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DISPROPORTIONATE SHARE HOSPITAL (DSH) PAYMENT EXAMINATION

Connecticut State Fiscal Year 2011

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

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TRAINING OVERVIEW

- **DSH Audit Overview**
- **SFTP Site process**
- **Review SFY 2011 Medicaid DSH Examination Survey**
- **FAQ's – DSH Reporting**
- **Conclusion / Looking Forward**

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DSH PAYMENTS

DSH implemented under Section 1923 of the Social Security Act (42 U.S. Code, Section 1396r-4)

Medicaid DSH payments are intended to cover no more that the uncompensated care costs for Medicaid and uninsured (for hospitals that qualify)

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DSH AUDIT FEDERAL REGULATION

- FR Vol. 73, No. 245, Friday, Dec. 19, 2008
  - Independent Certified Audit of State DSH Payment Adjustments
- 42 CFR 447.299 (c)
  - Medicaid Reporting Requirements

42 CFR 455.300 Purpose

42 CFR 455.301 Definitions

42 CFR 455.304 Conditions for FFP

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FEDERAL REGULATION

Medicaid DSH Reporting Requirements

For DSH year 2005 and after state must annually report:

1. Hospital Name
2. Estimate of hospital-specific DSH limit
3. Medicaid I/P utilization rate
4. Low income utilization rate
5. State defined DSH qualification criteria
6. IP/OP Medicaid FFS basic rate payments
7. IP/OP Medicaid managed care payments
8. Supplemental/enhanced Medicaid IP/OP payments
9. Total Medicaid IP/OP payments

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FEDERAL REGULATION

Medicaid Reporting Requirements:

For DSH year 2005 and after state must annually report:

10. Total cost of care for Medicaid IP/OP Services
11. Total Medicaid uncompensated care
12. Uninsured IP/OP revenue
13. Total applicable Section 1011 payments
14. Total cost of IP/OP care for the uninsured
15. Total uninsured IP/OP uncompensated care costs
16. Total annual uncompensated care costs
17. DSH payments

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FEDERAL REGULATION

New Reporting Elements for 2011:

18. Medicaid Provider Number
19. Medicare Provider Number
20. Total Hospital Cost
21. Out of State Hospitals must report items 1-6, 8, 9, 17, 18 and 19.

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FEDERAL REGULATION

Definitions: (42 CFR 455.301)

Independent certified audit

- Auditor operates independently from Medicaid agency and subject hospitals
- Express an opinion for each verification
- Identify data issues or other caveats

Medicaid state plan rate year

- 12 month period defined by state's approved Medicaid state plan that estimates eligible uncompensated care costs and determines corresponding DSH payments as well as other Medicaid payment rates

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FEDERAL REGULATION

Conditions for Federal Financial Participation (42 CFR 455.304)

- **General**
  - The state must submit an independent audit to CMS for each completed Medicaid state plan rate year
  - FFP is not available for expenditures for DSH payments that are found in the independent certified audit to exceed the hospital-specific eligible uncompensated care cost limit
- **Timing**
  - Audits must be completed by the last day of the federal fiscal year ending three years from the end of the Medicaid state plan rate year under audit
  - 2011 audits are due to the state by September 30, 2014

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FEDERAL REGULATION

Conditions for Federal Financial Participation (42 CFR 455.304)

- **Documentation**
  - State must use the following data sources to complete the independent certified audit:
    - Approved Medicaid state plan
    - Payments and utilization information from State's MMIS
    - Medicare 2552-96 (Teaching Hospitals use version that includes direct medical education in allowable costs)
    - Audited hospital financial statement and accounting records

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FEDERAL REGULATION

Conditions for Federal Financial Participation (FFP) (42 CFR 455.304)

Specific Requirements

- Verification No. 1: Each hospital in the state that qualifies for a DSH payment is allowed to retain that payment to offset its uncompensated costs.
- Verification No. 2: DSH payments made to each qualifying hospital comply with the hospital-specific DSH payment limit. The DSH payments made in the audited Medicaid state plan year must be measured against the actual uncompensated care cost in that same plan year.
- Verification No. 3: Only uncompensated care costs of furnishing inpatient and outpatient hospital services to Medicaid and uninsured individuals are eligible for inclusion of the hospital-specific DSH limit.

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FEDERAL REGULATION

Conditions for Federal Financial Participation (FFP) (42 CFR 455.304)

- **Specific Requirements (continued)**
  - Verification No. 4: For purposes of the hospital-specific DSH limit, Medicaid payments which are in excess of Medicaid costs must be applied against the uncompensated care costs.
  - Verification No. 5: Any information and records of all of a hospital's Medicaid inpatient and outpatient and uninsured service costs have been separately documented and retained by the state.
  - Verification No. 6: The information in Verification No. 5 includes a description of the methodology for calculating each hospital's payment limit under Section 1923(g)(1).

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FEDERAL REGULATION

Conditions for Federal Financial Participation (FFP) (42 CFR 455.304)

- **Transition Provision**
  - 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.
  - SPY **2011** is first year with the potential for pay back of FFP for DSH payments exceeding limit.

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SELECT CMS RESPONSES TO COMMENTS

Medicaid Services

- A state cannot include in calculating the hospital-specific DSH limit cost of services that are not defined under its Medicaid state plan as a Medicaid inpatient or outpatient hospital service *(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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SELECT CMS RESPONSES TO COMMENTS

Medicaid Services (continued)

- 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)*
- 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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SELECT CMS RESPONSES TO COMMENTS

Uninsured Services

- Uninsured Services: Uninsured patients are individuals with no source of third party health care coverage (insurance). If the patient had health insurance, even if the third party insurer did not pay, those services are insured and cannot be reported as uninsured on the survey.*
  - *There is some allowance for exhausted or limited benefits based on the January 18, 2012 proposed rule.
- 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)*
- A state cannot include in calculating the hospital-specific DSH limit cost of services that are not defined under its Medicaid state plan as a Medicaid inpatient or outpatient hospital service. *(Auditing & Reporting pg. 77907 & Reporting pg. 77913)*

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SELECT CMS RESPONSES TO COMMENTS

Uninsured Services (continued)

- Cost of services for individuals who have health insurance are not included in calculating the hospital-specific limit, even if insurance claims for the particular service are denied for any reason. *(Reporting pg. 77911)* *
  - *There is some allowance for exhausted or limited benefits based on the January 18, 2012 proposed rule.
- Costs associated with services furnished to individuals who have limited health insurance or other third party coverage are not included in the calculation of the hospital-specific limit. *(Reporting pages 77911 & 77913)* *
  - *There is some allowance for exhausted or limited benefits based on the January 18, 2012 proposed rule.
- The DSH limit does not include amounts associated with unpaid co-pays or deductibles. *(Reporting pg. 77911)*

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SELECT CMS RESPONSES TO COMMENTS

Uninsured Services (continued)

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)*

- An individual with insurance that provides only an ambulatory benefit would qualify as having health insurance (not uninsured) unless the benefit is further limited so that it is considered an excepted benefit (for example, restricted to onsite ambulatory medical clinics, limited to a particular diagnosis, or restricted to an indemnity benefit). We are not aware of health insurance plans that offer only ambulatory benefits, and do not believe this is a common practice in the industry. *(Reporting pg. 77916) **
  - *There is some allowance for exhausted or limited benefits based on the January 18, 2012 proposed rule.

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SELECT CMS RESPONSES TO COMMENTS

Uninsured Payments

- Uncompensated inpatient and outpatient hospital care costs for individuals without third party coverage is offset by payments actually made by or on behalf of those patients in the Medicaid state plan rate year under audit. *(Reporting pg. 77913)*

- Revenues (cash receipts) required to be offset against a hospital's DSH limit include any amounts received by the hospital by or on behalf of either self-pay or uninsured individuals during the Medicaid state plan rate year under audit. *(Reporting pg. 77913)*

- 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)*

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SELECT CMS RESPONSES TO COMMENTS

Uninsured Payments (continued)

- Due to the inability to control these revenue streams and to foster administrative ease, audits should take into account these self-pay revenues (including liens and collections) during the year in which they are received, irrespective of whether such revenues are applicable to a prior period. *(Reporting pg. 77927)*

- Section 1011 payments are made to a hospital for costs incurred for the provision of specific services to specific aliens to the extent that the provider was not otherwise reimbursed for such services. Because a portion of the Section 1011 payments are made for uncompensated care costs that are also eligible under the hospital-specific DSH limit a defined portion of the section 1011 payments must be recognized as an amount paid on behalf of those uninsured. *(Reporting pg. 77916)*

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SELECT CMS RESPONSES TO COMMENTS

Other Reporting Issues

CMS confirms that intergovernmental transfers (IGT) cannot be included as a cost for purposes of calculating the hospital-specific DSH limit. An IGT is not a cost of providing health care services. *(Reporting pg. 77920)*

Medicaid hospital payments include the total computable federal and non-federal share payment amount. Certified Public Expenditure (CPE) and IGT are non-federal share payments to the extent that governmentally operated hospitals are the source. *(Reporting pg. 77922)*

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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SELECT CMS RESPONSES TO COMMENTS

Reporting (Institution for Mental Disease)

- The reporting requirement should include whether the DSH facility is an IMD. Identification of whether a DSH facility is an IMD will assist CMS in assessing the appropriateness of the DSH payment. *(Reporting pg. 77929)*
- 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)*

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SELECT CMS RESPONSES TO COMMENTS

