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

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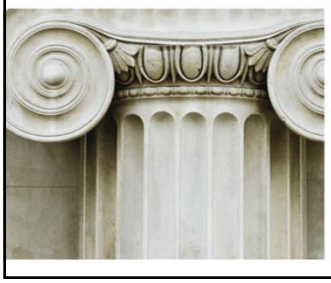


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OVERVIEW

- 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 4th, 2016
- Surveys returned by December 9th, 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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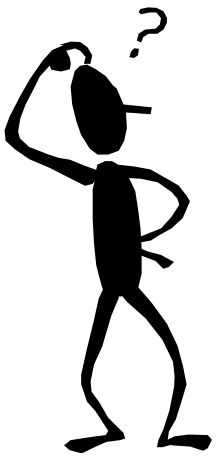

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PAID CLAIMS DATA UPDATE FOR 2014

- 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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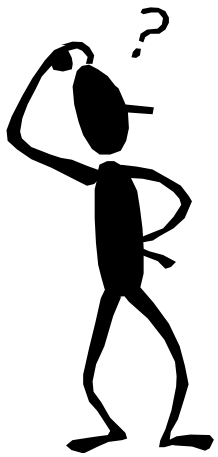

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DSH EXAMINATION SURVEYS

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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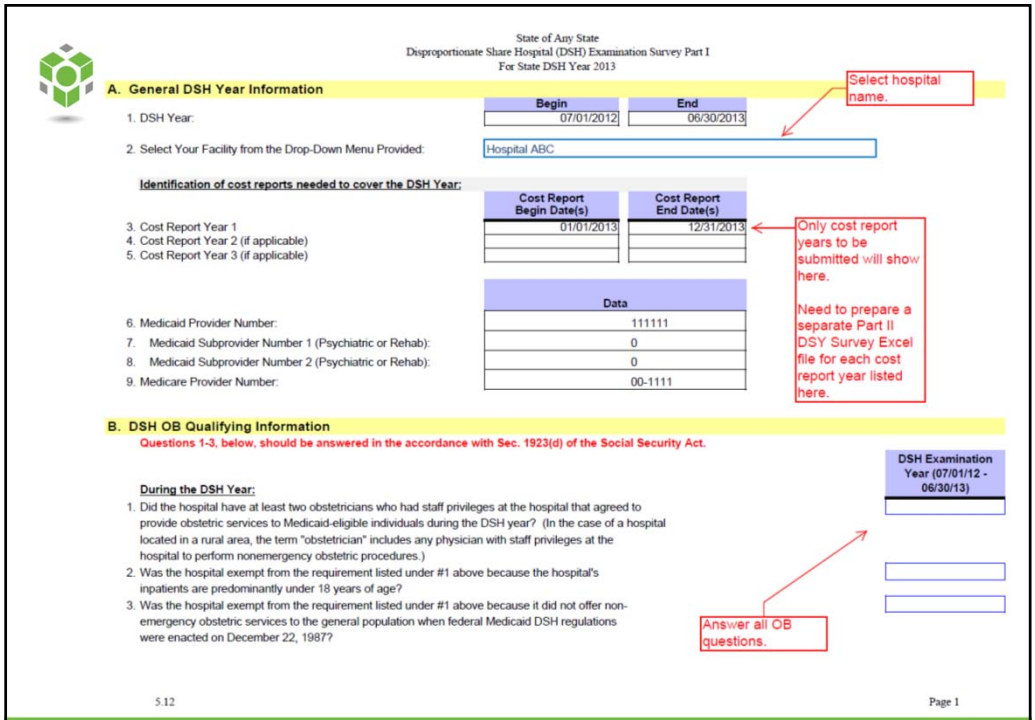

State of Any State
Disproportionate Share Hospital (DSH) Examination Survey Part I
For State DSH Year 2013

A. General DSH Year Information

Select hospital name.

	Begin	End
1. DSH Year:	07/01/2012	06/30/2013

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

Identification of cost reports needed to cover the DSH Year:

	Cost Report Begin Date(s)	Cost Report End Date(s)
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.

Need to prepare a separate Part II DSY Survey Excel file for each cost report year listed 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:	DSH Examination Year (07/01/12 - 06/30/13)
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.

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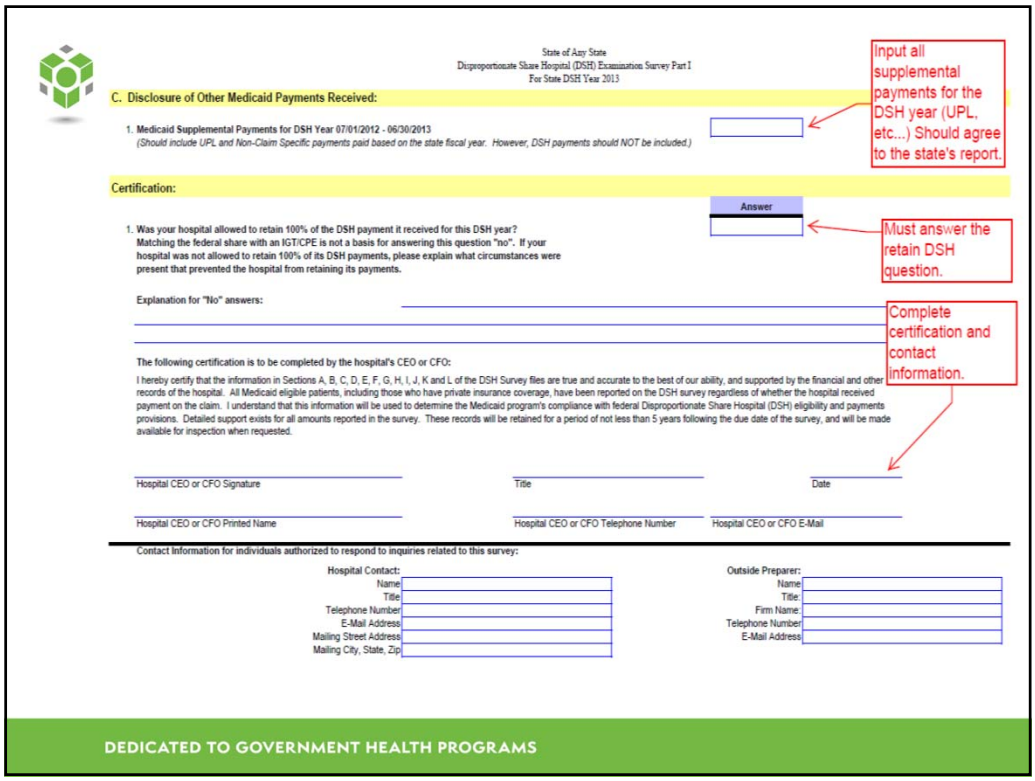

