MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

DSH YEAR 2018 PAYMENT EXAMINATION AND DSH HOSPITAL UC DY7 RECONCILIATION

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

OVERVIEW

- DSH Examination Policy
- DSH and UC Timeline
- DSH Year 2018 Examination Impact
- Overview of DSH Year 2018 Survey
- Overview of Exhibits and Claims Data
- 2018 Highlights
- Recap of Prior Year Examination (2017)
- Web Portal
- UC Final Reconciliations – Engagement Year 2021

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

RELEVANT DSH POLICY

- DSH Implemented under Section 1923 of the Social Security Act (42 U.S. Code, Section 1396r-4)
- Audit/Reporting implemented in FR Vol. 73, No. 245, Friday, Dec. 19, 2008, Final Rule
- Medicaid Reporting Requirements
  42 CFR 447.299 (c)
- Independent Certified Audit of State DSH Payment Adjustments
  42 CFR 455.300 Purpose
  42 CFR 455.301 Definitions
  42 CFR 455.304 Conditions for FFP
- February, 2010 CMS FAQ titled, "*Additional Information on the DSH Reporting and Audit Requirements*"
- Allotment Reductions and Additional Reporting Requirements implemented in FR Vol. 78, No. 181, September 18, 2014, Final Rule

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

RELEVANT DSH POLICY (CONT.)

- CMCS Informational Bulletin Dated December 27, 2014 delaying implementation of Medicaid DSH Allotment reductions 2 years
- April 1, 2014 – P.L. 113-93 (Protecting Access to Medicare Act) delays implementation of Medicaid DSH Allotment reductions 1 additional year
- Additional Information of the DSH Reporting and Audit Requirements – Part 2, clarification published April 7, 2014
- Audit/Reporting implemented in FR Vol. 79, No. 232, Wednesday, December 3, 2014, Final Rule
- “Medicare Access and CHIP Reauthorization Act” – Public Law, April 16, 2015, Sec. 412 delayed DSH reductions until FY 2018
- State DSH Hospital Allotment Reductions, July 28, 2017 FR Vol. 52, No. 144, Proposed Rule

RELEVANT DSH POLICY (CONT.)

- DSH Treatment of Third Party Payers in UCC in FR Vol. 82, No. 62, Monday, April 3, 2017, Final Rule

- CMS Bulletin dated December 31, 2018 removing CMS FAQs 33 & 34 from DSH guidance

- Bi-partisan Budget Act of 2018, enacted on February 9, 2018 delayed DSH reductions until FY 2020

- CARES Act §3813 delayed until December 1, 2020

- Consolidated Appropriations Act of 2021 delayed DSH reductions until FY 2024

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

DSH YEAR 2018 EXAMINATION
UC DSH DY7 RECON TIMELINE

- Surveys emailed March 04, 2021
- Surveys returned by April 05, 2021
- Draft DSH report to HHSC by September 13, 2021
- Final DSH report to HHSC by November 15, 2021
- Draft UC results to HHSC by December 3, 2021
- Final UC results to HHSC by December 17, 2021

UC FINAL RECONCILIATION TIMELINE

- Final Reconciliations by December 17, 2021
  - DY7: All Hospitals
    - DSH UC Hospitals completed with DSH Examination
    - Non-DSH UC Hospitals: plan to be notified in mid/late May 2021 with a mid/late June 2021 submission deadline

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

DSH YEAR 2018 EXAMINATION IMPACT

- The DSH 2018 examination report will be the eighth year that will result in DSH payment recoupment for hospitals found to have received DSH payments in excess of their actual Uncompensated Care Costs.
- 1 TAC 355.8065(o)(1)(D): A hospital that fails to provide requested information or to otherwise comply with the independent certified audit requirements may be subject to a withholding of Medicaid disproportionate share payments or other appropriate sanctions.

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

DSH EXAMINATION SURVEYS

General Instruction – Survey Files

- The survey is split into 2 separate Excel files:
  - DSH Survey Part I – DSH Year Data
    - DSH year-specific information
    - Always complete one copy.
  - DSH Survey Part II – Cost Report Period Data
    - Cost report period-specific information
    - Complete a separate copy for each cost report period needed to cover the DSH year.
- 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.

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

DSH EXAMINATION SURVEYS

General Instruction – Survey Files

- Don’t complete a DSH Part II survey for a cost report period already submitted in a previous DSH exam year.
    - Example: Hospital A provided a survey for their year ending 12/31/17 with the DSH examination of MSP rate year 2017 in the prior year. In the DSH year 2018 exam, Hospital A would only need to submit a survey for their year ending 12/31/18. See MSLC FAQ #1 for details.
- Fourteen hospitals with year end changes or that are new to DSH will have to complete 2 period ends.

