Cross	Blue Cross	000000	000000	01/01/00	000-00-0000	John, Anthony	01/01/00	01/01/00	01/01/00	100	No	Physician	0	10000	0	Blue Cross	Unpaid	10000
Self Pay Payments	Self Pay	Self Pay	000000	000000	01/01/00	000-00-0000	John, Anthony	01/01/00	01/01/00	01/01/00	100	No	Hospital	10000	0	0	Self Pay	Unpaid	10000
Self Pay Payments	Self Pay	Self Pay	000000	000000	01/01/00	000-00-0000	John, Anthony	01/01/00	01/01/00	01/01/00	100	No	Physician	0	10000	0	Self Pay	Unpaid	10000

Exhibit B - Cash Basis Patient Payments

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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 Medicaid/Medicare cross-over 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, Name, Admit, Discharge, Service Indicator, Rev Code, Total Charges, Days, Medicare Traditional Payments, Medicare Managed Care Payments, Medicaid FFS Payments, Medicaid Managed Care Payments, Private Insurance 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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MSD ID	Primary Payor Plan	Secondary Payor Plan	Hospital #	PCN	Patient's MCD Recipient #	Patient's DOB	Patient's Name	Patient's Address	Admit Date	Discharge Date	Service Indicator	Total Charges	Medicare Traditional Payments	Medicare Managed Care Payments	Medicaid FFS Payments	Medicaid Managed Care Payments	Private Insurance Payments	Self-Pay Payments	Sum All Payments
MSD001	MSD001	MSD001	MSD001	MSD001	MSD001	MSD001	MSD001	MSD001	MSD001	MSD001	MSD001	MSD001	MSD001	MSD001	MSD001	MSD001	MSD001	MSD001	MSD001
MSD002	MSD002	MSD002	MSD002	MSD002	MSD002	MSD002	MSD002	MSD002	MSD002	MSD002	MSD002	MSD002	MSD002	MSD002	MSD002	MSD002	MSD002	MSD002	MSD002
MSD003	MSD003	MSD003	MSD003	MSD003	MSD003	MSD003	MSD003	MSD003	MSD003	MSD003	MSD003	MSD003	MSD003	MSD003	MSD003	MSD003	MSD003	MSD003	MSD003
MSD004	MSD004	MSD004	MSD004	MSD004	MSD004	MSD004	MSD004	MSD004	MSD004	MSD004	MSD004	MSD004	MSD004	MSD004	MSD004	MSD004	MSD004	MSD004	MSD004
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MSD006	MSD006	MSD006	MSD006	MSD006	MSD006	MSD006	MSD006	MSD006	MSD006	MSD006	MSD006	MSD006	MSD006	MSD006	MSD006	MSD006	MSD006	MSD006	MSD006
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MSD008	MSD008	MSD008	MSD008	MSD008	MSD008	MSD008	MSD008	MSD008	MSD008	MSD008	MSD008	MSD008	MSD008	MSD008	MSD008	MSD008	MSD008	MSD008	MSD008
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EXHIBIT C - MANAGED CARE

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## ■ 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 examination.
- 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, Medicare cross-over, 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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## ■ 2014 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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## ■ 2014 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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## ■ 2014 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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## ■ 2014 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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## ■ 2014 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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## ■ 2014 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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## ■ 2014 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.
- CMS Proposed Rule issued 8/15/16 specifically defines uncompensated costs as net of all payments to Medicaid eligible patients.
- 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 FFS, Medicaid Managed Care, Medicare Traditional, Medicare Managed Care, Private Insurance and Self-Pay payments into their individual columns as laid out in the Exhibit A-C template that was provided.

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## ■ 2014 CHANGES

- Website: <https://dsh.mslc.com>
- Each hospital must return web portal registration form in order to receive access
- New method for transmitting detailed Medicaid claims files to hospitals and for hospitals to submit the required documentation.
- HIPAA compliant Web Portal, secure, two-way file transmissions through a hospital-specific web page
- Faster and more user-friendly than mailing encrypted CDs or maintaining FTP accounts

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## ■ 2014 CHANGES

- Website: first time log-in
  - Click Forgot Password
  - Enter the email address and click Send Forgot Password Email.
  - Expect an email from MSLC with a link to set the password.
  - Log-in to the website using email address and new password.
  - Review and confirm providers visible on your account.