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DSH YEAR SURVEY PART II SECTION D – GENERAL INFORMATION

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

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

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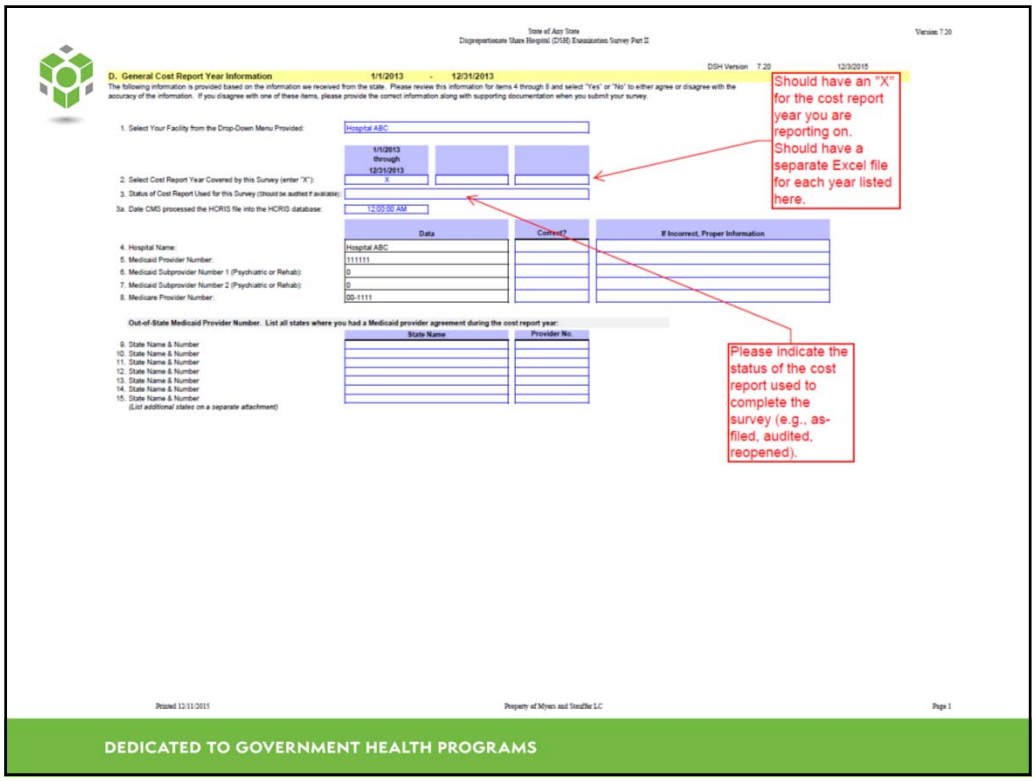

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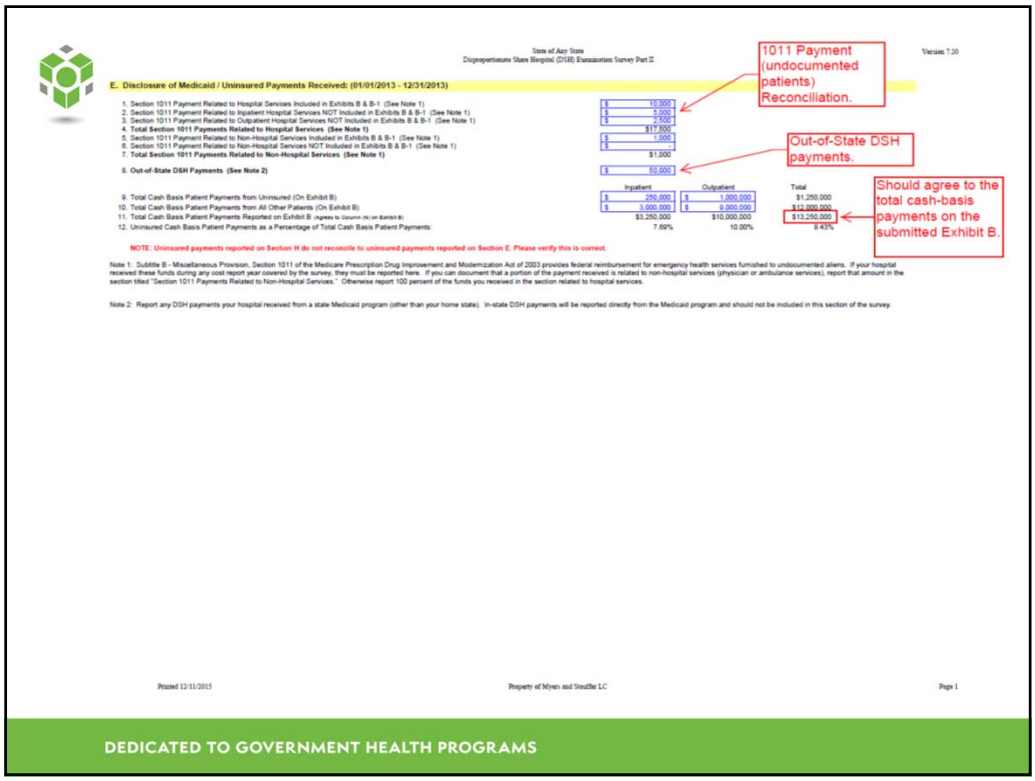
DSH YEAR SURVEY PART II SECTION E, MISC. PAYMENT INFO.