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

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.

DSH SURVEY PART I – DSH YEAR DATA

Section A

- DSH Year should already be filled in.

- Hospital name should already be selected. If not, contact Myers and Stauffer and request a new Survey.

- Verify the cost report year end dates. This should only include those that weren't previously submitted for DSH examination.

    - If these are incorrect, please contact Myers and Stauffer and request a new Survey.

Section B

- Answer ALL OB questions using drop-down boxes.
- If Question 1 is answered yes, provide the names and license numbers of two physicians that meet this requirement.
- Questions 3a and 3b must be completed if answering Yes to 3.

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

DSH SURVEY PART I – DSH YEAR DATA

Section C

- Enter your total Medicaid Supplemental Payments for the DSH Year including UC, GME, and Non-Claim Specific payments, for the DSH state plan rate year. Do not include payments for non-hospital services. 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”.
- The DSH payment for State Hospitals is retained by the State and this is **not** a basis for answering the question “No”.
- Enter hospital contact information; this is where we will mail results, if necessary.
- Have CEO or CFO sign this section after completion of Part II of the survey.

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

DSH SURVEY PART I – DSH YEAR DATA

Checklist

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

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

DSH YEAR SURVEY PART II
SECTION D – GENERAL INFORMATION

Submit one copy of the Part II Survey for each cost report period not previously submitted for DSH examination.

- Question #2 – An “X” should be shown in the column of the cost report period survey you are preparing. (if you have multiple periods listed, you will need to prepare multiple surveys). If there is an error in the period ends, contact Myers and Stauffer to request new surveys.

- Question #3 – This question may be already answered based on pre-loaded HCRIS data. If your hospital is going to update the cost report data to a more recent version of the cost report (supported with documentation), select the status of the cost report you are using with this drop-down box.

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

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

- 1-7: 1011 Payments - Section 1011 payments have concluded for Texas and this section should be left blank.
- 8: If your facility received DSH payments from another state (other than Texas) these payments must be reported on this section of the survey (calculate amount for the cost report period).
- 9-12: Enter in total cash basis patient payment totals from Exhibit B as instructed. These are check totals to compare to the supporting Exhibit B.

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

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

- 13-16: Medicaid managed care payments
  - Indicate on question 13 whether or not your hospital received any Medicaid managed care payments not paid at the claim level.
  - If question 13 is Yes, enter the amounts of non-claims based managed care payments on lines 14 and 15, distinguishing between hospital and non-hospital services.
  - Provide detailed support (remittance) for amounts entered on lines 14 and 15.

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

DSH YEAR SURVEY PART II SECTION F, MIUR/LIUR

- The state must report your actual MIUR and LIUR for the DSH year - data is needed to calculate the **federal** 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).

DSH YEAR SURVEY PART II SECTION F, MIUR/LIUR

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

- Myers and Stauffer will pre-load CMS HCRIS cost report data into this section. If it is incorrect or doesn't agree to a more recently audited version of the cost report, please correct as needed and update question #3 in Section D.

- Totals should agree with the cost report worksheets G-2 and G-3. If not, provide an explanation with the survey.

- Contractuals by service center are set-up to calculate based on total revenues and the total contractuals from G-3. If you have contractuals by service center or the calculation does not reasonably state the contractual split between hospital and non-hospital, overwrite the formulas as needed and submit the necessary support.

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

DSH YEAR SURVEY PART II SECTION G, COST REPORT DATA

- Calculation of “Medicaid” Routine Cost Per Diems
  - Days
  - Cost
- Calculation of “Medicaid” Ancillary Cost-to-Charge Ratios
  - Charges
  - Cost
- NF, SNF, and Swing Bed Cost for Medicaid, Medicare, and Other Payers

DSH SURVEY PART II
SECTION H, IN-STATE MEDICAID

- Enter inpatient (routine) days, I/P and O/P charges, and payments. The form will calculate cost and shortfall / long-fall for:
  - In-State FFS Medicaid Primary *(Traditional Medicaid)*
  - In-State Medicaid Managed Care Primary *(Medicaid MCO with some Medicare Medicaid Plan)*
  - In-State Medicare FFS Cross-Overs + MMP *(Traditional Medicare with Traditional Medicaid Secondary and Medicare Medicaid Plan)*
  - In-State Other Medicaid Eligibles ("OME") *(Medicaid <u>not billed</u> including Commercial Primary/Medicaid Secondary claims)*

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

DSH SURVEY PART II
SECTION H, IN-STATE MEDICAID

Allocation of Days and Charges to the appropriate Cost Center

- In 2013 HHSC changed its practice on acceptable cost allocation methodologies. See the **Cost Allocation Methodologies** document emailed with your surveys.