Auditing (General)

- If audited Medicare cost reports are not available, the DSH report and audit may need to be based on Medicare cost reports as filed. *(Auditing pg. 77929 and CMS Feb. 2010 FAQ #1 – Additional Information on the DSH Reporting and Audit Requirements)*

- The methodology will need to exclude costs from services furnished to individuals with third party coverage, prisoners, duplicate accounts, individuals included in calculating the Medicaid shortfall, charges associated with elective procedures, and any professional charges. *(Auditing pg. 77930)*

- In instances where the hospital financial and cost reporting periods differ from the Medicaid state plan rate year, states and auditors may need to review multiple audited hospital financial reports and cost reports to fully cover the Medicaid state plan rate year under audit. At most, two financial and/or cost reports should provide the appropriate data. The data may need to be allocated based on the months covered by the financial or cost reporting period that are included in the Medicaid state plan period under audit. *(Auditing pg. 77930)*

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SELECT CMS RESPONSES TO COMMENTS

Auditing (Time Period Subject to Audit)

To the extent that a significant adjustment to Medicaid payments occurs and States claim Federal matching dollars (or return Federal matching dollars) as a prior period adjustment, States should correct the audit and report by indicating post-audit adjustments to Medicaid and DSH payments (or uncompensated care costs if Medicaid payment adjustments affect the Medicaid shortfall). When post-audit retroactive adjustments to Medicaid payments are not significant, the payments should be measured during the audit of the Medicaid State plan rate year in which the revenues are received. *CMS Feb. 2010 FAQ #17-Additonal Information on the DSH Reporting and Audit Requirements.*

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CMS PROPOSED RULE JANUARY 18, 2012

- CMS released a proposed rule in the January 18, 2012 Federal Register to clarify the definition of uninsured and prisoners.
  - Under this proposed rule, the DSH audit will now look at whether a patient is uninsured using a “service-specific” approach as opposed to the creditable coverage approach previously employed.

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CMS PROPOSED RULE JANUARY 18, 2012

- Under this proposed rule, the following may be considered uninsured:
  - Individuals with exhausted insurance benefits at the time of service
  - Individuals who have reached lifetime insurance limits for certain services
  - Individuals whose benefit package does not cover the hospital service received (must be a covered service under the Medicaid state plan)

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CMS PROPOSED RULE JANUARY 18, 2012

- Definition of a Service
  - A “service” should include the same elements that would be included for the same or similar services under Medicaid generally. The intent being that a hospital will generally determine that an individual is either insured or not insured for a given hospital stay, and will not separate out component parts of the hospital stay based on the level of payment received.

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CMS PROPOSED RULE JANUARY 18, 2012

- Specific Exclusions Listed in the Proposed Rule:
  - Bad Debts for individuals with third party coverage
  - Unpaid coinsurance/deductibles for individuals with third party coverage
  - Prisoners

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CMS PROPOSED RULE JANUARY 18, 2012

- Prisoners are defined 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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CMS PROPOSED RULE JANUARY 18, 2012

- This rule isn't final but we will assume that it will become final prior to the DSH audit completion.
- Please complete the DSH Survey assuming that the proposed rule will become final.
- Include all uninsured patients meeting the proposed rule definition on Exhibits A and B and report the days, charges and payments on the DSH Survey.

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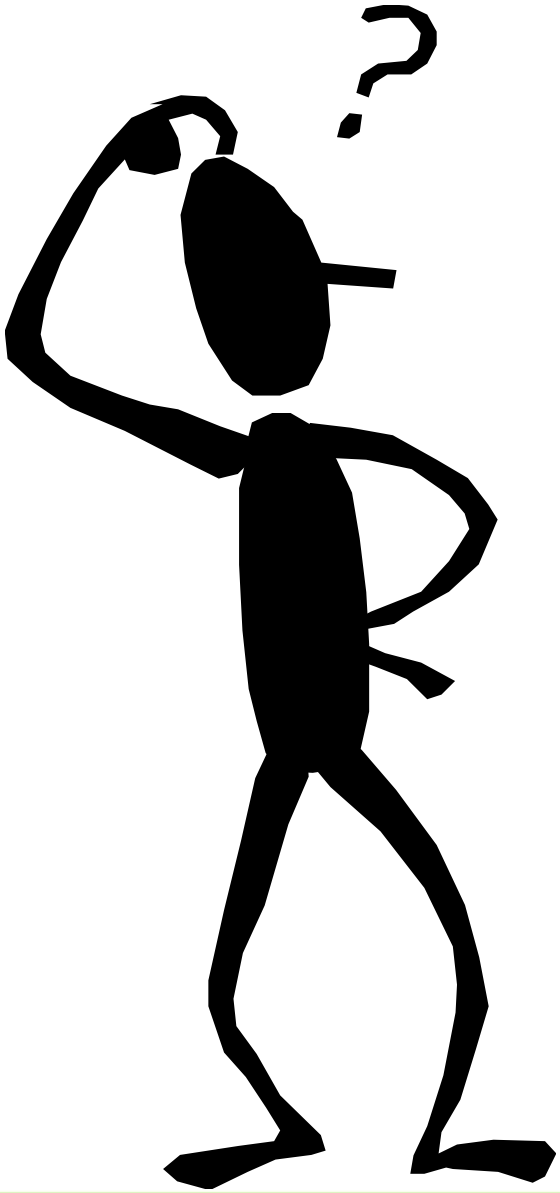
QUESTIONS/COMMENTS?



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SFTP SITE ACCESS PROCEDURES

- The SFTP site location has been changed to https://transfer.mslc.com/
- Due to the changes in HIPAA requirements, each person who requests access to the site will need to completed an sign a Terms of Use Agreement
- Once signed, the completed form can be scanned and e-mailed back to Myers and Stauffer

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MEDICAID DSH EXAMINATION SURVEYS

New data gathering method is being implemented during MSP 2011.

- Allows for more transparency of the process
- Providers can see how their data impacts the DSH calculation

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MEDICAID DSH EXAMINATION SURVEYS

General Instruction

- The survey has been split into 2 separate Excel files:
  - DSH Survey Part I – DSH Year Data
    - Includes all DSH year -specific information
    - Always complete one copy
  - DSH Survey Part II – Cost Report Year Data
    - Includes all cost report year-specific information
    - Complete a separate copy for each cost report year needed to cover the DSH year.
    - Hospitals with a year end that is different from the MSP year may have to complete 2 or 3 surveys

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MEDICAID DSH EXAMINATION SURVEYS

General Instruction

- DSH Survey Part II – Cost Report Year Data (continued)
  - Hospitals should complete a survey for each cost report year that that is included in the DSH audit years.

Both surveys have an Instructions tab. 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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MEDICAID 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
  - 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

Enter your total Medicaid Supplemental Payments for the DSH Year.

- 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 I and Part II of the survey. This page should be printed, signed, scanned and sent to Myers and Stauffer.

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

A. General DSH Year Information

	Begin	End
1. DSH Year:	10/01/2010	09/30/2011

2. Select Your Facility from the Drop-Down Menu Provided: 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	01/01/2010	12/31/2010
4. Cost Report Year 2 (if applicable)	01/01/2011	12/31/2011
5. Cost Report Year 3 (if applicable)		

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

Select Hospital Name

Only cost report years to be submitted will show here.

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

B. DSH OB Qualifying Information

Questions 1-3, below, should be answered in the accordance with Sec. 1923(d) of the Social Security Act.

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

	Answer
1. Did the hospital have at least two obstetricians who had staff privileges at the hospital that agreed to provide obstetric services to Medicaid-eligible individuals during the DSH year? (In the case of a hospital located in a rural area, the term "obstetrician" includes any physician with staff privileges at the hospital to perform obstetric procedures.)	
2. Was the hospital exempt from the requirement listed under #1 above because the hospital's inpatients are predominantly under 18 years of age?	
3. Was the hospital exempt from the requirement listed under #1 above because it did not offer non-emergency obstetric services to the general population when federal Medicaid DSH regulations were enacted on December 22, 1987?	

Answer all OB questions

5.12

Page 1

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

C. Disclosure of Other Medicaid Payments Received:

1. **Medicaid Supplemental Payments for DSH Year 10/01/2010 - 09/30/2011** $ 500,000
   (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.

Certification:

	Answer
1. Was your hospital allowed to retain 100% of the DSH payment it received for this DSH year? Matching the federal share with an IGT/CPE is not a basis for answering this question "no". If your hospital was not allowed to retain 100% of its DSH payments, please explain what circumstances were present that prevented the hospital from retaining its payments.	

Must answer the retain DSH question.

Explanation for "No" answers:

Complete Certification and Contact Information.

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

I hereby certify that the information in Sections A, B, C, D, E, F, G, H, I, J, K and L of the DSH Survey files are true and accurate to the best of our ability, and supported by the financial and other records of the hospital. I understand that this information will be used to determine the Medicaid program's compliance with federal Disproportionate Share Hospital (DSH) eligibility and payments provisions. Detailed support exists for all amounts reported in the survey. These records will be retained for a period of not less than 5 years following the due date of the survey, and will be made available for inspection when requested.