- 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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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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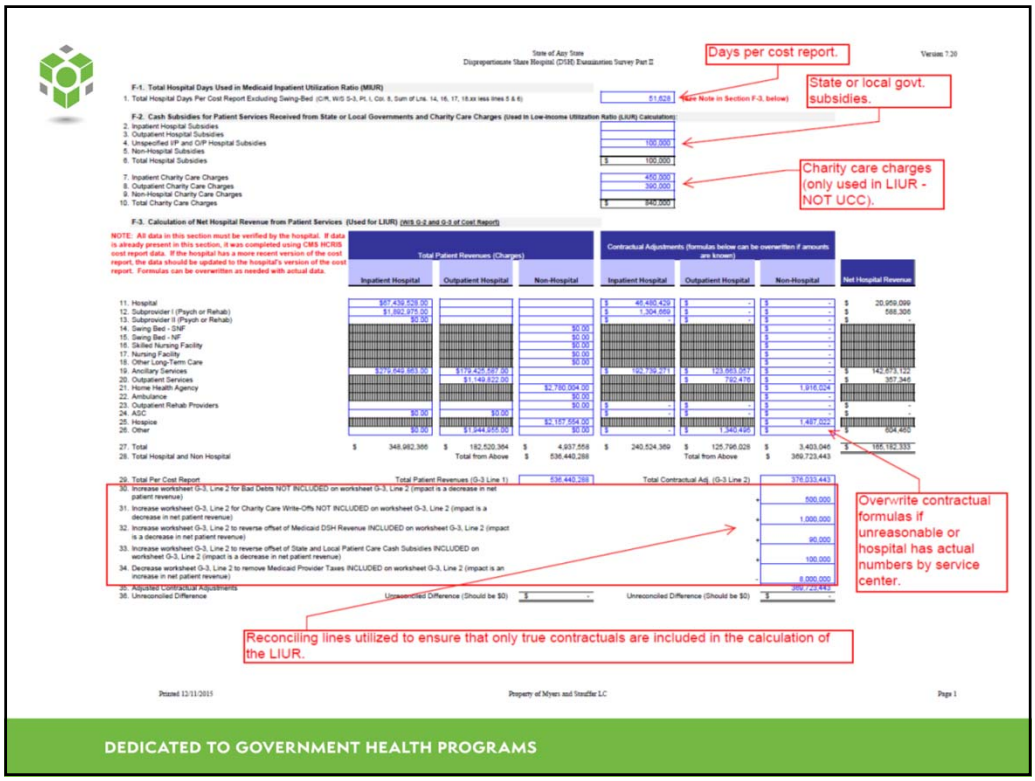

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DSH YEAR SURVEY PART II SECTION G, COST REPORT DATA

- 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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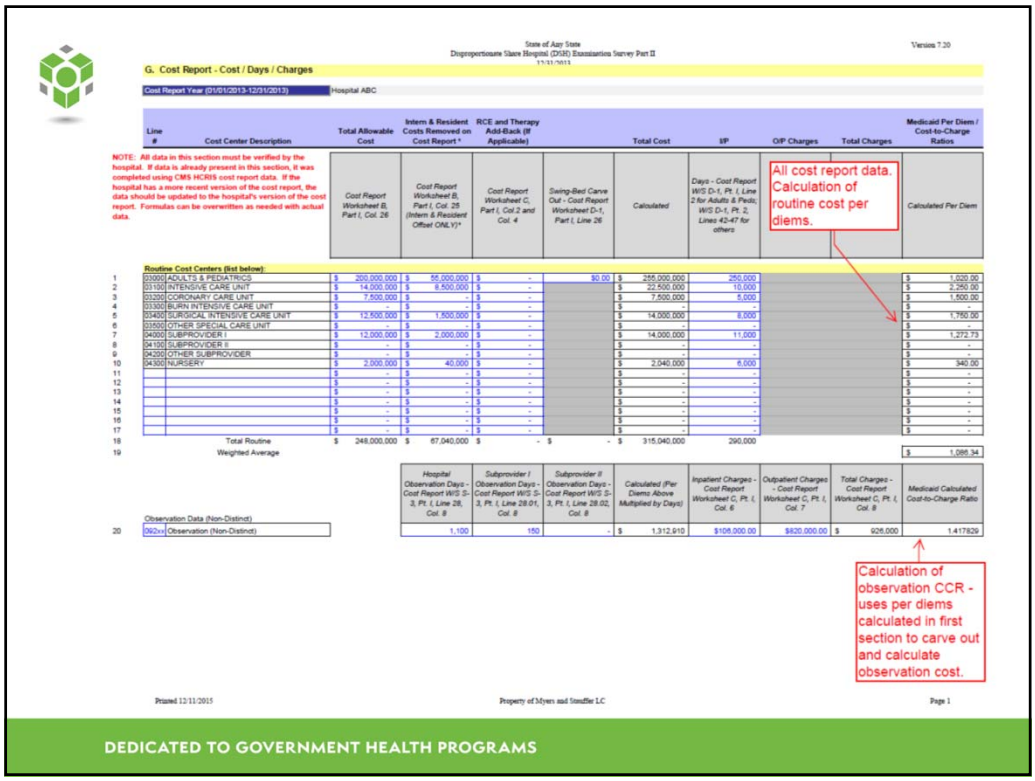

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Disproportionate Share Hospital (DSH) Examination Survey Part II
Version 7.20

G. Cost Report - Cost / Days / Charges

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

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

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

Line #	Cost Center Description	Total Allowable Cost	Intern & Resident Costs Removed on Cost Report *	RCE and Therapy Add-Back (If Applicable)	Total Cost	I/P	O/P 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 (Intern & Resident Offset ONLY)*	Cost Report Worksheet C, Part I, Col.2 and Col. 4	Swing-Bed Carve Out - Cost Report Worksheet D-1, Part I, Line 26	Calculated	Days - Cost Report W/S D-1, Pt. I, Line 2 for Adults & Peds; W/S D-1, Pt. 2, Lines 42-47 for others			Calculated Per Diem
	Routine Cost Centers (list below):									
1	03000 ADULTS & PEDIATRICS	$ 200,000,000	$ 55,000,000	$ -	$0.00	$ 255,000,000	250,000			$ 1,020.00
2	03100 INTENSIVE CARE UNIT	$ 14,000,000	$ 8,500,000	$ -		$ 22,500,000	10,000			$ 2,250.00
3	03200 CORONARY CARE UNIT	$ 7,500,000	$ -	$ -		$ 7,500,000	5,000			$ 1,500.00
4	03300 BURN INTENSIVE CARE UNIT	$ -	$ -	$ -		$ -	-			$ -
5	03400 SURGICAL INTENSIVE CARE UNIT	$ 12,500,000	$ 1,500,000	$ -		$ 14,000,000	8,000			$ 1,750.00
6	03500 OTHER SPECIAL CARE UNIT	$ -	$ -	$ -		$ -	-			$ -
7	04000 SUBPROVIDER I	$ 12,000,000	$ 2,000,000	$ -		$ 14,000,000	11,000			$ 1,272.73
8	04100 SUBPROVIDER II	$ -	$ -	$ -		$ -	-			$ -
9	04200 OTHER SUBPROVIDER	$ -	$ -	$ -		$ -	-			$ -
10	04300 NURSERY	$ 2,000,000	$ 40,000	$ -		$ 2,040,000	6,000			$ 340.00
11		$ -	$ -	$ -		$ -	-			$ -
12		$ -	$ -	$ -		$ -	-			$ -
13		$ -	$ -	$ -		$ -	-			$ -
14		$ -	$ -	$ -		$ -	-			$ -
15		$ -	$ -	$ -		$ -	-			$ -
16		$ -	$ -	$ -		$ -	-			$ -
17		$ -	$ -	$ -		$ -	-			$ -
18	Total Routine	$ 248,000,000	$ 67,040,000	$ -	$ -	$ 315,040,000	290,000			
19	Weighted Average									$ 1,086.34