- Revenue code Crosswalk: as 1:1 or 1:many; Exhibit X – Revenue Code Crosswalk Template.

- Title XVIII Crossover Allocation or "Crossover Revenue and Usage Report" (% to total) for FFS + MMP crossover.

DSH SURVEY PART II
SECTION H, IN-STATE MEDICAID

- Medicaid Payments Generally Include:
  - Claim payments.
    - Traditional Medicaid, Medicaid Managed Care, Traditional Medicare, Medicare HMO, Private Insurance, and Self-Pay
- Medicaid cost report settlements.
- Medicare non-claims based payments (cross-overs).

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

DSH SURVEY PART II SECTION H, UNINSURED

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

DSH SURVEY PART II
SECTION H, UNINSURED

- In 2013 HHSC changed its practice on acceptable cost allocation methodologies. See the **Cost Allocation Methodologies** document emailed with your surveys.
  - Revenue Code Crosswalk: as 1:1 or 1:many; Exhibit X – Revenue Code Crosswalk Template.
- State/Local-only claims with no Medicare or private insurance liability can be included in Exhibit A. (Subset of uninsured; not its own payer)
  - See Additional Information of the DSH Reporting and Audit Requirements – Part 2, clarification published April 7, 2014, item #12.

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 confirm that this message is the result of use of adjudication date and not improper mapping.
- Calculated payments as a percentage of cost by payor (at bottom)
  - Payment-to-Cost Ratios (PCRs) calculated with Medicare & Private Insurance payments
  - Review percentages for reasonableness

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

DSH SURVEY PART II
SECTION I, OUT OF STATE MEDICAID

- Report Out-of-State (“OOS”) Medicaid days, ancillary charges and payments.
- Report in the same format as Section H including cost allocation by revenue code using Exhibit X. 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.

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

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

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

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 Sections H & I of the survey. (Days should also be excluded from H & I.)
- Medicaid and uninsured charges/days included in the cost report D-4 series as part of the total organ acquisition charges/days, must be excluded from Sections H & I of the survey.
- The reporting basis of organ activity should mirror that of the related payor

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

DSH SURVEY PART II
SECTION L, PROVIDER TAXES

- Cameron, Webb and Hidalgo Counties began administering a Local Provider Participation Fund (LPPF) for their hospitals as a result of the legislative session 2013.

- Hays, Gregg, Bowie, McLennan, Brazos and Bell Counties, as well as the city of Beaumont began administering a LPPF for their hospitals as a result of the legislative session 2015.

- Williamson, Grayson, Angelina, Smith, and Tom Green Counties began administering a LPPF for their hospitals as a result of the legislative session 2017.

- The hospital districts of Dallas and Tarrant counties, as well as the city of Amarillo, began administering a LPPF for their hospitals as a result of the legislative session 2017.

- Multiple localities/districts passed LPPF legislation during the 2019 session; due to timing, LPPF payments are not expected to be reported by participating hospitals for cost reports spanning the DSH 2018 year.

DSH SURVEY PART II
SECTION L, PROVIDER TAXES

- Federally, this mechanism is considered a provider tax or provider assessment and portions of the hospital's provider tax or provider assessment are allowable for DSH purposes.

- Section L is used to report allowable Medicaid Provider Tax (LPPF).

- Added 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 (expense/contractual should be reflected).

- Supporting documentation of LPPF expenses incurred and payments made during the cost report periods under examination should be submitted with the DSH Survey.

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

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., charges).
- 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).

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

MMIS CLAIMS AND ENCOUNTERS UPDATE

- Medicaid Fee-For-Service claims and Medicaid Managed Care encounter data
  - Same general format as last year.
  - Some Medicare Medicaid Plan (MMP) included in this population.
  - Reported based on cost report year (using adjudication date).
  - At revenue code level. Most claims will now be summarized by revenue code. The cost center code from Medlog mapping is reported when no revenue code is available in claims detail.
  - Detailed data is available upon request (Web Portal).
  - Will exclude non-Title 19 services (such as SCHIP).

