FREQUENTLY ASKED QUESTIONS
Texas Disproportionate Share Hospital (DSH) Program Examination
Medicaid State Plan Rate Year (10/01/2017 – 09/30/2018)

1. **Why do we have to report two Part II Surveys for twenty-four months of Medicaid and uninsured claims instead of just reporting claims for the 12 months of the DSH year?**

CMS regulations state that costs and revenues must first be determined by cost reporting period and then allocated to the Medicaid State Plan (MSP) Rate Year under review. This is a change from the methodology used prior to the DSH 2009 examination.

For example, if a hospital has a cost reporting year end of 06/30 they would need to complete ***two*** twelve month Part II surveys, one for the year ended 06/30/2013 and one for the year ended 06/30/2014. The hospital would ***NOT*** complete one Part II survey for the six months ended in 2012 and a separate Part II survey for the six months ended in 2013.

The portion of the cost report year based Uncompensated Care Cost (UCC) prorated to the MSP rate year is based on a percentage of applicable cost report days. The table below illustrates this allocation. In this example the cost report year end is 6/30 and each spanning cost report UCC is fixed at $1,000,000. Year 1 allocates 273 of 365 days (74.79%). Year 2 allocates 92 of 365 days (25.21%). The percentages are not rounded.

Texas Medicaid DSH Examination Uncompensated Care Cost (UCC) For State Fiscal Year: 10/1/2012 - 9/30/2013

	Cost Report Year Begin		Cost Report Year End	Adjusted DSH Uncompensated Care Cost (UCC)		% of Year Applicable		Totals
Cost Report Year 1 UCC:	7/1/2012	-	6/30/2013	$ 1,000,000	X	74.7945%	=	$ 747,945
Cost Report Year 2 UCC:	7/1/2013	-	6/30/2014	$ 1,000,000	X	25.2055%	=	$ 252,055

This is evidenced by the citations below from the DSH Auditing Final Rule and the General DSH Audit and Reporting Protocol.

a. *From: FR Vol. 73, No. 245, Friday, Dec. 19, 2008*

(*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.

b. From: General DSH Audit and Reporting Protocol

Data Sources:

The following are to be considered the primary data sources utilized by states, hospitals and the independent auditors to complete the DSH audit and the accompanying report. In many instances, hospital financial and cost report periods will differ from the Medicaid State plan rate year. In these instances, hospitals should use multiple audited financial reports and hospital cost reports to fully cover the Medicaid State plan rate year under audit. The data should be directly allocated based on the months covered by the financial or cost reporting period that directly related to the Medicaid State plan period under audit. For instance, if a Medicaid State plan rate year runs from 7/1/04 to 6/30/05 but a DSH hospital receiving payments under the Medicaid State plan operates its financial and cost reporting based on a calendar year, the hospital would need to use financial and cost reports for calendar years 2004 and 2005. The hospital would allocate 50% of all costs and revenues in each financial and cost reporting period to determine costs and revenues associated with the Medicaid State plan rate year 2005.

Comment: This states that the hospital would allocate 50% of all costs and revenues, not 50% of days and charges. In order to allocate 50% of all costs and revenues of each cost reporting period a hospital must first calculate 100% of all costs and revenues for each cost reporting period.

c. From: General DSH Audit and Reporting Protocol

Data Sources: - General Cost Determination: Uncompensated Care Cost Determination

The Medicare cost allocation process will be used to determine facility costs for inclusion in determining DSH eligible hospital costs. In order to provide complete financial information for the Medicaid State plan rate year under audit, hospitals must use two or more Medicare costs reports if the cost reporting period does not correspond with the Medicaid State plan rate year under audit. Once costs are allocated according to the Medicare cost allocation process, those costs should be allocated to the Medicaid State plan rate year on a pro-rata basis to develop 12 full months of costs.

Comment: This states that once costs are allocated to the cost reporting period they are then pro-rated to the MSP rate year, not pro-rated *before* costs are allocated.

2. **Will we have to report two cost report years' worth of claims (24 months) for every DSH audit?**

   No, Part II surveys completed in the previous year will be used again in the subsequent year to span that DSH year. If the hospital reports two years of uncompensated care costs for the cost report periods spanning DSH year 2017, they will only need to report one additional year of uncompensated care cost for the cost report periods spanning DSH year 2018 (assuming no change to the hospital fiscal year end).

3. **Does the provider have to populate Section H, I, J, and K?**

   Yes, the hospital should utilize their Exhibit X – Revenue Code Crosswalk to report days, charges and payments by cost center for Medicaid and the uninsured. In addition, each hospital should verify that the pre-populated HRCIS data in all other Sections are properly stated.