Line #	Cost Center Description	Hospital Observation Days - Cost Report W/S S-3, Pt. I, Line 28, Col. 8	Subprovider I Observation Days - Cost Report W/S S-3, Pt. I, Line 28.01, Col. 8	Subprovider II Observation Days - Cost Report W/S S-3, Pt. I, Line 28.02, Col. 8	Calculated (Per Diems Above Multiplied by Days)	Inpatient Charges - Cost Report Worksheet C, Pt. I, Col. 6	Outpatient Charges - Cost Report Worksheet C, Pt. I, Col. 7	Total Charges - Cost Report Worksheet C, Pt. I, Col. 8	Medicaid Calculated Cost-to-Charge Ratio
	Observation Data (Non-Distinct)								
20	092xx Observation (Non-Distinct)	1,100	150	-	$ 1,312,910	$108,000.00	$820,000.00	$ 926,000	1.417829

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

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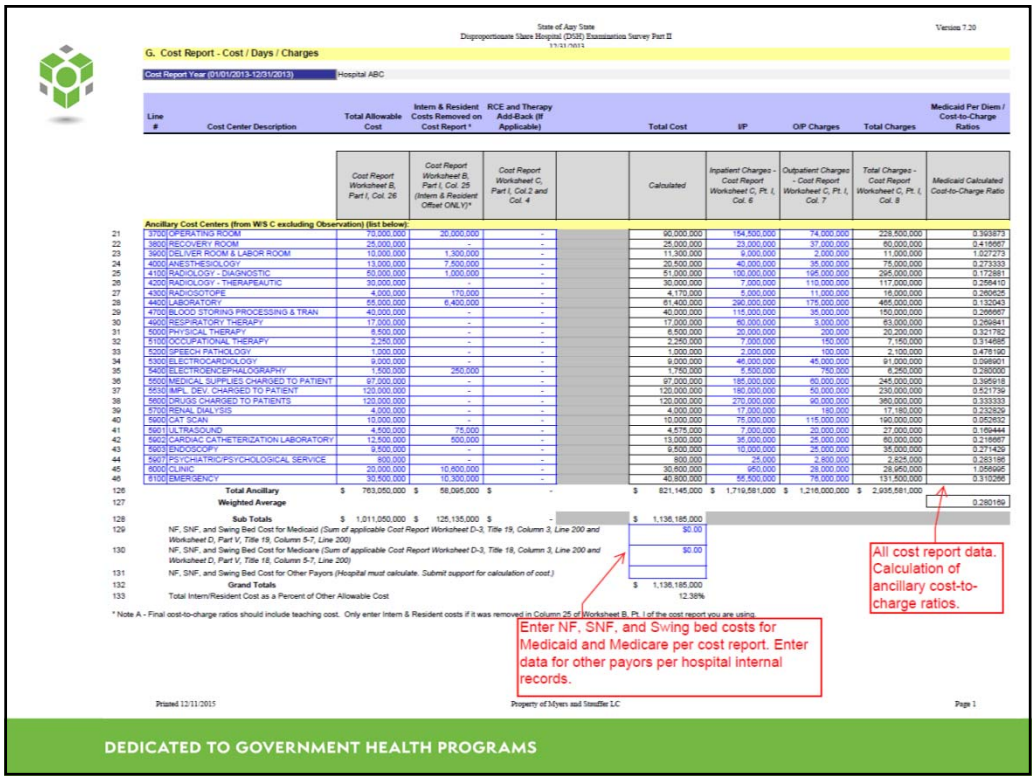

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Disproportionate Share Hospital (DSH) Examination Survey Part II
Version 7.20

G. Cost Report - Cost / Days / Charges

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

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

Line #	Cost Center Description	Total Allowable Cost	Intern & Resident Costs Removed on Cost Report *	RCE and Therapy Add-Back (If Applicable)	Total Cost	I/P	O/P 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 (Intern & Resident Offset ONLY)*	Cost Report Worksheet C, Part I, Col.2 and Col. 4	Calculated	Inpatient Charges - Cost Report Worksheet C, Pt. I, Col. 6	Outpatient Charges - Cost Report Worksheet C, Pt. I, Col. 7	Total Charges - Cost Report Worksheet C, Pt. I, Col. 8	Medicaid Calculated Cost-to-Charge Ratio
	Ancillary Cost Centers (from W/S C excluding Observation) (list below):								
21	3700 OPERATING ROOM	70,000,000	20,000,000	-	90,000,000	164,500,000	74,000,000	238,500,000	0.399873
22	3800 RECOVERY ROOM	25,000,000	-	-	25,000,000	23,000,000	37,000,000	60,000,000	0.419667
23	3900 DELIVER ROOM & LABOR ROOM	10,000,000	1,300,000	-	11,300,000	9,000,000	2,000,000	11,000,000	1.027273
24	4000 ANESTHESIOLOGY	13,000,000	7,500,000	-	20,500,000	40,000,000	35,000,000	75,000,000	0.273333
25	4100 RADIOLOGY - DIAGNOSTIC	50,000,000	1,000,000	-	51,000,000	100,000,000	195,000,000	295,000,000	0.172881
26	4200 RADIOLOGY - THERAPEAUTIC	30,000,000	-	-	30,000,000	7,000,000	110,000,000	117,000,000	0.256410
27	4300 RADIOISOTOPE	4,000,000	170,000	-	4,170,000	5,000,000	11,000,000	16,000,000	0.260625
28	4400 LABORATORY	55,000,000	6,400,000	-	61,400,000	290,000,000	175,000,000	465,000,000	0.132043
29	4700 BLOOD STORING PROCESSING & TRAN	40,000,000	-	-	40,000,000	115,000,000	35,000,000	150,000,000	0.266667
30	4900 RESPIRATORY THERAPY	17,000,000	-	-	17,000,000	60,000,000	3,000,000	63,000,000	0.269841
31	5000 PHYSICAL THERAPY	6,500,000	-	-	6,500,000	20,000,000	200,000	20,200,000	0.321782
32	5100 OCCUPATIONAL THERAPY	2,250,000	-	-	2,250,000	7,000,000	150,000	7,150,000	0.314685
33	5200 SPEECH PATHOLOGY	1,000,000	-	-	1,000,000	2,000,000	100,000	2,100,000	0.476190
34	5300 ELECTROCARDIOLOGY	9,000,000	-	-	9,000,000	46,000,000	45,000,000	91,000,000	0.098901
35	5400 ELECTROENCEPHALOGRAPHY	1,500,000	250,000	-	1,750,000	5,500,000	750,000	6,250,000	0.280000
36	5500 MEDICAL SUPPLIES CHARGED TO PATIENT	97,000,000	-	-	97,000,000	185,000,000	60,000,000	245,000,000	0.395918
37	5530 IMPL. DEV. CHARGED TO PATIENT	120,000,000	-	-	120,000,000	180,000,000	50,000,000	230,000,000	0.521739
38	5600 DRUGS CHARGED TO PATIENTS	120,000,000	-	-	120,000,000	270,000,000	90,000,000	360,000,000	0.333333
39	5700 RENAL DIALYSIS	4,000,000	-	-	4,000,000	17,000,000	180,000	17,180,000	0.232826
40	5900 CAT SCAN	10,000,000	-	-	10,000,000	75,000,000	115,000,000	190,000,000	0.052632
41	5901 ULTRASOUND	4,500,000	75,000	-	4,575,000	7,000,000	20,000,000	27,000,000	0.169444
42	5902 CARDIAC CATHETERIZATION LABORATORY	12,500,000	500,000	-	13,000,000	35,000,000	25,000,000	60,000,000	0.216667
43	5903 ENDOSCOPY	9,500,000	-	-	9,500,000	10,000,000	25,000,000	35,000,000	0.271429
44	5907 PSYCHIATRIC/PSYCHOLOGICAL SERVICE	800,000	-	-	800,000	25,000	2,800,000	2,825,000	0.283186
45	6000 CLINIC	20,000,000	10,600,000	-	30,600,000	950,000	28,000,000	28,950,000	1.056995
46	6100 EMERGENCY	30,500,000	10,300,000	-	40,800,000	55,500,000	76,000,000	131,500,000	0.310266
126	**Total Ancillary**	$ 763,050,000	$ 58,095,000	$ -	$ 821,145,000	$ 1,719,581,000	$ 1,216,000,000	$ 2,935,581,000	
127	**Weighted Average**								0.280169
128	**Sub Totals**	$ 1,011,050,000	$ 125,135,000	$ -	$ 1,136,185,000				
129	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)*				$0.00				
130	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)*				$0.00				
131	NF, SNF, and Swing Bed Cost for Other Payors *(Hospital must calculate. Submit support for calculation of cost.)*								
132	**Grand Totals**				$ 1,136,185,000				
133	Total Intern/Resident Cost as a Percent of Other Allowable Cost				12.36%				