MMIS CLAIMS AND ENCOUNTERS UPDATE

- Medicare/Medicaid cross-over claims data
  - Same general format as last year.
  - Medicare Medicaid Plan (MMP) included in this population.
  - This data will be in summary only, will not be at revenue code level.
  - Title XVIII Allocation Template or a “Crossover Revenue and Usage Report” must be utilized to allocate these days and charges to the appropriate cost centers.
  - Reported based on cost report year (using adjudication date).

MMIS CLAIMS/ENCOUNTERS UPDATE

- Medicare/Medicaid cross-over paid claims data (cont.)
  - Hospital is responsible for ensuring all Medicare payments are included in the final survey even if the payments are not reflected on the state's paid claim totals. Non-claims based Medicare payments may include, but are not restricted to:

Medicare Cost Report settlement	Bad Debt reimbursement
Direct GME payments	IME payments
Medicare DSH adjustment	Inpatient capital payments
Organ Acquisition payments	Intern and resident payments
Pass-through cost payments	Transitional corridor payments

  - Note: The expectation is that Critical Access Hospitals are reimbursed at cost after sequestration.

MMIS CLAIMS AND ENCOUNTERS UPDATE

- Medicare/Medicaid cross-over paid claims data (cont.)

  If it appears that non-claims based Medicare payments for crossover services have not been adequately accounted for, Myers and Stauffer may estimate these payments.

  If the hospital has any questions regarding which Medicare payments to include on the DSH survey, the hospital should reconcile the Medicare PS&R to the Medicare Cost Report Worksheet E schedules to verify that ALL non-claims based Medicare payments have been included. Hospitals often do not consider tentative settlements, for example.

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

CLAIMS AND ENCOUNTERS INFORMAL APPEAL FORM

- Per Federal DSH regulation and HHSC policy, hospitals must rely on MMIS data for Medicaid claims.

- If you find the MMIS data to be materially in error, you must complete the Claims and Encounters Informal Appeal Form. Failure to utilize the Form will result in a rejection of your request for MMIS claims and Encounters review.

- **Informal MMIS data appeals are limited to compilation errors made by MSLC**. Other data issues (e.g. adjudication errors by TMHP or MCOs, omitted claims or encounters, charge/payment amount discrepancies, billing errors by the hospital already appealed to HHSC, etc.) should have been considered and resolved during HHSC's formal data appeal processes for program years 2020 and 2021 and should not be listed on the Claims and Encounters Informal Appeal Form.

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

CLAIMS AND ENCOUNTERS INFORMAL APPEAL FORM FOR COMPILATION ERRORS

- Hospitals must include every claim that the hospital wishes to be considered. If the hospital believes that an error applies uniformly to a vast number of claims and/or hospitals (systemic), but only provides a sample of the problem, the hospital assumes the risk that the problem is not systemic. If the sample is not big enough to discover a systemic error or the error is not found to be systemic, only the actual claims or encounters appealed on the form will be considered for revision.

- Include appealed claims with MMIS data in appropriate Payor columns. Do not include with Other Medicaid Eligible - Not Billed.

- **Form must be submitted no later than your survey due date.**

CLAIMS AND ENCOUNTERS INFORMAL APPEAL FORM FOR COMPILATION ERRORS

- If the PCN and the ICN are not a valid combination, they will be rejected and no further review will be completed.

- Valid PCN
  - No more than 9 digits
  - PCN starting with Alpha character, number 8 or number 9 are not valid PCN for DSH
  - PCN starting with number 7 are not valid unless the claim is adjudicated after 10/1/2014

- Valid ICN
  - 24 digit claim specific Medicaid ICN: PPP/CCC/MMM/CCYY/JJJ/BBBBB/SSS (don’t include forward slash)

SELF-REPORTED CLAIMS AND ENCOUNTERS

- Other Medicaid Eligible (Medicaid not billed)
  - Medicaid-eligible patient services where Medicaid did not receive the claim would not have been included in the state's data. The hospital must submit these eligible services on Exhibit C for these claims to be included in the DSH uncompensated care cost (UCC).
  - Must include all payments from all payers including commercial and Medicare.
  - Must include revenue code detail.
  - Must EXCLUDE SCHIP and other non-Title 19 services.
  - Should be reported based on cost report year (using discharge date).