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## ■ 2014 CHANGES

- Website: upload and download
  - MMIS data will be sent via website
  - Upload documents on DSH checklist
  - MSLC will review, accept or reject
    - Once document is approved provider is no longer able to upload to that event.
    - Will need to notify MSLC of need to revise as-filed documents.

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## ■ PRIOR YEAR DSH EXAMINATION (2013)

### 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.
- Some hospitals failed to provide complete Other Medicaid Eligible data.

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## ■ PRIOR YEAR DSH EXAMINATION (2013)

### 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 (2013)

### 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 (2013)

### 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 (2013)

### 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 (2013)

### 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.).

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## ■ PRIOR YEAR DSH EXAMINATION (2013)

### 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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## ■ 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 web portal:  
<https://dsh.mslc.com>

Contacts:

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Latoria Henderson (804) 418-8164

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Johanna Linkenhoker (804) 418-8125

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

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# SFY 2018 DSH Submission Requirements

State of Nevada  
Division of Health Care Financing & Policy



## SFY 2018 DSH Submission Timeline

Submission Requirement	Due Date
<p>OB Survey</p> <ul style="list-style-type: none"> <li>• Required from all NV hospitals</li> <li>• Urban vs. Rural</li> </ul>	<p>Friday, January 20, 2017</p>
<p>MIUR Template</p> <ul style="list-style-type: none"> <li>• Required from all NV hospitals</li> <li>• CRS Reports to be sent 2/1/2017 (may request CRS reports as early as 1/9/2017)</li> </ul>	<p>Friday, February 17, 2017</p>
<p>LIUR Template</p> <ul style="list-style-type: none"> <li>• Required from all <i>potentially eligible</i> hospitals (hospitals required to file will be notified)</li> </ul>	<p>Friday, March 24, 2017</p>
<p>UCCR &amp; Backup</p> <ul style="list-style-type: none"> <li>• Required from all <i>eligible</i> hospitals (hospitals required to file will be notified)</li> </ul>	<p>Friday, June 2, 2017</p>

**Note:** All submission templates are available on the DHCFP website: <http://dhcftp.nv.gov/Resources/Rates/RatesSupplementalPymtDSH/>  
Due dates listed are the **latest** acceptable date of submission. Items may be submitted any time prior to the scheduled due date.



## DHCFP Secure FTP

- ▶ Uncompensated Care Cost Reports and related backup should be submitted via SFTP
  - ▶ More secure  
(It is recommended that all files containing PHI still be encrypted and password protected)
  - ▶ Instant access to files
- ▶ All participating hospitals may be granted access to the DHCFP SFTP
  - ▶ Limited to no more than two users per facility
- ▶ Instructions for use will be posted to the DHCFP website and provided to each user upon access approval
- ▶ Contact Amber LaFollette to obtain SFTP credentials:  
*[alafollette@drcfp.nv.gov](mailto:alafollette@drcfp.nv.gov) / 775-684-3173*

▶ <https://mmft.nv.gov/>



## DSH Workgroup

- ▶ A Public Workshop has tentatively been scheduled to discuss the State of Nevada DSH program:

**Date of Meeting:** December 12, 2016

**Time of Meeting:** 1:30 PM

**Place of Meeting:** Public Utilities Commission  
1150 East William Street, Hearing Room B  
Carson City, Nevada 89701

**Place of Video-Conference:** Public Utilities Commission  
9075 West Diablo Drive, Suite 250, Hearing Room B  
Las Vegas, NV 89148

▶ *Additional details and an agenda will be provided when the official notice is published.*



## DHCFP Contacts for SFY 2018 DSH

State of Nevada  
Division of Health Care Financing & Policy

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*Primary DSH Contact:*

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