* Note A - Final cost-to-charge ratios should include teaching cost. Only enter Intern & Resident costs if it was removed in Column 25 of Worksheet B, Pt. I of the cost report you are using.

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

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DEDICATED TO GOVERNMENT HEALTH PROGRAMS

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

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).*

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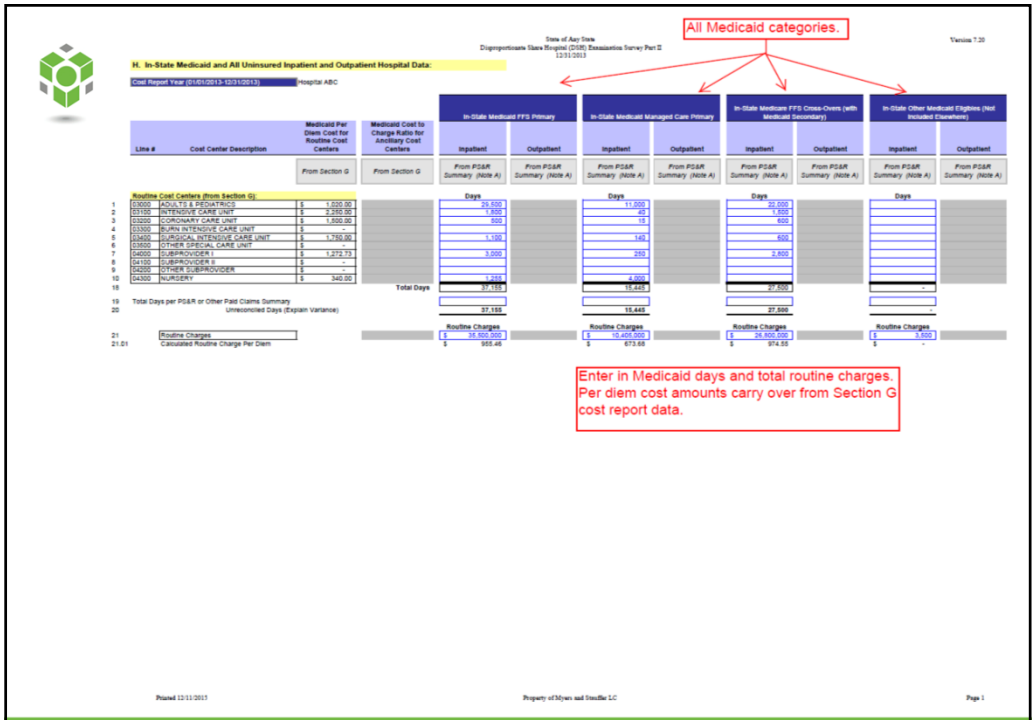

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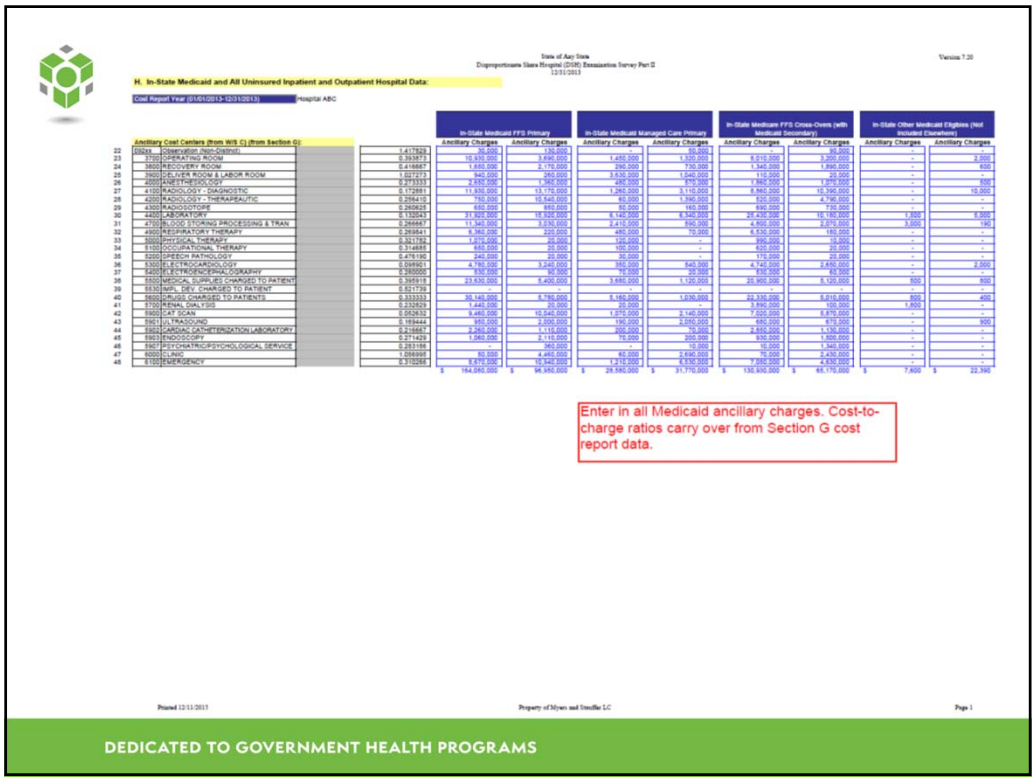