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

SELF-REPORTED CLAIMS AND ENCOUNTERS

- Other Medicaid Eligible (cont.)
  - 2008 DSH Rule requires that ***all*** Medicaid eligibles are reported on the DSH survey and included in the UCC calculation. This has been clarified in FR Vol. 82, No. 62.
  - **New In-State Other Medicaid Eligibles Provider Representation form included in notification package to assist providers in correctly and completely reporting in-state OME.**
  - Exhibit C should be submitted for this population. If we do not receive an Exhibit C and/or the completed OME Representation noted above, we may reject the hospital's submission and list the hospital as non-compliant in the 2018 DSH examination report.
  - Ensure that you ***separately report*** Medicaid, Medicaid MCO, Medicare, Medicare HMO, private insurance, and self-pay payments in Exhibit C.
  - Discussion on current court cases and developments affecting treatment of Medicare and Private Insurance payments later in the presentation.

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

SELF-REPORTED CLAIMS AND ENCOUNTERS

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

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

SELF-REPORTED CLAIMS DATA

- Uninsured Services
    - As in the past, uninsured charges/days will be reported on Exhibit A and self pay patient payments (made by or on behalf of the patient) will be reported on Exhibit B.
    - Must include revenue code detail.
    - Exhibit A uninsured charges/days should be reported based on cost report year (using discharge date).
    - Exhibit B patient payments will be reported based on cash basis (received during the cost report year).

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

SELF-REPORTED CLAIMS DATA

- State/Local-only Indigent Care Programs
    - Payments related to programs where a private Managed Care Organization is delivering the services to the indigent patients and is paying the hospital for the services provided must be reported on the Survey. Payments received by the hospital from the MCO must be used to offset costs per CMS FAQ April 7, 2014 (#12).
    - These claims are a subset of Uninsured Exhibit A for days and charges and a subset of Exhibit B for payments.
    - Days and charges must include revenue code detail.
    - Days and Charges should be reported based on cost report year (using discharge date) and on the accrual basis. Payments should be reported based on cost report year (date of collection) and on the cash basis.

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

EXHIBIT A – UNINSURED CHARGES/DAYS BY REVENUE CODE

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

EXHIBIT A – UNINSURED CHARGES/DAYS BY REVENUE CODE

- Exhibit A:
    - Include *Primary Payor Plan*, *Secondary Payor Plan*, Provider #, PCN, *Birth Date, SSN, Gender, Name, Admit, Discharge, Service Indicator,* ***Revenue Code****, Total Charges, Days, Patient Payments, Private Insurance Payments, and Claim Status* fields.
    - A complete list (key) of payor plans is required to be submitted separately with the survey.

EXHIBIT A – UNINSURED CHARGES/DAYS BY REVENUE CODE

- Claim Status (Column R) is the same as the prior year – need to indicate if Exhausted / Non-Covered Insurance claims are being included under the December 3, 2014 final rule.
  - If exhausted / non-covered insurance services are included on Exhibit A, then they must also be included as uninsured 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).

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

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

- Survey form Exhibit B has been designed to assist hospitals in collecting and reporting all patient payments received on a cash basis.
- Exhibit B should include all patient payments regardless of their insurance status.
- Total patient payments from this exhibit are entered in Section E of the survey.
- Insurance status should be noted on each patient payment so you can sub-total the uninsured hospital patient payments and enter them in Section H of the survey.

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

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

- Patient payments received for uninsured services need to be reported on a cash basis.

- For example, a cash payment received during the 2018 cost report year that relates to a service provided in the 2008 cost report year, must be used to reduce uninsured cost for the 2018 cost report year.

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

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

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

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

EXHIBIT C – HOSPITAL-PROVIDED MEDICAID DATA BY REVENUE CODE

- 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. Data must be reported at the revenue code level. Otherwise, the data may not be allowed in the final UCC.

EXHIBIT C – HOSPITAL-PROVIDED MEDICAID DATA BY REVENUE CODE

- Types of data that may require an Exhibit C are as follows:
  - Self-reported Commercial/Medicaid data (Survey Section H) for Medicaid covered services not billed to Medicaid (Other Medicaid Eligible)
  - All self-reported Out-of-State Medicaid categories (Survey Section I)

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

EXHIBIT C – HOSPITAL-PROVIDED MEDICAID DATA BY REVENUE CODE

- Exhibit C
    - Include *Primary Payor Plan*, *Secondary Payor Plan, Hospital MCD #, PCN,* ***Patient's MCD Recipient #, DOB, Social, Gender****, Name, Admit, Discharge, Adjudication, Service Indicator,* ***Revenue Code****, Total Charges, Days, Medicare Traditional Payments, Medicare Managed Care Payments, Medicaid FFS Payments, Medicaid MCO Payments, Private Insurance Payments, Self-Pay Payments, and Sum All Payments* fields.
    - A complete list (key) of payor plans is required to be submitted separately with the survey.