Hospital CEO or CFO Signature | Title | Date

Hospital CEO or CFO Printed Name | Hospital CEO or CFO Telephone Number | Hospital CEO or CFO E-Mail

Contact information for individuals authorized to respond to inquiries related to this survey:

Hospital Contact:
Name
Title
Telephone Number
E-Mail Address
Mailing Street Address
Mailing City, State, Zip

Outside Preparer:
Name
Title:
Firm Name:
Telephone Number
E-Mail Address

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DSH SURVEY PART II
SECTION D – GENERAL INFORMATION

Submit one copy for each cost report year

- 2552-96 Version for use with the 2552-96 Cost Report Years
- 2552-10 Version for use with the 2552-10 Cost Report Years

Section D – General Information

- Question #2 – Since Myers and Stauffer has pre-loaded the survey with HCRIS cost report data, an "X" should already 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 different status cost report, you will need to select the status of the cost report you are using with this drop-down box.

DSH Version 6.00 1/3/2013

D. General Cost Report Year Information 1/1/2010 - 12/31/2010

The following information is provided based on the information we received from the state. Please review this information for items 4 through 8 and select "Yes" or "No" to either agree or disagree with the accuracy of the information. If you disagree with one of these items, please provide the correct information along with supporting documentation when you submit your survey.

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

	1/1/2010 through 12/31/2010	1/1/2011 through 12/31/2011	
2. Select Cost Report Year Covered by this Survey (enter "X"):	X		

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

	Data	Correct?	If Incorrect, Proper Information
4. Hospital Name:	Hospital ABC	Yes	
5. Medicaid Provider Number:	111111	Yes	
6. Medicaid Subprovider Number 1 (Psychiatric or Rehab):	0	Yes	
7. Medicaid Subprovider Number 2 (Psychiatric or Rehab):	0	Yes	
8. Medicare Provider Number:	001111	Yes	

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	Kansas	0123
10. State Name & Number	Illinois	1244
11. State Name & Number	Iowa	1511
12. State Name & Number	Arkansas	1586
13. State Name & Number		
14. State Name & Number		
15. State Name & Number		

(List additional states on a separate attachment)

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

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

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DSH 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), received but not included in Exhibit B, 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.

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

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

1. Section 1011 Payment Related to Hospital Services Included in Exhibits B & B-1 (See Note 1)	$ 10,000
2. Section 1011 Payment Related to Inpatient Hospital Services NOT Included in Exhibits B & B-1 (See Note 1)	$ 5,000
3. Section 1011 Payment Related to Outpatient Hospital Services NOT Included in Exhibits B & B-1 (See Note 1)	$ 2,500
4. **Total Section 1011 Payments Related to Hospital Services (See Note 1)**	$17,500
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)	$ -
7. **Total Section 1011 Payments Related to Non-Hospital Services (See Note 1)**	$1,000
8. **Out-of-State DSH Payments (See Note 2)**	$ 50,000

	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	$ 9,000,000	$12,000,000
11. Total Cash Basis Patient Payments Reported on Exhibit B(Agrees to Column (H) on Exhibit B)	$3,250,000	$10,000,000	$13,250,000
12. Uninsured Cash Basis Patient Payments as a Percentage of Total Cash Basis Patient Payments:	7.69%	10.00%	9.43%

1011 Payment (undocumented patients) Reconciliation

Out-of-state DSH payments

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

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

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

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DSH SURVEY PART II SECTION F MIUR/LIUR

- The state must report your actual MIUR and LIUR for the DSH year - data is needed to calculate the MIUR/LIUR.
- Section F-1: Total hospital days from cost report. Myers and Stauffer will pre-load CMS HCRIS cost report data into this section. If it is incorrect or doesn't agree to a more recently audited version of the cost report, please correct as needed and update question #3 in Section D.
- Section F-2: If cash subsidies are specified for I/P or O/P services, record them as such, otherwise record entire amount as unspecified.
- Section F-2: Report charity care charges based on your own hospital financials or the definition used for your state DSH payment (support must be submitted).

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DSH 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.

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

F. MIUR / LIUR Qualifying Data from the Cost Report (01/01/2010 – 12/31/2010)

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

1.	Total Hospital Days Per Cost Report Excluding Swing-Bed (C/R, W/S S-3, Pt. I, Col. 6, Sum of Lnr. 12, 14, 14.x less lines 3 & 4)	51,628

(See Note in Section F-3, below)

Days per cost report

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

2.	Inpatient Hospital Subsidies	
3.	Outpatient Hospital Subsidies	
4.	Unspecified I/P and O/P Hospital Subsidies	100,000
5.	Total Hospital Subsidies	$ 100,000
6.	Inpatient Charity Care Charges	450,000
7.	Outpatient Charity Care Charges	390,000
8.	Total Charity Care Charges	$ 840,000

State or Local Govt. Subsidies

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

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

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

		Total Patient Revenues (Charges)			Contractual Adjustments (formulas below can be overwritten if amounts are known)			
		Inpatient Hospital	Outpatient Hospital	Non-Hospital	Inpatient Hospital	Outpatient Hospital	Non-Hospital	Net Hospital Revenue
9.	Hospital	$ 67,433,528			$ 47,103,012	$ -	$ -	$ 20,330,516
10.	Subprovider I (Psych or Rehab)	$ 1,892,375			$ 1,322,313	$ -	$ -	$ 570,662
11.	Subprovider II (Psych or Rehab)	$ -			$ -	$ -	$ -	$ -
12.	Swing Bed - SNF			$ -			$ -	
13.	Swing Bed - NF			$ -			$ -	
14.	Skilled Nursing Facility			$ -			$ -	
15.	Nursing Facility			$ -			$ -	
16.	Other Long-Term Care			$ -			$ -	
17.	Ancillary Services	$ 279,643,863	$ 179,425,587		$ 135,345,804	$ 125,335,429	$ -	$ 138,394,217
18.	Outpatient Services		$ 1,149,822			$ 803,193	$ -	$ 346,629
19.	Home Health Agency			$ 2,780,004			$ 1,341,936	
20.	Ambulance			$ -			$ -	
21.	Outpatient Rehab Providers			$ -	$ -	$ -	$ -	
22.	ASC	$ -	$ -		$ -	$ -	$ -	
23.	Hospice			$ 2,157,554			$ 1,507,132	
24.	Other	$ -	$ 1,344,355		$ -	$ 1,358,623	$ -	
25.	Total	$ 348,982,366	$ 182,520,364	$ 4,937,558	$ 243,777,130	$ 127,497,245	$ 3,449,068	
26.	Total Hospital and Non Hospital		Total from Above	$ 536,440,288		Above	$ 374,723,443	
27.	Total Hospital State and Local Patient Care Cash Subsidies							
28.	Adjusted Total Hospital Revenues (For Use in the LIUR)							
29.	Total Per Cost Report		Total Patient Revenues (G-3 Line 1)	536,440,288		Total Contractual Adj. (G-3 Line 2)	376,033,443	
30.	Reconciling item if needed						500,000	
31.	Reconciling item if needed						1,000,000	
32.	Reconciling item if needed						90,000	
33.	Reconciling item if needed						100,000	
34.	Adjusted Contractual Adjustments						374,723,442.98	
35.	Unreconciled Difference		Unreconciled Difference (Should be $0)	$ -		Unreconciled Difference (Should be $0)	$ -	

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

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DSH SURVEY PART
SECTION G, COST REPORT DATA

- Calculation of Routine Cost Per Diems
  - Days
  - Costs
- Calculation of Ancillary Cost-to-Charge Ratios
  - Charges
  - Cost

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

Version 7.10

G. Cost Report - Cost / Days / Charges

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

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

	Line #	Cost Center Description	Total Allowable Cost	Intern & Resident Costs Removed on Cost Report *	RCE and Therapy Add-Back (If Applicable)		Provider Tax Assessment	Total Cost	IP	O/P Charges	Total Charges	Medicaid Per Diem / Cost-to-Charge Ratios
			Cost Report Worksheet B, Part I, Col. 27	Cost Report Worksheet B, Part I, Col. 26 (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	Allocation of Provider Tax from Section L of the Survey Based on Total Cost	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			ted Per Diem
		Routine Cost Centers (list below):										
1	02500	ADULTS & PEDIATRICS	$ 200,000,000	$ 55,000,000	$ -	$ -	$ -	$ 255,000,000	250,000			$ 1,020.00
2	02600	INTENSIVE CARE UNIT	$ 14,000,000	$ 8,500,000	$ -		$ -	$ 22,500,000	10,000			$ 2,250.00
3	02700	CORONARY CARE UNIT	$ 7,500,000	$ -	$ -		$ -	$ 7,500,000	5,000			$ 1,500.00
4	02800	BURN INTENSIVE CARE UNIT	$ -	$ -	$ -		$ -	$ -	-			$ -
5	02900	SURGICAL INTENSIVE CARE UNIT	$ 12,500,000	$ 1,500,000	$ -		$ -	$ 14,000,000	8,000			$ 1,750.00
6	03000	OTHER SPECIAL CARE UNIT	$ -	$ -	$ -		$ -	$ -	-			$ -
7	03100	SUBPROVIDER I	$ 12,000,000	2,000,000	$ -		$ -	$ 14,000,000	11,000			$ 1,272.73
8	03101	SUBPROVIDER II	$ -	$ -	$ -		$ -	$ -	-			$ -
9	03300	NURSERY	$ 2,000,000	$ 40,000	$ -		$ -	$ 2,040,000	6,000			$ 340.00
10			$ -	$ -	$ -		$ -	$ -	-			$ -
11			$ -	$ -	$ -		$ -	$ -	-			$ -
12			$ -	$ -	$ -		$ -	$ -	-			$ -
13			$ -	$ -	$ -		$ -	$ -	-			$ -
14			$ -	$ -	$ -		$ -	$ -	-			$ -
15			$ -	$ -	$ -		$ -	$ -	-			$ -
16			$ -	$ -	$ -		$ -	$ -	-			$ -
17			$ -	$ -	$ -		$ -	$ -	-			$ -
18		Total Routine	$ 248,000,000	$ 67,040,000	$ -	$ -	$ -	$ 315,040,000	290,000			
19		Weighted Average										$ 1,086.34