State of Any State
Disproportionate Share Hospital (DSH) Examination Survey Part II
12/31/2013

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

	Ancillary Cost Centers (from W/S C) (from Section G)		In-State Medicaid FFS Primary		In-State Medicaid Managed Care Primary		In-State Medicare FFS Cross-Overs (with Medicaid Secondary)		In-State Other Medicaid Eligibles (Not Included Elsewhere)	
			Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges
22	0924 Observation (Non-Distinct)	1.417829	30,000	130,000	-	60,000	95,000		-	-
23	3700 OPERATING ROOM	0.393873	10,930,000	3,690,000	1,450,000	1,320,000	8,810,000	3,200,000	-	2,000
24	3800 RECOVERY ROOM	0.416667	1,650,000	2,175,000	290,000	710,000	1,340,000	1,890,000	-	600
25	3900 DELIVER ROOM & LABOR ROOM	1.027273	940,000	260,000	3,630,000	1,040,000	110,000	20,000	-	-
26	4000 ANESTHESIOLOGY	0.273333	2,530,000	1,360,000	280,000	510,000	1,960,000	1,270,000	-	550
27	4100 RADIOLOGY - DIAGNOSTIC	0.172881	11,930,000	13,170,000	1,260,000	3,110,000	8,860,000	10,390,000	-	10,000
28	4200 RADIOLOGY - THERAPEAUTIC	0.256410	750,000	10,540,000	60,000	1,390,000	520,000	4,790,000	-	-
29	4300 RADIOISOTOPE	0.260625	660,000	660,000	60,000	160,000	690,000	730,000	-	-
30	4400 LABORATORY	0.132043	31,920,000	15,920,000	8,140,000	6,340,000	25,430,000	15,190,000	7,500	5,000
31	4700 BLOOD STORING PROCESSING & TRAN	0.266667	11,340,000	3,230,000	2,410,000	590,000	4,800,000	2,270,000	3,000	190
32	4900 RESPIRATORY THERAPY	0.269841	6,360,000	220,000	480,000	70,000	6,530,000	180,000	-	-
33	5000 PHYSICAL THERAPY	0.321782	1,070,000	20,000	120,000	-	990,000	10,000	-	-
34	5100 OCCUPATIONAL THERAPY	0.314685	605,000	20,000	100,000	-	620,000	20,000	-	-
35	5200 SPEECH PATHOLOGY	0.476190	240,000	20,000	30,000	-	170,000	20,000	-	-
36	5300 ELECTROCARDIOLOGY	0.098901	4,750,000	3,240,000	350,000	540,000	4,740,000	2,850,000	-	2,000
37	5400 ELECTROENCEPHALOGRAPHY	0.260000	630,000	90,000	70,000	20,000	630,000	60,000	-	-
38	5500 MEDICAL SUPPLIES CHARGED TO PATIENT	0.395918	23,530,000	5,400,000	3,680,000	1,120,000	20,900,000	5,120,000	550	650
39	5530 IMPL. DEV. CHARGED TO PATIENT	0.521739	-	-	-	-	-	-	-	-
40	5800 DRUGS CHARGED TO PATIENTS	0.333333	30,140,000	8,780,000	5,160,000	1,030,000	22,330,000	5,810,000	850	450
41	5700 RENAL DIALYSIS	0.232929	1,440,000	20,000	20,000	-	1,890,000	100,000	1,800	-
42	5900 CAT SCAN	0.052632	9,460,000	10,040,000	1,870,000	2,140,000	7,020,000	8,870,000	-	-
43	5901 ULTRASOUND	0.189444	950,000	2,200,000	190,000	2,050,000	680,000	870,000	-	900
44	5902 CARDIAC CATHETERIZATION LABORATORY	0.218667	2,360,000	1,110,000	200,000	70,000	2,880,000	1,130,000	-	-
45	5903 ENDOSCOPY	0.271429	1,060,000	3,110,000	70,000	200,000	930,000	1,850,000	-	-
46	5907 PSYCHIATRIC/PSYCHOLOGICAL SERVICE	0.283186	-	360,000	-	10,000	10,000	1,340,000	-	-
47	6000 CLINIC	1.056995	60,000	4,460,000	60,000	2,690,000	70,000	2,430,000	-	-
48	5100 EMERGENCY	0.370266	8,670,000	10,940,000	1,210,000	6,130,000	7,260,000	4,630,000	-	-
			$ 164,640,000	$ 96,950,000	$ 28,580,000	$ 31,770,000	$ 130,930,000	$ 65,170,000	$ 7,600	$ 22,390

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

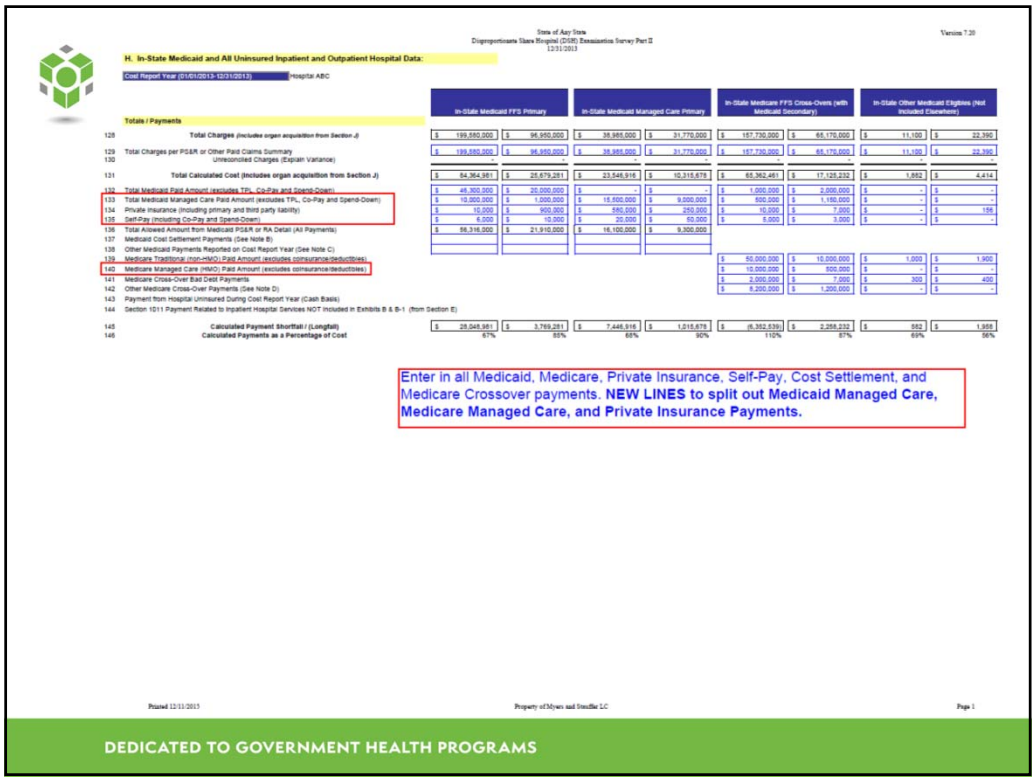
MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