EXHIBIT C – HOSPITAL-PROVIDED MEDICAID DATA BY REVENUE CODE

- Exhibit C
    - Include Patient Medicaid Recipient Number (required; needed to compare to TX MMIS data)
        - Should also include Birth Date, Social Security Number and Gender
- Submit Exhibit C in the format shown using Excel or a CSV file using the tab or | (pipe symbol above the enter key).
- Exhibits missing required elements (including Medicaid ID) may be rejected and the associated claims removed from the Survey

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

2018 HIGHLIGHTS

- Updated Non-covered revenue code listing (redistributed March 8, 2021)
- In-State Other Medicaid Eligible Provider Representation – new form; required if no or abnormal OME reported
- Exhibits C – Patient Medicaid ID required, as well as DOB, SSN and Gender
- *Managed Care contracts with all-inclusive rates.* If MCO payments are all-inclusive, providers should remove the professional fee portion of the payment from the DSH surveys, if identifiable. If hospital cannot identify the pro-fee portion of the payment, a reasonable % to total allocation of payments to professional fees will be accepted.

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

2018 HIGHLIGHTS

- 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 (FR Vol. 82, No. 62), which dictates that Medicare and Commercial 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).

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

2018 HIGHLIGHTS

- On August 18, 2020 CMS released a bulletin regarding the treatment of Third Party Payers (TPP) in calculating Uncompensated Care Costs (UCC) for DSH. The bulletin recommends using one of two described methods.
    - The state of Texas has elected to utilize Method #2 from this bulletin, combined with CMS *Additional Information on the DSH Reporting and Audit Requirements – Part 2* FAQ #21
- Myers and Stauffer will still collect and measure Uncompensated Care Costs to include all Medicaid eligible costs and payments, including payments from Medicare and Commercial insurance. In accordance with the April 3, 2017 Final Rule, CMS August 18, 2020 bulletin and FAQ #21, uncompensated care costs for the DSH 2018 examination will be calculated to include a prorated amount of Medicare and private insurance payments.

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

2018 HIGHLIGHTS

- 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).
    - Hospital results will resemble those issued during the 2017 DSH examination
- To ensure accurate reporting of all payments, please submit all information exactly as requested in Exhibit C. Specifically, ensure that you **separately identify** each claim's Medicaid FFS, Medicaid Managed Care, Medicare Traditional, Medicare Managed Care, Private Insurance, and Self-Pay payments into their individual columns as laid out in the Exhibit C template.

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

PRIOR YEAR DSH EXAMINATION (2017)

Significant Findings in Final Report

- One hospital had a DSH payment greater than its UCC
- One hospital did not submit the DSH documentation requested.
- The majority of hospitals did not or could not obtain out-of-state Medicaid Paid Claims Summaries (PS&Rs).
- Disclosures regarding treatment of Medicare/Other Insurance payments and Texas' use of adjudication date as reporting basis of Medicaid billed claims

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

PRIOR YEAR DSH EXAMINATION (2017)

Common Issues Noted During Examination

- Large fluctuations in level of OME claims reported, often with no or inadequate explanation of operational or billing changes
- Blanket exclusion of all dual-eligible patients from OME
- Improper shifting from routine cost centers to ancillary cost centers (disregarding revenue codes)
- Extremely low levels of uninsured payments reported
- Failure to include all Medicare payments on crossovers (e.g. tentative settlements)

PRIOR YEAR DSH EXAMINATION (2017)

Common Issues Noted During Examination

- Non-covered Medicaid services or non-hospital services in self-reported data (e.g. cosmetic or other elective procedures, SNF, RHC, home health, etc.)
- Duplicate patient claims in self-reported data and MMIS data, indicating flawed queries for Exhibits A and C
  - Traditional Medicare/Traditional Medicaid dual-eligibles in OME
  - Traditional Medicaid primary in OME/Uninsured

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

PRIOR YEAR DSH EXAMINATION (2017)

Common Issues Noted During Examination

- Inclusion of patients in the uninsured charges listing (Exhibit A) that are concurrently listed as insured in the payments listing (Exhibit B)
- Patients listed as both insured and uninsured in Exhibit B for the same dates of service
- DARS or CSHCN claims reported in Exhibit A with no corresponding payments reported in Exhibit B

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

PRIOR YEAR DSH EXAMINATION (2017)