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

All Cost Report Data. Calculation of Routine Cost Per Diems

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

G. Cost Report - Cost / Days / Charges

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

Line #		Cost Center Description	Total Allowable Cost	Intern & Resident Costs Removed on Cost Report *	RCE and Therapy Add-Back (If Applicable)		Provider Tax Assessment	Total Cost	I/P	O/P Charges	Total Charges	Medicaid Per Diem / Cost-to-Charge Ratios
			Cost Report Worksheet B, Part I, Col. 27	*Cost Report Worksheet B, Part I, Col. 26 (Intern & Resident Offset ONLY)**	*Cost Report Worksheet C, Part I, Col.2 and Col. 4*		*Allocation of Provider Tax from Section L of the Survey Based on Total Cost*	*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	03700	OPERATING ROOM	$ 70,000,000	$ 20,000,000	$ -		$ -	$ 90,000,000	$ 154,500,000	$ 74,000,000	$ 228,500,000	0.393873
22	03800	RECOVERY ROOM	$ 25,000,000	$ -	$ -		$ -	$ 25,000,000	$ 23,000,000	$ 37,000,000	$ 60,000,000	0.416667
23	03900	DELIVERY ROOM & LABOR ROOM	$ 10,000,000	$ 1,300,000	$ -		$ -	$ 11,300,000	$ 9,000,000	$ 2,000,000	$ 11,000,000	1.027273
24	04000	ANESTHESIOLOGY	$ 13,000,000	$ 7,500,000	$ -		$ -	$ 20,500,000	$ 40,000,000	$ 35,000,000	$ 75,000,000	0.273333
25	04100	RADIOLOGY-DIAGNOSTIC	$ 50,000,000	$ 1,000,000	$ -		$ -	$ 51,000,000	$ 100,000,000	$ 195,000,000	$ 295,000,000	0.172881
26	04200	RADIOLOGY-THERAPEUTIC	$ 30,000,000	$ -	$ -		$ -	$ 30,000,000	$ 7,000,000	$ 110,000,000	$ 117,000,000	0.256410
27	04300	RADIOISOTOPE	$ 4,000,000	$ 170,000	$ -		$ -	$ 4,170,000	$ 5,000,000	$ 11,000,000	$ 16,000,000	0.260625
28	04400	LABORATORY	$ 55,000,000	$ 6,400,000	$ -		$ -	$ 61,400,000	$ 290,000,000	$ 175,000,000	$ 465,000,000	0.132043
29	04600	WHOLE BLOOD & PACKED RED BLOOD C	$ 40,000,000	$ -	$ -		$ -	$ 40,000,000	$ 115,000,000	$ 35,000,000	$ 150,000,000	0.266667
30	04900	RESPIRATORY THERAPY	$ 17,000,000	$ -	$ -		$ -	$ 17,000,000	$ 60,000,000	$ 3,000,000	$ 63,000,000	0.269841
31	05000	PHYSICAL THERAPY	$ 6,500,000	$ -	$ -		$ -	$ 6,500,000	$ 20,000,000	$ 200,000	$ 20,200,000	0.321782
32	05100	OCCUPATIONAL THERAPY	$ 2,250,000	$ -	$ -		$ -	$ 2,250,000	$ 7,000,000	$ 150,000	$ 7,150,000	0.314685
33	05200	SPEECH PATHOLOGY	$ 1,000,000	$ -	$ -		$ -	$ 1,000,000	$ 2,000,000	$ 100,000	$ 2,100,000	0.476190
34	05300	ELECTROCARDIOLOGY	$ 9,000,000	$ -	$ -		$ -	$ 9,000,000	$ 46,000,000	$ 45,000,000	$ 91,000,000	0.098901
35	05400	ELECTROENCEPHALOGRAPHY	$ 1,500,000	$ 250,000	$ -		$ -	$ 1,750,000	$ 5,500,000	$ 750,000	$ 6,250,000	0.280000
36	05500	MEDICAL SUPPLIES CHARGED TO PATI	$ 97,000,000	$ -	$ -		$ -	$ 97,000,000	$ 185,000,000	$ 60,000,000	$ 245,000,000	0.395918
37	05530	IMPL. DEV. CHARGED TO PATIENT	$ 120,000,000	$ -	$ -		$ -	$ 120,000,000	$ 180,000,000	$ 50,000,000	$ 230,000,000	0.521739
38	05600	DRUGS CHARGED TO PATIENTS	$ 120,000,000	$ -	$ -		$ -	$ 120,000,000	$ 270,000,000	$ 90,000,000	$ 360,000,000	0.333333
39	05700	RENAL DIALYSIS	$ 4,000,000	$ -	$ -		$ -	$ 4,000,000	$ 17,000,000	$ 180,000	$ 17,180,000	0.232829
40	05900	CAT SCAN	$ 10,000,000	$ -	$ -		$ -	$ 10,000,000	$ 75,000,000	$ 115,000,000	$ 190,000,000	0.052632
41	05901	ULTRASOUND	$ 4,500,000	$ 75,000	$ -		$ -	$ 4,575,000	$ 7,000,000	$ 20,000,000	$ 27,000,000	0.169444
42	05902	CARDIAC CATHERIZATION LABORATO	$ 12,500,000	$ 500,000	$ -		$ -	$ 13,000,000	$ 35,000,000	$ 25,000,000	$ 60,000,000	0.216667
43	05903	ENDOSCOPY	$ 9,500,000	$ -	$ -		$ -	$ 9,500,000	$ 10,000,000	$ 25,000,000	$ 35,000,000	0.271429
44	05907	PSYCHIATRIC/PSYCHOLOGICAL SERVIC	$ 800,000	$ -	$ -		$ -	$ 800,000	$ 25,000	$ 2,800,000	$ 2,825,000	0.283186
45	06000	CLINIC	$ 20,000,000	$ 10,600,000	$ -		$ -	$ 30,600,000	$ 950,000	$ 28,000,000	$ 28,950,000	1.056995
46	06100	EMERGENCY	$ 30,500,000	$ 10,300,000	$ -		$ -	$ 40,800,000	$ 55,500,000	$ 76,000,000	$ 131,500,000	0.310266
101		Total Ancillary	$ 763,050,000	$ 58,095,000	$ -		$ -	$ 821,145,000	$ 1,719,581,000	$ 1,216,000,000	$ 2,935,581,000	
102		Weighted Average										0.280169
103		Grand Totals	$ 1,011,050,000	$ 125,135,000	$ -		$ -	$ 1,136,185,000				
104		Total Intern/Resident Cost as a Percent of Other Allowable Cost						12.38%				

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

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

MYERS AND STAUFFER LC
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DSH SURVEY PART II
SECTION H, IN-STATE MEDICAID

- Enter inpatient (routine) days, I/P and O/P ancillary charges. 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, Medicaid eligible but not billed, private insurance primary/Medicaid secondary, and other Medicaid not included elsewhere)*

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

Version 6.00

All Medicaid Categories

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

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

Line #	Cost Center Description	Medicaid Per Diem Cost for Routine Cost Centers	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 Section G	From Section G	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)
	Routine Cost Centers (from Section G):			Days		Days		Days		Days	
1	02500 ADULTS & PEDIATRICS	$ 1,020.00		29,500		11,000		22,000		5	
2	02600 INTENSIVE CARE UNIT	$ 2,250.00		1,600		40		1,500			
3	02700 CORONARY CARE UNIT	$ 1,500.00		500		15		600			
4	02800 BURN INTENSIVE CARE UNIT	$ -									
5	02900 SURGICAL INTENSIVE CARE UNIT	$ 1,750.00		1,100		140		600			
6	03000 OTHER SPECIAL CARE UNIT	$ -									
7	03100 SUBPROVIDER I	$ 1,272.73		3,000		250		2,800			
8	03101 SUBPROVIDER II	$ -									
9	03300 NURSERY	$ 340.00		1,255		4,000					
10		$ -									
11		$ -									
12		$ -									
13		$ -									
14		$ -									
15		$ -									
16		$ -									
17		$ -									
18			Total Days	36,955		15,445		27,500		5	
19	Total Days per PS&R or Other Paid Claims Summary										
20	Unreconciled Days (Explain Variance)			36,955		15,445		27,500		5	
				Routine Charges		Routine Charges		Routine Charges		Routine Charges	
21	Routine Charges			$ 35,500,000		$ 10,405,000		$ 26,800,000		$ 3,500	
21.01	Calculated Routine Charge Per Diem			$ 960.63		$ 673.88		$ 974.55		$ 700.00	