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

   On December 3, 2014, the Department of Health and Human Services Centers for Medicare & Medicaid Services (CMS) published 79 FR 71679, a final rule to modify the definition of uninsured for purposes of auditing DSH payments.

   Per 79 FR 71679: "This final rule addresses the hospital-specific limitation on Medicaid disproportionate share hospital (DSH) payments under the Social Security Act (the Act). Under this limitation, DSH payments to a hospital cannot exceed the uncompensated costs of furnishing hospital services by the hospital to individuals who are Medicaid-eligible or ''have no health insurance (or other source of third party coverage) for the services furnished during the year.'' This rule provides that, in auditing DSH payments, the quoted test will be applied on a service-specific basis; so that the calculation of uncompensated care for purposes of the hospital-specific DSH limit will include the cost of each service furnished to an individual by that hospital for which the individual had no health insurance or other source of third party coverage." By comparison, CMS states: "The regulatory definition published in the 2008 DSH final rule was more restrictive than the service-specific definition and is applied on an individual-specific basis rather than a service-specific basis."

   To summarize this final rule for uninsured services:

   - If the individual has no source of third-party coverage for the specific inpatient hospital or outpatient hospital service, states should classify the individual as uninsured and include all costs and revenues associated with that particular service when calculating the hospital-specific DSH limit.

- Individuals who have exhausted benefits before obtaining services will be considered uninsured.

- Individuals who exhaust covered benefits during the course of a service will not be considered uninsured for that particular service. If the individual is not Medicaid eligible and has a **source of third party coverage for all or a portion of the single inpatient stay** for a particular service, the costs and revenues of that service **cannot be included** in the hospital-specific DSH limit.

- Individuals with **high deductible or catastrophic plans** are considered insured for the service even in instances when the policy requires the individual to satisfy a deductible and/or share in the overall cost of the hospital service. The cost and revenues associated with these claims **cannot be included** in the hospital-specific DSH limit.

Based on this final rule, Myers and Stauffer can accept uninsured supporting documentation for services provided to patients where their insurance coverage was "Exhausted" or "Non-covered".

Excluded prisoners were reiterated in the final 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

5. 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.

6. **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)*

7. **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)*

8. **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.

9. **Can bad debts be considered uninsured?**

   Bad debts cannot be considered uninsured if the patient has third party coverage.

10. **How do IMDs (Institutes for Mental Disease) report patients between the ages of 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 new uninsured rule (see #4 above), these patients may be included in the DSH UCC if Medicare is exhausted.

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

Not if the automobile policy pays for the service (such as when an automobile liability insurance policy pays for a hospital stay). *(Reporting pages 77911 & 77916)*

12. 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. Exhibit B must also include payments received by the hospital from Managed Care Organizations contracted to administer and pay for services under a State/Local-Only Indigent Care Program (see FAQ 14 below).

13. 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.

14. 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)* However, payments related to state and local only indigent care program claims for such programs where a private Managed Care Organization (MCO) is delivering the services to the indigent patients and is paying the hospital for the services provided must be reported on Exhibit B. Per CMS FAQ published April 7, 2014 (#12), these payments from the MCO must be netted against cost in the UCC calculation. These payments should NOT include any state/local government indigent care program claims where the patient is also enrolled in Medicaid, Medicare, or private insurance.

15. 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)*. For UC purposes, these may be allowable on the Schedule 1 and 2 Survey. Please see Schedule 1 and 2 instructions for further details.

16. Do Dual eligibles (Medicare/Medicaid) and Commercial Primary with Medicaid Secondary services have to be included in the Medicaid UCC?

Yes. Costs attributable to Medicaid eligible patients should be included in the calculation of the uncompensated care costs. To calculate the uncompensated care costs for hospital services on or after June 2, 2017, CMS believes it is necessary to take into account the

Medicare, Commercial and Medicaid payments made even if the Medicaid payments are zero.

UPDATE:
On December 31, 2018, CMS released a bulletin stating that it was withdrawing FAQs 33 and 34 from the Medicaid Disproportionate Share Hospital guidance that was issued in January 2010 titled "Additional Information on the DSH Reporting and Audit Requirements." This means that these FAQs are no longer operative. CMS also stated in this bulletin that hospital services on or after June 2, 2017 are covered by a Final Rule issued on April 3, 2017, which dictates that Medicare and private insurance payments be included in the DSH uncompensated care cost calculation. On August 13, 2019 the United States Court of Appeals for the District of Columbia Circuit overturned the District Court ruling in *Children's Hospital Ass'n of Texas v. Azar* and reinstated the April 3, 2017 DSH Final Rule (Decision No. 18-1778).