Common Issues Noted During Examination

- Organ acquisition days and charges reported in Sections J/K and in Sections H/I simultaneously
  - Inconsistent reporting bases for organ activity between Sections H/I and J/K
- Payor plans reported on Exhibits A and C that are not consistent with the associated claim's classification (i.e. reporting insured payor plans on Exhibit A as uninsured with no indication of exhaustion/non-coverage)
  - Note: Claims with apparently insured payors with no exhaustion/non-coverage indicated may be removed

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

PRIOR YEAR DSH EXAMINATION (2017)

Common Issues Noted During Examination

- "Exhausted" / "Insurance Non-Covered" reported in uninsured <u>incorrectly</u> included the following:
  - Services partially exhausted. The entire stay, for all services, must be fully exhausted.
  - Denied due to timely filing.
  - Denied for medical necessity.
  - Denials for pre-certification.

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

PRIOR YEAR DSH EXAMINATION (2017)

Common Issues Noted During Examination

- Incorrect reporting of LPPF expense; inadequate documentation submitted to support expense.
- Hospitals should be prepared to reconcile general ledger/trial balance to cost report Worksheet A and DSH Survey Section L.

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

MOST COMMON QUESTIONS

See the FAQ emailed with your DSH Surveys. We will update the FAQ as needed based on feedback from these webinar sessions.

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

DSH APPLICATION WEB PORTAL

- We launched a web portal for providers to have a common place for handling file submissions.
- Can handle uploading and downloading of PHI.
- Protections based on IP address or a range of IP addresses.
- Contacts can be flagged as PHI-safe for downloading PHI from the portal.
- Contacts that are the same across projects only need one login.

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

DSH APPLICATION WEB PORTAL

- We have opened two Web Portals – one for each project
  - TX DSH 2018 Examination
  - TX 2021 UC Reconciliation (All DY7)
- For each hospital the web portal has Pages for each cost report year currently under review. Toggle between years using the dropdown**. Files must be loaded to the appropriate year.**
- Every document type has a unique Event; events have been added for new reporting requirements (OME representation; LPPF, etc.). **Files must be loaded to the appropriate Event.**
- Contact us immediately if you have a change in staffing and need to change Web Portal Access Rights

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

UC FINAL RECONCILIATIONS

- Final Reconciliation of TXHUC Schedules 1, 2 and 3 will be based on the actual cost of services for that demonstration year.

- For hospitals that received both a DSH payment and a UC Distribution for the same year, the results of the DSH examination will represent the Schedule 3 final HSL.

- UC limits include costs that are not allowable under the DSH rules.
  - Schedule 1 – Physicians and Mid-Level Professionals
  - Schedule 2 – Pharmacy Costs Related to the Texas Vendor Drug Program

- Schedule 1 and Schedule 2 costs will be calculated in a manner as closely resembling the TXHUC schedules as possible.

- IMDs will be required to accurately segregate and exclude the IMD 22-64 population. This exclusion should be supported with documentation.

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

UC FINAL RECONCILIATION IMPACT

- **Per TAC §355.8201,** Uncompensated Care distributions in excess of uncompensated cost of Schedule 1, 2 and 3 will be subject to recoupment.

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

RELEVANT UC POLICY

- Texas Healthcare Transformation and Quality Improvement Program Attachment H Part 1 (UC Claiming Protocol and Application Part I: UC Claiming for Hospitals and Physician Groups) – updated November 04, 2016
  - No Interim Reconciliation
  - Final Reconciliation based on Best Available Medicare Cost Report
- Texas Administrative Code §355.8201 Waiver Payments to Hospitals for Uncompensated Care
- Texas Health and Human Services Commission Policy and Practices

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

SCHEDULE 1 AND 2 SURVEY – COST REPORT YEAR DATA

- Separate workbook from the DSH Survey
- Requires best available Medicare cost reports
- By Cost Report Period End
- Closely resembles TXHUC Schedule 1 and 2 forms and instructions.

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

SCHEDULE 1 AND 2 SURVEY – COST REPORT YEAR DATA

Instructions

- Separate tab in Schedule 1 and 2 survey
- Updated to November 04, 2016 UC Protocol
- Updated based on common issues from previous groups of UC Final Reconciliations
- Includes detailed guidance for completing the Schedules

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

SCHEDULE 1 AND 2 SURVEY – COST REPORT YEAR DATA

Checklist

- Separate tab in Schedule 1 and 2 survey.
- Should be completed after Schedule 1 and 2 surveys are prepared.
- Includes list of all supporting documentation that needs to be submitted with the survey for reconciliation.
- Closely matches the web portal
- Includes Myers and Stauffer address and phone numbers.