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

Printed 1/3/2013 Property of Myers and Stauffer LC Page 1

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

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

	Ancillary Cost Centers (from W/S C) (from Section G):				In-State Medicaid FFS Primary		In-State Medicaid Managed Care Primary		In-State Medicare FFS Cross-Overs (with Medicaid Secondary)		In-State Other Medicaid Eligibles (Not Included Elsewhere)	
					Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges
22	062xx	Observation (Non-Distinct)		1.417829	30,000	130,000	-	50,000	-	80,000	-	-
23	03700	OPERATING ROOM		0.393873	10,930,000	3,690,000	1,450,000	1,320,000	8,010,000	3,200,000	-	2,000
24	03800	RECOVERY ROOM		0.416667	1,650,000	2,170,000	290,000	730,000	1,340,000	1,890,000	-	600
25	03900	DELIVERY ROOM & LABOR ROOM		1.027273	940,000	260,000	3,630,000	1,040,000	110,000	20,000	-	-
26	04000	ANESTHESIOLOGY		0.273333	2,650,000	1,360,000	480,000	570,000	1,860,000	1,070,000	-	500
27	04100	RADIOLOGY-DIAGNOSTIC		0.172881	11,930,000	13,170,000	1,260,000	3,110,000	8,860,000	10,390,000	-	10,000
28	04200	RADIOLOGY-THERAPEUTIC		0.256410	750,000	10,540,000	60,000	1,390,000	520,000	4,790,000	-	-
29	04300	RADIOISOTOPE		0.260625	650,000	850,000	50,000	160,000	690,000	730,000	-	-
30	04400	LABORATORY		0.132043	31,920,000	15,920,000	6,140,000	6,340,000	25,430,000	10,180,000	1,500	5,000
31	04700	BLOOD STORING PROCESSING & TRAN		0.266667	11,340,000	3,030,000	2,410,000	590,000	7,800,000	2,070,000	3,000	190
32	04900	RESPIRATORY THERAPY		0.269841	8,360,000	220,000	480,000	70,000	6,530,000	180,000	-	-
33	05000	PHYSICAL THERAPY		0.321782	1,070,000	20,000	120,000	-	990,000	10,000	-	-
34	05100	OCCUPATIONAL THERAPY		0.314685	650,000	20,000	100,000	-	620,000	20,000	-	-
35	05200	SPEECH PATHOLOGY		0.476190	240,000	20,000	30,000	-	170,000	20,000	-	-
36	05300	ELECTROCARDIOLOGY		0.098901	4,780,000	3,240,000	350,000	540,000	4,740,000	2,650,000	-	2,000
37	05400	ELECTROENCEPHALOGRAPHY		0.280000	530,000	90,000	70,000	20,000	530,000	60,000	-	-
38	05500	MEDICAL SUPPLIES CHARGED TO PATI		0.395918	23,830,000	5,400,000	3,680,000	1,120,000	20,900,000	5,120,000	500	800
39	05530	IMPL. DEV. CHARGED TO PATIENT		0.521739								
40	05600	DRUGS CHARGED TO PATIENTS		0.333333	30,140,000	5,780,000	5,160,000	1,030,000	22,330,000	5,010,000	800	400
41	05700	RENAL DIALYSIS		0.232829	1,440,000	20,000	20,000	-	3,890,000	100,000	1,800	-
42	05900	CAT SCAN		0.052632	9,460,000	10,040,000	1,070,000	2,140,000	7,020,000	5,870,000	-	-
43	05901	ULTRASOUND		0.169444	950,000	2,000,000	190,000	2,050,000	680,000	670,000	-	900
44	05902	CARDIAC CATHETERIZATION LABORATO		0.216667	2,260,000	1,110,000	200,000	70,000	2,850,000	1,130,000	-	-
45	05903	ENDOSCOPY		0.271429	1,060,000	2,110,000	70,000	200,000	930,000	1,500,000	-	-
46	05907	PSYCHIATRIC/PSYCHOLOGICAL SERVIC		0.283186	-	360,000	-	10,000	10,000	1,340,000	-	-
47	06000	CLINIC		1.056995	50,000	4,460,000	60,000	2,690,000	70,000	2,430,000	-	-
48	06100	EMERGENCY		0.310266	8,670,000	10,940,000	1,210,000	6,530,000	7,050,000	4,630,000	-	-

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

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DSH SURVEY PART II
SECTION H, IN-STATE MEDICAID

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

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

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

		In-State Medicaid FFS Primary		In-State Medicaid Managed Care Primary		In-State Medicare FFS Cross-Overs (with Medicaid Secondary)		In-State Other Medicaid Eligibles (Not Included Elsewhere)	
	Totals / Payments								
103	**Total Charges** ***(includes organ acquisition from Section J)***	$ 199,580,000	$ 96,950,000	$ 38,985,000	$ 31,770,000	$ 160,730,000	$ 65,170,000	$ 11,100	$ 22,390
104	Total Charges per PS&R or Other Paid Claims Summary	$ 199,580,000	$ 96,950,000	$ 38,985,000	$ 31,770,000	$ 160,730,000	$ 65,170,000	$ 11,100	$ 22,390
105	Unreconciled Charges (Explain Variance)	-	-	-	-	-	-	-	-
106	**Total Calculated Cost (includes organ acquisition from Section J)**	$ 83,014,961	$ 25,679,261	$ 23,546,616	$ 10,315,678	$ 66,182,462	$ 17,125,232	$ 6,982	$ 4,414
107	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)	$ 48,300,000	$ 20,000,000	$ 15,500,000	$ 9,000,000	$ 2,100,000	$ 3,000,000	$ -	$ -
108	Other Total Third Party Liability (including Co-Pay and Spend-Down but excluding Medicare on crossovers)	$ 16,000	$ 100,000	$ 600,000	$ 300,000	$ 15,000	$ 10,000	$ -	$ 156
109	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)	$ 48,316,000	$ 20,100,000	$ 16,100,000	$ 9,300,000				
110	Medicaid Cost Settlement Payments (See Note B)								
111	Other Medicaid Payments Reported on Cost Report Year (See Note C)								
112	Medicare Paid Amount (excludes coinsurance/deductibles)					$ 60,000,000	$ 10,500,000	$ 5,000	$ 1,900
113	Medicare Cross-Over Bad Debt Payments					$ 2,000,000	$ 7,000		
114	Other Medicare Cross-Over Payments (See Note D)					$ 8,200,000	$ 1,200,000	$ 300	$ 400
115	Payment from Hospital Uninsured During Cost Report Year (Cash Basis)								
116	Section 1011 Payment Related to Inpatient Hospital Services NOT Included in Exhibits B & B-1 (from Section E)								
117	**Calculated Payment Shortfall / (Longfall)**	$ 37,598,961	$ 5,579,261	$ 7,446,616	$ 1,015,678	$ (6,152,538)	$ 2,408,232	$ 1,682	$ 1,958
118	**Calculated Payments as a Percentage of Cost**	55%	78%	68%	90%	109%	86%	76%	56%

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

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DSH SURVEY PART II SECTION H, UNINSURED

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

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

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

	Line #	Cost Center Description	Medicaid Per Diem Cost for Routine Cost Centers	Medicaid Cost to Charge Ratio for Ancillary Cost Centers	Uninsured: Inpatient (See Exhibit A)	Uninsured: Outpatient (See Exhibit A)
			From Section G	From Section G	From Hospital's Own Internal Analysis	From Hospital's Own Internal Analysis
	Routine Cost Centers (from Section G):				Days	
1	02500	ADULTS & PEDIATRICS	$ 1,020.00		1,000	
2	02600	INTENSIVE CARE UNIT	$ 2,250.00		80	
3	02700	CORONARY CARE UNIT	$ 1,500.00		60	
4	02800	BURN INTENSIVE CARE UNIT	$ -			
5	02900	SURGICAL INTENSIVE CARE UNIT	$ 1,750.00		120	
6	03000	OTHER SPECIAL CARE UNIT	$ -			
7	03100	SUBPROVIDER I	$ 1,272.73		400	
8	03101	SUBPROVIDER II	$ -			
9	03300	NURSERY	$ 340.00		80	
10			$ -			
11			$ -			
12			$ -			
13			$ -			
14			$ -			
15			$ -			
16			$ -			
17			$ -			
18				Total Days	1,720	
19	Total Days per PS&R or Other Paid Claims Summary					
20		Unreconciled Days (Explain Variance)				
					Routine Charges	
21		Routine Charges			$ 1,650,000	
21.01		Calculated Routine Charge Per Diem			$ 959.30	
	Ancillary Cost Centers (from W/S C) (from Section G):				Ancillary Charges	Ancillary Charges
22	062xx	Observation (Non-Distinct)		1.417829	-	80,000
23	03700	OPERATING ROOM		0.393873	3,640,000	2,000,000
24	03800	RECOVERY ROOM		0.416667	1,160,000	1,250,000
25	03900	DELIVERY ROOM & LABOR ROOM		1.027273	100,000	30,000
26	04000	ANESTHESIOLOGY		0.273333	1,640,000	860,000
27	04100	RADIOLOGY-DIAGNOSTIC		0.172881	2,000,000	4,000,000
28	04200	RADIOLOGY-THERAPEUTIC		0.256410	140,000	1,990,000
29	04300	RADIOISOTOPE		0.260625	220,000	300,000
30	04400	LABORATORY		0.132043	5,000,000	6,000,000
31	04700	BLOOD STORING, PROCESSING & TRAN		0.266667	2,000,000	970,000
32	04900	RESPIRATORY THERAPY		0.269841	1,030,000	250,000
33	05000	PHYSICAL THERAPY		0.321782	300,000	10,000
34	05100	OCCUPATIONAL THERAPY		0.314685	210,000	10,000
35	05200	SPEECH PATHOLOGY		0.476190	40,000	-
36	05300	ELECTROCARDIOLOGY		0.098901	580,000	550,000
37	05400	ELECTROENCEPHALOGRAPHY		0.280000	110,000	40,000
38	05500	MEDICAL SUPPLIES CHARGED TO PATI		0.395918	3,000,000	2,000,000
39	05530	IMPL. DEV. CHARGED TO PATIENT		0.521739	-	-
40	05600	DRUGS CHARGED TO PATIENTS		0.333333	1,800,000	1,300,000
41	05700	RENAL DIALYSIS		0.232829	90,000	2,900,000
42	05900	CAT SCAN		0.052632	3,000,000	720,000
43	05901	ULTRASOUND		0.169444	290,000	290,000
44	05902	CARDIAC CATHETERIZATION LABORATO		0.216667	1,150,000	710,000
45	05903	ENDOSCOPY		0.271429	400,000	10,000
46	05907	PSYCHIATRIC/PSYCHOLOGICAL SERVIC		0.283188	-	-
47	06000	CLINIC		1.056995	10,000	1,870,000
48	06100	EMERGENCY		0.310266	2,100,000	7,000,000
	Totals / Payments					
103		**Total Charges** *(includes organ acquisition from Section J)*			$ 31,660,000 (Agrees to Exhibit A)	$ 35,240,000 (Agrees to Exhibit A)
104	Total Charges per PS&R or Other Paid Claims Summary					
105		Unreconciled Charges (Explain Variance)				
106		**Total Calculated Cost (includes organ acquisition from Section J)**			$ 9,713,438	$ 10,477,934
107	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)					
108	Other Total Third Party Liability (including Co-Pay and Spend-Down but excluding Medicare on crossovers)					
109	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)					
110	Medicaid Cost Settlement Payments (See Note B)					
111	Other Medicaid Payments Reported on Cost Report Year (See Note C)					
112	Medicare Paid Amount (excludes coinsurance/deductibles)					
113	Medicare Cross-Over Bad Debt Payments				(Agrees to Exhibit B and B-1)	(Agrees to Exhibit B and B-1)
114	Other Medicare Cross-Over Payments (See Note D)					
115	Payment from Hospital Uninsured During Cost Report Year (Cash Basis)				$ 250,000	$ 1,000,000
116	Section 1011 Payment Related to Inpatient Hospital Services NOT Included in Exhibits B & B-1 (from Sectio				$ 5,000	$ 2,500
117		**Calculated Payment Shortfall / (Longfall)**			$ 9,458,438	$ 9,475,434
118		**Calculated Payments as a Percentage of Cost**			3%	10%