Implications for DSH examinations: Myers and Stauffer will continue to collect and measure uncompensated care costs to include all Medicaid eligible costs and payments, including payments from Medicare and private insurance. In accordance with the April 3, 2017 Final Rule and Method #2 per the CMS Bulletin released August 18, 2020, combined with CMS *Additional Information on the DSH Reporting and Audit Requirements – Part 2, #21*, uncompensated care costs for the DSH 2018 examination will be calculated to include a prorated amount of Medicare and private insurance payments. This proration will be based on the number of days in a hospital's cost report period(s) that overlap the period from the June 2, 2017 Final Rule effective date to September 30, 2018 (Texas' DSH year-end).

17. Dual Eligible, do we report claims even if Medicaid made no payments?

Yes, hospitals should report dual-eligible claims even if Medicaid made no payments.

18. 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)*

19. What is the definition of Cash Subsidies in Survey Part II Section F?

Cash Subsidies in this section are payments received from locally-only funded programs and state-only funded programs. These payments should be consistent with the definitions used on the Texas DSH payment application. Please note that cash subsidies should be accumulated on the cost report year for each Part II survey.

20. What is the definition of Charity Care in Survey Part II Section F?

Charity Care charges must be consistent with §311.031 of the *Texas Health and Safety Code* and 1 *Texas Administrative Code* §355.8065(b) and should reconcile to your Audited Financial Statements. These charges should be consistent with the definitions used on the Texas DSH payment application. Please note that charity care charges should be accumulated on the cost report year for each Part II survey.

21. How do we capture Uncompensated Care Pool distributions (UC)?

Myers and Stauffer will forward the UC DY7 distribution reported by HHSC to each applicable hospital, including the amount applicable to the hospital-specific limit, to be reported on the DSH Part I Survey.

22. Where do we report Primary Care Case Management (PCCM)?

PCCM claims will be included in the fee-for-services claims provided by Texas MMIS (Accenture).

23. Is there a list of non-covered Medicaid revenue codes that could be made available?

Please refer to the Texas Medicaid Provider Manual for guidance regarding non-covered Medicaid services.

24. Data transmission to Myers and Stauffer – Does the data need to be encrypted?

Please follow your hospital policies regarding Protected Health Information. Myers and Stauffer provides a secure web-based portal for transferring files.

25. What happens if we can't get out-of-state or Managed Care Organization (MCO) PS&Rs or paid claims summaries?

If PS&Rs or paid claims summaries are not available from out-of-state Medicaid agencies or MCOs, please utilize the hospital's accounting records to report these claims and include with your survey submission a detailed claims listing using Exhibit C.

26. Do we have to follow the formatting of Exhibit A, B and C to report patient level detail by revenue code?

YES. Exhibits A, B and C are formatted to provide the level of detail necessary to support hospital reported claims that are summarized by revenue code for cost center grouping on Sections H and I using your Medicare crosswalk. These Exhibits are formatted specifically to allow for computerized testing of detailed claims. Exhibit data received in anything other than the prescribed formats will be rejected and the submission will be considered incomplete/non-compliant.

27. **Regarding Survey Part I – Physician Certification: Are these physicians for state year 2018 or current year?**

    These physicians should be for Medicaid state plan rate year 2018.

28. How should a hospital report patient payments for "package plans"?

If "package plans" refers to Managed Care Organization payments, then (per CMS protocol) any managed care payments received that include payments for services other than those that qualify for inpatient or outpatient hospital services must be separated to include that portion of the payment applicable to inpatient or outpatient hospital services. If the hospital cannot separate the component parts of a managed care payment, the full amount of the payment must be counted as in IP/OP hospital managed care payment.

29. Can ambulance or air ambulance be included on the DSH survey?

Ambulance/Air Ambulance should not be included on the DSH survey. In order for a service to be included in the hospital specific DSH limit (reported on the survey) that service must be billed and reimbursed as an inpatient or outpatient hospital service and included as a Medicaid covered hospital inpatient or outpatient service in the Medicaid Provider Manual. Hospital-operated Ambulance should have an ambulance provider number and bill for those services using that number and not as a hospital service.

30. Can ESRD be included on the DSH survey?

ESRD should not be included on the DSH survey. In order for a service to be included in the hospital specific DSH limit (reported on the survey) that service must be billed and reimbursed as an inpatient or outpatient hospital service and included as a Medicaid covered hospital inpatient or outpatient service in the Medicaid Provider Manual. Hospital-operated ESRD should have a renal dialysis provider number and bill for those services using that number and not as a hospital service.