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

SCHEDULE 1 – PHYSICIANS AND MID-LEVEL PROFESSIONALS

- Schedule 1 Column 1
  - Total physician and/or mid-level practitioner costs must agree to the best available Medicare Cost Report
  - See the Instructions Tab of the Schedule 1 and 2 Survey for detailed instructions related to Column 1
  - For cost report periods beginning on or after 10/01/2013 RHC may be allowable
  - For cost report periods beginning on or after 10/01/2012 time studies (or contracts containing equivalent information) are required for physicians and signed time proxies, at a minimum, are required for mid-level professionals

SCHEDULE 1 – PHYSICIANS AND MID-LEVEL PROFESSIONALS

- If Schedule 1 Allocation Statistic Basis is Hospital Charges
  - Your Medicare cost report and DSH Part II Surveys and support must be used as the source for these statistics
  - Cost center specific total charges should agree to your Medicare cost report.
  - Total aggregate charges should be used for cost centers not found on the DSH Survey such as General Service or Non-Reimbursable Cost Center (NRCC)
- If Schedule 1 Allocation Statistic Basis is Physician Charges
  - Your hospital records should be used as the source for these statistics

SCHEDULE 1 – PHYSICIANS AND MID-LEVEL PROFESSIONALS

- Schedule 1 Medicaid and Uninsured Charges, if using hospital charges as allocation statistic
  - Your Part II DSH Surveys and support must be used as the source for these charges
  - Please provide a supporting schedule that shows how you combined Medicaid payers from the DSH survey
  - Should include Other Medicaid Eligible and FFS Crossover charges

SCHEDULE 2 - TEXAS VENDOR DRUG PROGRAM

- Pharmacy costs related to prescription drugs provided by hospitals participating in the Texas Vendor Drug program.
- These pharmacy costs are not related to services provided by the hospital's retail pharmacy or billed to a third party payer under revenue code 253.
- Column 1 and 1a must come from the Medicare cost report.
- Must be able to document that Medicaid and uninsured charges are not duplicated on DSH Survey.
- Myers and Stauffer will rely on the Texas Vendor Drug Lookup to verify participation
- http://www.txvendordrug.com/providers/index.asp

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

PRIOR UC FINAL RECONCILIATIONS

Common Issues

- Cannot include costs on Schedule 1 that were not included on the Medicare Cost Report, Worksheet A, Columns 1 and/or 2 (NRCC exception noted below)
- Cannot include costs brought on to the Medicare Cost Report only on Worksheet A-8-1 (NRCC only exception)
- Cost center on Schedule 1 should agree to cost center on Cost Report where costs appeared on Worksheet A, columns 1 and/or 2 (should not reclass)

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

PRIOR UC FINAL RECONCILIATIONS

Common Issues

- Must provide <u>adequate</u> time studies or contracts containing the same information as a time study for physicians. <u>Signed</u> time proxies are required at a minimum for mid-level professionals.
- Must include all payments received by the hospital or assigned to the hospital for Schedule 1 and 2 services
- Cannot include costs on Schedule 2 unless they are related to hospital patients and the costs are related to the Texas Vender Drug program

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

PRIOR UC FINAL RECONCILIATIONS

Common Issues

- Schedule 2 cannot include retail pharmacy costs
- Hospitals must be prepared to prove that the Medicaid and uninsured charges reported on Schedule 2 are not duplicated on the DSH Survey

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

OTHER INFORMATION

- HHSC needs to be contacted as soon as possible of any business transaction or process that has a potential impact on a hospital's eligibility and/or payments for DSH or UC.
- If you are contemplating or have just entered into:
  - Change of ownership, merger, change of operating entity (including public operator to private operator or vice versa, filing bankruptcy, split a single hospital into multiple hospitals, changing licensee or license type (e.g., to or from a specialty hospital)

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

OTHER INFORMATION

Please use the DSH Part I Survey Submission Checklist and the Schedule 1 and 2 Checklist when preparing to submit your DSH and UC surveys and supporting documentation.

Send survey and other data to Myers and Stauffer by setting up a secure **Web Portal** account with us -or- please mail to:

Myers and Stauffer LC
Attn: TX DSH Examination
1131 SW Winding Road, Suite C
Topeka, KS 66615
(800) 255-2309
txdsh@mslc.com

Note: Exhibits and other support include protected health information and must be sent accordingly (no e-mail).