Uninsured days - should agree to Exhibit A

Uninsured Charges must agree to Exhibit A

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

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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-6/D-4 series as part of the total organ acquisition charges/days, must be excluded from Sections H & I of the survey.

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

Cost Report Year (-) #N/A

In-state organ acquisitions

		Total Organ Acquisition Cost	Revenue for Medicaid/Uninsured Organs Sold	Total Useable Organs (Count)	In-State Medicaid FFS Primary		In-State Medicaid Managed Care Primary		In-State Medicare FFS Cross-Overs (with Medicaid Secondary)		In-State Other Medicaid Eligibles (Not Included Elsewhere)		Uninsured	
					Charges	Useable Organs (Count)	Charges	Useable Organs (Count)	Charges	Useable Organs (Count)	Charges	Useable Organs (Count)	Charges	Useable Organs (Count)
		Cost Report Worksheet D-6, Pt. III, Col. 1, Ln 53	Similar to Instructions from Cost Report WIS D-6, Pt. III, Col. 1, Ln 56 (substitute Medicare with Medicaid/uninsured). See Note C below.	Cost Report Worksheet D-6, Pt. III, Line 54	From Paid Claims Data or Provider Logs (Note A)	From Paid Claims Data or Provider Logs (Note A)	From Paid Claims Data or Provider Logs (Note A)	From Paid Claims Data or Provider Logs (Note A)	From Paid Claims Data or Provider Logs (Note A)	From Paid Claims Data or Provider Logs (Note A)	From Paid Claims Data or Provider Logs (Note A)	From Paid Claims Data or Provider Logs (Note A)	From Hospital's Own Internal Analysis	From Hospital's Own Internal Analysis
Organ Acquisition Cost Centers (list below):														
1	Lung Acquisition	$ -		0										
2	Kidney Acquisition	$ -		0										
3	Liver Acquisition	$ -		0										
4	Heart Acquisition	$ -		0										
5	Pancreas Acquisition	$ -		0										
6	Intestinal Acquisition	$ -		0										
7	Islet Acquisition	$ -		0										
8														
9	Totals	$ -	$ -	-	$ -	-	$ -	-	$ -	-	$ -	-	$ -	-
10	Total Cost					-		-		-		-		-

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

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

Cost Report Year (-) #N/A

Out-of-state organ acquisitions

		Total Organ Acquisition Cost	Revenue for Medicaid/Uninsured Organs Sold	Total Useable Organs (Count)	Out-of-State Medicaid FFS Primary		Out-of-State Medicaid Managed Care Primary		Out-of-State Medicare FFS Cross-Overs (with Medicaid Secondary)		Out-of-State Other Medicaid Eligibles (Not Included Elsewhere)	
					Charges	Useable Organs (Count)	Charges	Useable Organs (Count)	Charges	Useable Organs (Count)	Charges	Useable Organs (Count)
		Cost Report Worksheet D-6, Pt. III, Col. 1, Ln 53	Similar to Instructions from Cost Report WIS D-6, Pt. III, Col. 1, Ln 56 (substitute Medicare with Medicaid/uninsured). See Note C below.	Cost Report Worksheet D-6, Pt. III, Line 54	From Paid Claims Data or Provider Logs (Note A)	From Paid Claims Data or Provider Logs (Note A)	From Paid Claims Data or Provider Logs (Note A)	From Paid Claims Data or Provider Logs (Note A)	From Paid Claims Data or Provider Logs (Note A)	From Paid Claims Data or Provider Logs (Note A)	From Paid Claims Data or Provider Logs (Note A)	From Paid Claims Data or Provider Logs (Note A)
Organ Acquisition Cost Centers (list below):												
11	Lung Acquisition	$ -	$ -	0								
12	Kidney Acquisition	$ -	$ -	0								
13	Liver Acquisition	$ -	$ -	0								
14	Heart Acquisition	$ -	$ -	0								
15	Pancreas Acquisition	$ -	$ -	0								
16	Intestinal Acquisition	$ -	$ -	0								
17	Islet Acquisition	$ -	$ -	0								
18		$ -	$ -	0								
19	Totals	$ -	$ -	-	$ -	-	$ -	-	$ -	-	$ -	-
20	Total Cost					-		-		-		-

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

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DSH SURVEY PART II
SECTION L, PROVIDER TAXES

- **Federal Register / Vol. 75, No. 157 dated Monday, August 16, 2010 (CMS-1498-F)**
  - Discussion on costs of provider taxes as allowable costs for CAHs (page 50362)
  - CMS is concerned that, even if a particular tax may be an allowable cost that is related to the care of Medicare beneficiaries, providers may not, in fact, ‘‘incur’’ the entire amount of these assessed taxes. (page 50363)

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DSH SURVEY PART II
SECTION L, PROVIDER TAXES

"This clarification will not have an effect of disallowing any particular tax but rather make clear that our **Medicare contractors** will continue to **make a determination** of whether a provider tax is allowable, on a **case-by-case basis**, using our current and longstanding reasonable cost principles. In addition, the **Medicare contractors** will continue to determine if an adjustment to the amount of allowable provider taxes is warranted to account for payments a provider receives that are associated with the assessed tax." (emphasis added)

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DSH SURVEY PART II
SECTION L, PROVIDER TAXES

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

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DSH SURVEY PART II
SECTION L, PROVIDER TAXES

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

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DSH SURVEY PART II
SECTION L, PROVIDER TAXES

- Section L is included to assist in reconciling total provider tax expense reported in the cost report and the amount actually incurred by a hospital (paid to the state).
- Complete the section using cost report data and hospital's own general ledger

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DSH SURVEY PART II
SECTION L, PROVIDER TAXES

- All permissible provider tax not included in allowable cost on the cost report will be added back and allocated to the Medicaid and uninsured UCC on a reasonable basis (e.g., cost).

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DSH SURVEY PART II
SECTION L, PROVIDER TAXES

- At a minimum the following should still be excluded from the final tax expense:
  - Additional payments paid into the association "pool" should NOT be included in the tax expense
  - Association fees
  - Non-hospital taxes (e.g., nursing home and pharmacy taxes)

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

Version 7.10

L. Provider Tax Assessment Reconciliation / Adjustment

An adjustment is necessary to properly reflect the Medicaid and uninsured share of the provider tax assessment for some hospitals. The Medicaid and uninsured share of the provider tax assessment collected is an allowable cost in determining hospital-specific DSH limits and, therefore, can be included in the DSH audit survey. However, depending on how your hospital reports it on the Medicare cost report, an adjustment may be necessary to ensure the cost is properly reflected in determining your hospital-specific DSH limit. For instance, if your hospital removed part or all of the provider tax assessment on the Medicare cost report, the full amount of the provider tax assessment would not have been apportioned to the various payers through the step down allocation process, resulting in the Medicaid and uninsured share being understated in determining the hospital-specific DSH limit. If your hospital needs to make an adjustment for the Medicaid and uninsured share of the provider tax assessment, please fill out the reconciliation below, and submit the supporting general ledger entries and other supporting documentation to Myers and Stauffer, LC along with your hospital's DSH audit surveys.