NEW

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



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Disproportionate Share Hospital (DSH) Examination 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

	Totals / Payments	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)	
128	**Total Charges** *(includes organ acquisition from Section J)*	$ 199,580,000	$ 96,950,000	$ 38,985,000	$ 31,770,000	$ 157,730,000	$ 65,170,000	$ 11,100	$ 22,390
129	Total Charges per PS&R or Other Paid Claims Summary	$ 199,580,000	$ 96,950,000	$ 38,985,000	$ 31,770,000	$ 157,730,000	$ 65,170,000	$ 11,100	$ 22,390
130	Unreconciled Charges (Explain Variance)	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
131	**Total Calculated Cost (includes organ acquisition from Section J)**	$ 64,364,961	$ 25,679,281	$ 23,546,916	$ 10,315,679	$ 65,362,461	$ 17,125,232	$ 1,882	$ 4,414
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)	$ 48,900,000	$ 20,000,000	$ -	$ -	$ 1,000,000	$ 2,000,000	$ -	$ -
133	Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down)	$ 10,000,000	$ 1,000,000	$ 15,500,000	$ 9,000,000	$ 500,000	$ 1,150,000	$ -	$ -
134	Private Insurance (including primary and third party liability)	$ 10,000	$ 900,000	$ 560,000	$ 250,000	$ 10,000	$ 7,000	$ -	$ 156
135	Self-Pay (including Co-Pay and Spend-Down)	$ 6,000	$ 10,000	$ 20,000	$ 50,000	$ 6,000	$ 3,000	$ -	$ -
136	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)	$ 58,316,000	$ 21,910,000	$ 16,100,000	$ 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 Traditional (non-HMO) Paid Amount (excludes coinsurance/deductibles)					$ 50,000,000	$ 10,000,000	$ 1,000	$ 1,900
140	Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)					$ 10,000,000	$ 500,000	$ -	$ -
141	Medicare Cross-Over Bad Debt Payments					$ 2,000,000	$ 7,000	$ 300	$ 400
142	Other Medicare Cross-Over Payments (See Note D)					$ 6,200,000	$ 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 / (Longfall)**	$ 25,048,961	$ 3,769,281	$ 7,446,916	$ 1,015,679	$ (6,362,539)	$ 2,258,232	$ 582	$ 1,958
146	**Calculated Payments as a Percentage of Cost**	61%	85%	68%	90%	110%	87%	69%	56%

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 LC
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

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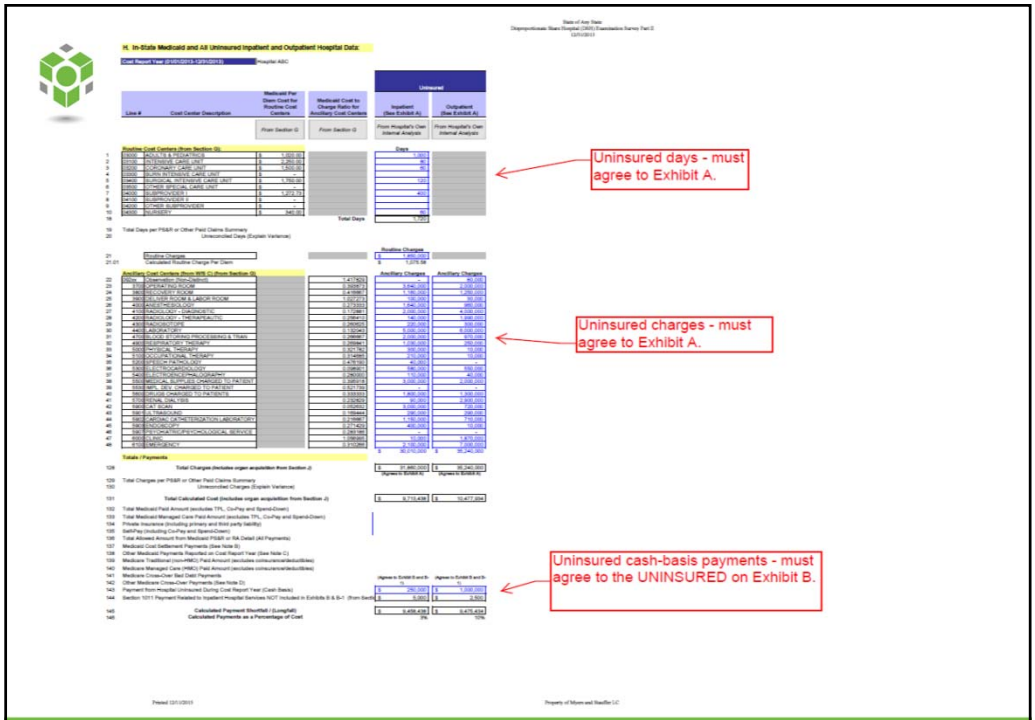
CERTIFIED PUBLIC ACCOUNTANTS

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



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

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

MYERS AND STAUFFER LC
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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.

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

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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.

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

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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.

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

MYERS AND STAUFFER LC
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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.

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

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

- Total organ acquisition cost and total useable organs will be pre-loaded from HCRIS data. If it is incorrect or doesn't agree to a more recently audited version of the cost report, please correct as needed and update question #3 in Section D.
- These schedules should be used to calculate organ acquisition cost for Medicaid (in-state and out-of-state) and uninsured.
- Summary claims data (PS&R) or similar documents and provider records (organ counts) must be provided to support the charges and useable organ counts reported on the survey. The data for uninsured organ acquisitions should be reported separately from the Exhibit A.