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

Worksheet A Provider Tax Assessment Reconciliation:

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

DSH UCC Provider Tax Assessment Adjustment:

17	Gross Allowable Assessment Not Included in the Cost Report	$ 5,000,000

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

Enter in G/L and Cost Report total tax amounts

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

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

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

Tax add back adjustment is estimated here but is subject to audit

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EXHIBIT A – UNINSURED CHARGES/DAYS BY REVENUE CODE

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

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EXHIBIT A - UNINSURED

- 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 proposed rule since that rule is not final.
  - 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).

Exhibit A - Uninsured Charges

Claim Type (A)	Primary Payor Plan (B)	Secondary Payor Plan (C)	Hospital's Medicaid Provider # (D)	Patient Identifier Number (PCN) (E)	Patient's Birth Date (F)	Patient's Social Security Number (G)	Patient's Gender (H)	Name (I)	Admit Date (J)	Discharge Date (K)	Service Indicator (Inpatient / Outpatient) (L)	Revenue Code (M)	Total Charges for Services Provided (N)	Routine Days of Care (O)	Total Patient Payments for Services Provided (P)	Total Third Party Payments for Services Provided (Q)	Claim Status (Exhausted or Non-Covered Service, if applicable) (R)	Account # (S)
Uninsured Charges	Charity	Self-Pay	12345	2222222	1/1/1960	999-99-999	Female	Doe, Jane	3/1/2010	3/11/2010	Inpatient	110	$ 4,000.00	7				55555
Uninsured Charges	Charity	Self-Pay	12345	2222222	1/1/1960	999-99-999	Female	Doe, Jane	3/1/2010	3/11/2010	Inpatient	200	$ 4,500.00	3				55555
Uninsured Charges	Charity	Self-Pay	12345	2222222	1/1/1960	999-99-999	Female	Doe, Jane	3/1/2010	3/11/2010	Inpatient	250	$ 5,200.25					55555
Uninsured Charges	Charity	Self-Pay	12345	2222222	1/1/1960	999-99-999	Female	Doe, Jane	3/1/2010	3/11/2010	Inpatient	300	$ 2,700.00					55555
Uninsured Charges	Charity	Self-Pay	12345	2222222	1/1/1960	999-99-999	Female	Doe, Jane	3/1/2010	3/11/2010	Inpatient	360	$ 15,000.75					55555
Uninsured Charges	Charity	Self-Pay	12345	2222222	1/1/1960	999-99-999	Female	Doe, Jane	3/1/2010	3/11/2010	Inpatient	450	$ 1,000.25					55555
Uninsured Charges	Medicare		12345	4444444	7/12/1965	999-99-999	Male	Jones, James	6/15/2010	6/15/2010	Outpatient	250	$ 150.00		$ 500.00		Exhausted	66666
Uninsured Charges	Medicare		12345	4444444	7/12/1965	999-99-999	Male	Jones, James	6/15/2010	6/15/2010	Outpatient	450	$ 750.00		$ 500.00		Exhausted	66666
Uninsured Charges	Blue Cross		12345	1111111	3/5/2000	999-99-999	Male	Smith, Mike	6/10/2010	6/10/2010	Outpatient	450	$ 1,100.00			$ 100.00	Non-Covered Service	77777

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 ’11 cost report year that relates to a service provided in the ’06 cost report year, must be used to reduce uninsured cost for the ’11 cost report year.
- Submit Exhibit B in the format shown using Excel or a CSV file using the tab or | (pipe symbol above the enter key).

Claim Type (A)	Primary Payor Plan (B)	Secondary Payor Plan (C)	Transaction Code (D)	Hospital's Medicaid Provider # (E)	Patient Identifier Number (PCN) (F)	Patient's Birth Date (G)	Patient's Social Security Number (H)	Patient's Gender (I)	Name (J)	Admit Date (K)	Discharge Date (L)	Date of Cash Collection (M)	Amount of Cash Collections (N)	Indicate if Collection is a 1011 Payment (O)	Service Indicator (Inpatient / Outpatient) (P)	Total Hospital Charges for Services Provided (Q)	Total Physician Charges for Services Provided (R)	Total Other Non-Hospital Charges for Services Provided (S)	Insurance Status When Services Were Provided (Insured or Uninsured) (T)	Claim Status (Exhausted or Non-Covered Service, if applicable) (U)	Calculated Hospital Uninsured Collections if (T)="Uninsured" or (U)="Exhausted" or "Non-Covered Service", (Q)x((Q)+(R)+(S))* (N), 0)	Account # (W)
Self Pay Payments	Medicare	Medicaid	500	12345	3333333	2/7/2025	999-99-999	Male	Jones, Anthony	7/12/1995	7/14/1995	1/7/2010	$ 50	No	Inpatient	$ 10,000	$ 900	$ -	Insured		$ -	67891
Self Pay Payments	Medicare	Medicaid	500	12345	3333333	2/7/2025	999-99-999	Male	Jones, Anthony	7/12/1995	7/14/1995	2/1/2010	$ 50	No	Inpatient	$ 10,000	$ 900	$ -	Insured		$ -	67891
Self Pay Payments	Medicare	Medicaid	500	12345	3333333	2/7/2025	999-99-999	Male	Jones, Anthony	7/12/1995	7/14/1995	3/1/2010	$ 50	No	Inpatient	$ 10,000	$ 900	$ -	Insured		$ -	67891
Self Pay Payments	Medicare	Medicaid	500	12345	3333333	2/7/2025	999-99-999	Male	Jones, Anthony	7/12/1995	7/14/1995	4/1/2010	$ 50	No	Inpatient	$ 10,000	$ 900	$ -	Insured		$ -	67891
Self Pay Payments	Blue Cross		150	12345	9999999	9/25/1979	999-99-999	Male	Smith, John	9/21/2000	9/24/2000	9/30/2009	$ 150	No	Outpatient	$ 2,000	$ -	$ 50	Insured	Exhausted	$ 146	76912
Self Pay Payments	Blue Cross		150	12345	9999999	9/25/1979	999-99-999	Male	Smith, John	9/21/2000	9/24/2000	10/31/2009	$ 150	No	Outpatient	$ 2,000	$ -	$ 50	Insured	Exhausted	$ 146	76912
Self Pay Payments	Blue Cross		150	12345	9999999	9/25/1979	999-99-999	Male	Smith, John	9/21/2000	9/24/2000	11/30/2009	$ 150	No	Outpatient	$ 2,000	$ -	$ 50	Insured	Exhausted	$ 146	76912
Self Pay Payments	Self-Pay		500	12345	7777777	7/9/2000	999-99-999	Male	Cliff, Heath	12/31/2009	1/5/2010	5/15/2010	$ 90	No	Inpatient	$ 15,000	$ 1,000	$ -	Uninsured		$ 84	89123
Self Pay Payments	Self-Pay		500	12345	7777777	7/9/2000	999-99-999	Male	Cliff, Heath	12/31/2009	1/5/2010	5/31/2010	$ 90	No	Inpatient	$ 15,000	$ 1,000	$ -	Uninsured		$ 84	89123
Self Pay Payments	United Healthcare		500	12345	5555555	2/15/1960	999-99-999	Male	Johnson, Joe	9/1/2005	9/3/2005	11/12/2010	$ 130	No	Inpatient	$ 14,000	$ 400	$ 50	Insured	on-Covered Servi	$ 125	91234

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)
- 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).

Claim Type (A)	Primary Payor Plan (B)	Secondary Payor Plan (C)	Hospital's Medicaid Provider # (D)	Patient Identifier Number (PCN) (E)	Patient's Medicaid Recipient # (F)	Patient's Birth Date (G)	Patient's Social Security Number (H)	Patient's Gender (I)	Name (J)	Admit Date (K)	Discharge Date (L)	Service Indicator (Inpatient / Outpatient) (M)	Revenue Code (N)	Total Charges for Services Provided (O)	Routine Days of Care (P)	Total Medicare Payments for Services Provided (Q)	Total Medicaid Payments for Services Provided (R)	Party Liability Payments for Services Provided	Self-Pay Payments (T)	Sum of All Payments Received on Claim (Q)+(R)+(S)+(T)	Account # (V)
Medicaid MCO	Healthcare USA	BCBS Blue Advantage	12345	888888	123456789	1/1/1950	999-99-999	Male	James, Samuel	9/1/2009	9/4/2009	Inpatient	120	$ 1,200	3	$ -	$ 1,500	$ 50	$ -	$ 1,550	44444
Medicaid MCO	Healthcare USA	BCBS Blue Advantage	12345	888888	123456789	1/1/1950	999-99-999	Male	James, Samuel	9/1/2009	9/4/2009	Inpatient	206	$ 1,500	1	$ -	$ 1,500	$ 50	$ -	$ 1,550	44444
Medicaid MCO	Healthcare USA	BCBS Blue Advantage	12345	888888	123456789	1/1/1950	999-99-999	Male	James, Samuel	9/1/2009	9/4/2009	Inpatient	250	$ 100	-	$ -	$ 1,500	$ 50	$ -	$ 1,550	44444
Medicaid MCO	Healthcare USA	BCBS Blue Advantage	12345	888888	123456789	1/1/1950	999-99-999	Male	James, Samuel	9/1/2009	9/4/2009	Inpatient	300	$ 375	-	$ -	$ 1,500	$ 50	$ -	$ 1,550	44444
Medicaid MCO	Healthcare USA	BCBS Blue Advantage	12345	888888	123456789	1/1/1950	999-99-999	Male	James, Samuel	9/1/2009	9/4/2009	Inpatient	450	$ 1,500	-	$ -	$ 1,500	$ 50	$ -	$ 1,550	44444
Medicaid MCO	Family Health Partners		12345	666666	97865321	7/12/1965	999-99-999	Female	Johnson, Sandy	6/30/2010	6/30/2010	Outpatient	250	$ 100	-	$ -	$ 900	$ -	$ 75	$ 975	33333
Medicaid MCO	Family Health Partners		12345	666666	97865321	7/12/1965	999-99-999	Female	Johnson, Sandy	6/30/2010	6/30/2010	Outpatient	300	$ 375	-	$ -	$ 900	$ -	$ 75	$ 975	33333
Medicaid MCO	Family Health Partners		12345	666666	97865321	7/12/1965	999-99-999	Female	Johnson, Sandy	6/30/2010	6/30/2010	Outpatient	450	$ 1,500	-	$ -	$ 900	$ -	$ 75	$ 975	33333
Medicaid MCO	BCBS Blue Advantage	Self-Pay	12345	555555	654321978	3/5/2000	999-99-999	Female	Jeffery, Susan	2/28/2010	2/28/2010	Outpatient	300	$ 375	-	$ -	$ 1,000	$ 100	$ -	$ 1,100	22222
Medicaid MCO	BCBS Blue Advantage	Self-Pay	12345	555555	654321978	3/5/2000	999-99-999	Female	Jeffery, Susan	2/28/2010	2/28/2010	Outpatient	450	$ 1,500	-	$ -	$ 1,000	$ 100	$ -	$ 1,100	22222

EXHIBIT C – Example – Medicaid 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 all of Part I and all of the Part II surveys are prepared.
- Includes list of all supporting documentation that need to be submitted with the survey for audit.
- Includes Myers and Stauffer address and phone numbers.

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DSH SURVEY PART I – DSH YEAR DATA

Submission Checklist

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

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DSH SURVEY PART I – DSH YEAR DATA

Submission Checklist (cont.)

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

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DSH SURVEY PART I – DSH YEAR DATA

Submission Checklist (cont.)

7. Electronic copy of Exhibit C for hospital-generated data (includes Medicaid eligibles, Medicare cross-over, Medicaid MCO, Medicaid eligible but not billed, 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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DSH YEAR 2011 EXAMINATION TIMELINE - TENTATIVE

- FTP Site agreements due March 18, 2014
- Surveys uploaded to FTP Site March 24, 2014
- Surveys returned by April 30, 2014
- Desk Reviews May 2014 – July 2014
- Expanded Reviews July – September 2014
- Draft report to the state by September 30, 2014

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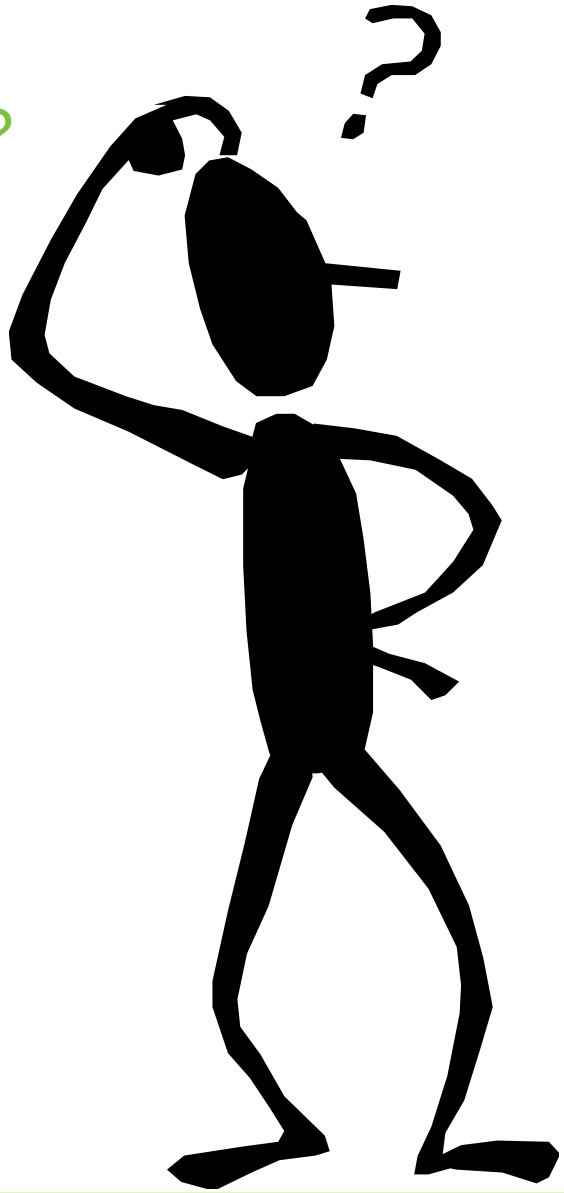
QUESTIONS/COMMENTS?



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FAQ'S

1. What is the definition of uninsured for Medicaid DSH purposes?
2. What is meant by "Exhausted" and "Non-Covered" in the uninsured Exhibits A and B?
3. What categories of services can be included in uninsured on the DSH survey?
4. Can a service be included as uninsured, if insurance didn't pay due to improper billing, late billing, or lack of medical necessity?
5. Can unpaid co-pays or deductibles be considered uninsured?
6. Can a hospital report their charity charges as uninsured?
7. Can bad debts be considered uninsured?
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?

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FAQ'S

9. Can a hospital report services covered under automobile polices as uninsured?

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

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

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

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

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

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

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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). If the patient had health insurance, even if the third party insurer did not pay, those services are insured and cannot be reported as uninsured on the survey. Prisoners must be excluded.

- CMS released a proposed rule in the January 18, 2012 Federal Register to clarify the definition of uninsured and prisoners.
- Under this proposed rule, the DSH examination will now look at whether a patient is uninsured using a “service-specific” approach as opposed to the creditable coverage approach previously employed.
- The rule is still not “final” but the survey does allow for hospitals to report “exhausted” and “insurance non-covered” services as uninsured.

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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 proposed rule as:

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

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FAQ

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

   Under the January 18, 2012 proposed rule, hospitals can report services if insurance is "exhausted" or if the service provided was "not covered" by insurance. The service must still be a hospital service that would normally be covered by Medicaid.

   Since the rule is not final, these services must be segregated on Exhibits A and B of the survey.

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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 proposed 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 proposed rule as an exhausted or insurance non-covered service.

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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 Proposed 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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CONCLUSION

- Although the process is different, the documentation requirements remain the same
- Uninsured costs will be calculated using the CMS proposed rule in anticipation of the final rule.
- New DSH Audit Guidance Expected sometime during 2014
- Please contact us with any questions you have regarding the surveys

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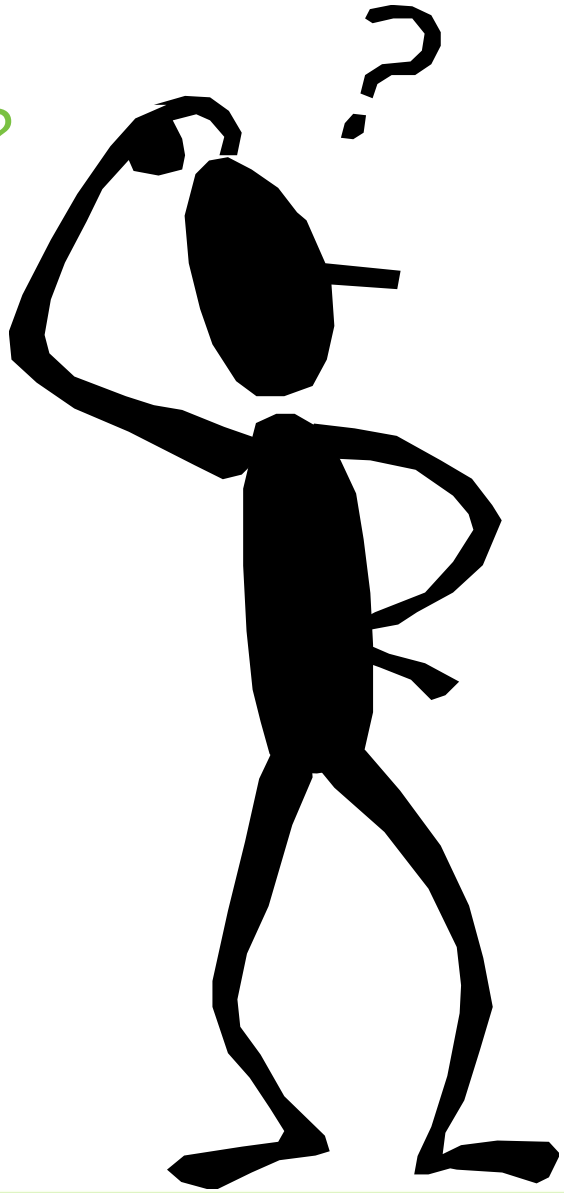
QUESTIONS/COMMENTS?



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