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

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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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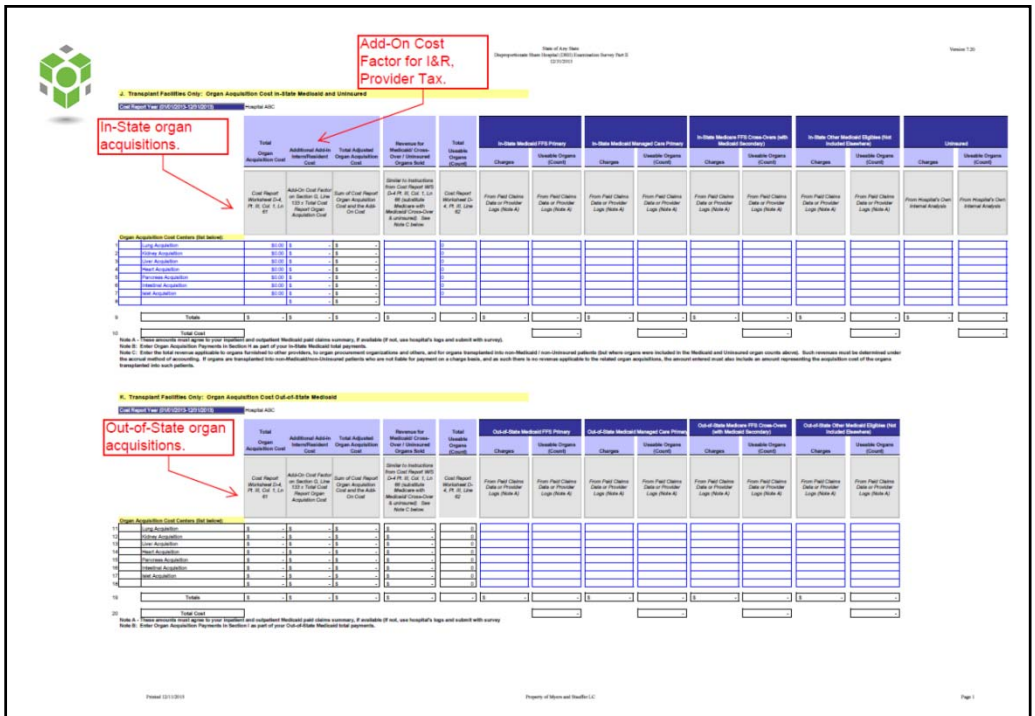

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EXHIBIT A – UNINSURED CHARGES/DAYS BY REVENUE CODE

- 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.

MYERS AND STAUFFER LC
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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.

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

MYERS AND STAUFFER LC
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EXHIBIT A - UNINSURED

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

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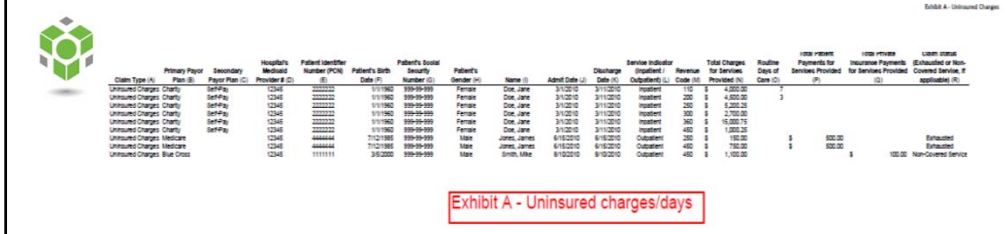

Exhibit A - Uninsured charges/days

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

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.

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

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.

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

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).

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

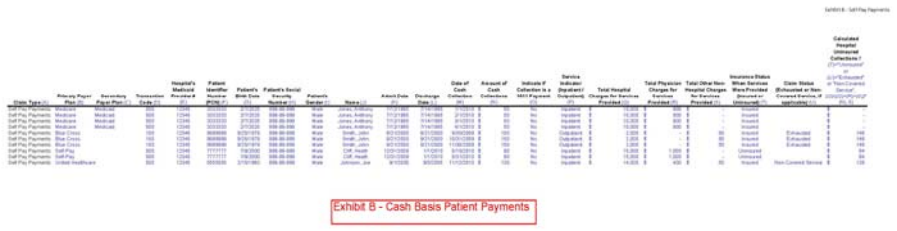

Exhibit B - Cash Basis Patient Payments

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

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.

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

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).

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

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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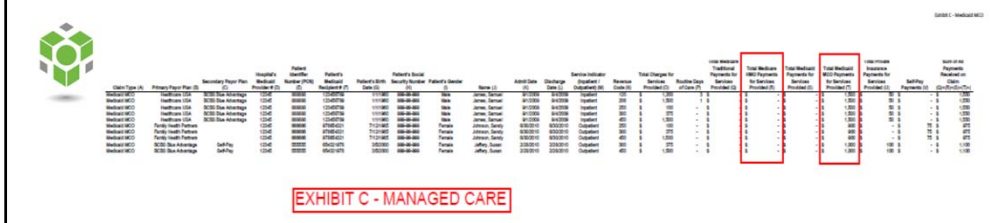

EXHIBIT C - MANAGED CARE

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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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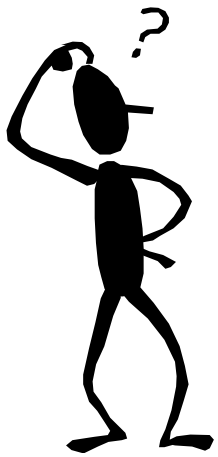

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2014 CLARIFICATIONS / CHANGES

- *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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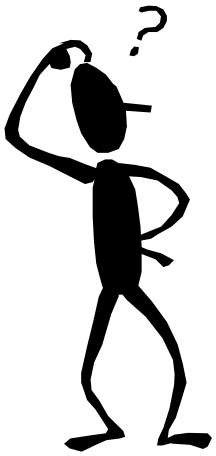

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PRIOR YEAR DSH EXAMINATION (2013)

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 polices 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
E-Mail: lhenderson@mslc.com
Johanna Linkenhoker (804) 418-8125
E-Mail: jlinkenhoker@mslc.com

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
OB Survey	• Required from all NV hospitals • Urban vs. Rural	Friday, January 20, 2017
MIUR Template	• Required from all NV hospitals • CRS Reports to be sent 2/1/2017 (may request CRS reports as early as 1/9/2017)	Friday, February 17, 2017
LIUR Template	• Required from all *potentially eligible* hospitals (hospitals required to file will be notified)	Friday, March 24, 2017
UCCR & Backup	• Required from all *eligible* hospitals (hospitals required to file will be notified)	Friday, June 2, 2017

Note: *All submission templates are available on the DHCFP website: http://dhcfp.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@dhcfp.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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