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DSH YEAR 2019 PAYMENT EXAMINATION AND DSH HOSPITAL UC DY8 RECONCILIATION

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

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OVERVIEW

- DSH Examination Policy
- DSH and UC Timeline
- DSH Year 2019 Examination Impact
- Recap of Prior Year Examination (2018)
- Overview of DSH Year 2019 Survey, Exhibits, and Claims Data
- Web Portal
- UC Final Reconciliations – Engagement Year 2022

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RELEVANT DSH POLICY

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

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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

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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

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DSH YEAR 2019 EXAMINATION
UC DSH DY8 RECON TIMELINE

- Surveys emailed March 04, 2022
- DSH Surveys returned by April 04, 2022
- UC Surveys (DSH Hospitals) returned by May 6, 2022
  - Staggered deadline (NEW) to promote improved submissions
- Draft DSH report to HHSC by September 15, 2022
- Final DSH report to HHSC by November 15, 2022
- Draft UC results to HHSC by December 2, 2022
- Final UC results to HHSC by December 16, 2022

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UC FINAL RECONCILIATION TIMELINE

- UC DY8 Results due to HHSC by December 16, 2022
  - DY8: All Hospitals
    - DSH UC Hospitals completed with DSH Examination
    - Non-DSH UC Hospitals: plan to be notified in mid/late May 2022 with a mid/late June 2022 HSL survey submission deadline
      - Non-DSH hospital UC survey submission deadline mid/late July 2022

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DSH YEAR 2019 EXAMINATION IMPACT

- The DSH 2019 examination report will be the ninth 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.

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DSH EXAMINATION SURVEYS

General Information – 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
    - Hospitals with year end changes, new, or returning to DSH may have to complete 2 period ends

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DSH EXAMINATION SURVEYS

General Instruction – HCRIS Data

- Certain sections of Part II survey preloaded with Healthcare Cost Report Information System (HCRIS) data from CMS
- Hospital is responsible for reviewing for accuracy
    - Ensure cost report data is best available (audited if possible)
- If no Medicare cost report on file, complete all lines as instructed

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DSH SURVEY PART I

- Section A: General DSH year information
- Section B: DSH qualifying information
- Section C: Disclosure of other Medicaid payments
- Certification
- Instructions
- Checklist

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DSH SURVEY PART II

- Section D: General Information
- Section E: Medicaid and Uninsured payments disclosure
  - Section 1011 payments
  - Out-of-state DSH payments
  - MCO non-claims based payments
  - Insured and uninsured cash basis payments
- Section F: MIUR and LIUR information
  - Hospital days
  - Cash subsidies and charity care charges
  - Patient revenues and contractual adjustments

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DSH SURVEY PART II

- Section G: Cost Report Data
  - Preloaded by Myers and Stauffer from HCRIS
  - Calculation of “Medicaid” Routine Cost Per Diems
    - Cost / Days
  - Calculation of “Medicaid” Ancillary Cost-to-Charge Ratios
    - Cost / Charges
  - NF, SNF, and Swing Bed Cost for Medicaid, Medicare, and Other Payers

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DSH SURVEY PART II

- Section H: In-State Medicaid and Uninsured
  - General Information
    - Calculates shortfall/longfall for In-state Medicaid and Uninsured
    - Captures routine days, IP and OP charges, and payments
    - Days and charges allocation methodologies
      - See the Cost Allocation Methodologies document
    - Report payments under corresponding payor, on correct payment line

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DSH SURVEY PART II

- Section H: In-State Medicaid Payors
  - In-State FFS Medicaid Primary (Traditional Medicaid)
    - Source of days, charges, claims payments is MMIS data
      - Excludes non-Title 19 services (e.g., SCHIP)
    - Based on cost report year (adjudication date)
    - Summarized by revenue code
    - Allocate days and charges using revenue code crosswalk
    - Medicaid cost report settlements
      - Included in notification packet

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DSH SURVEY PART II

- Section H: In-State Medicaid Payors (cont.)
  - In-State Medicaid Managed Care Primary
    - Medicaid MCO + Medicare Medicaid Plan (MMP)
    - Source of days, charges, claims payments is MMIS data
      - Excludes exclude non-Title 19 services (e.g., SCHIP)
    - Based on cost report year (adjudication date)
    - Summarized by revenue code
    - Allocate days and charges using revenue code crosswalk
    - Managed Care contracts with all-inclusive rates
      - Should exclude pro-fee portion of payment

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DSH SURVEY PART II

- Section H: In-State Medicaid Payors (cont.)
  - In-State Medicare FFS Cross-overs
    - MMP included in population
    - Source of days, charges, claims payments is MMIS data
    - Based on cost report year (adjudication date)
    - Summary data – no revenue codes
    - Cost allocation methodologies
      - Title XVIII Allocation Template
      - Crossover Revenue and Usage Report

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DSH SURVEY PART II

- Section H: In-State Medicaid Payors (cont.)
  - In-State Medicare FFS Cross-overs (cont.)
    - All Medicare payments must be reported
    - Non-claims based Medicare payments examples

Medicare cost report settlements	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

    - MSLC may estimate if no estimate/payments not accounted for
    - Hospital should reconcile Medicare PS&R to Medicare cost report

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DSH SURVEY PART II

- Section H: In-State Medicaid Payors (cont.)
  - In-State Medicare FFS Cross-overs (cont.)
    - Critical Access Hospitals
      - Reimbursed at cost after sequestration
      - COVID-19 Impact
        - 2% sequestration reduction suspended as of May 1, 2020

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DSH SURVEY PART II

- Section H: In-State Medicaid Payors (cont.)
  - Additional MMIS Data Information
    - Detailed data is available upon request
      - Download via web portal
    - Claims and Encounters Informal Appeal Form
      - Hospital may appeal material MMIS data errors
      - Appeal limited to compilation errors made by MSLC
      - Include every claim to be considered
      - Must include valid PCN / ICN combinations
      - Submit form by DSH Survey due date

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DSH SURVEY PART II

- Section H: In-State Medicaid Payors (cont.)
  - In-State Other Medicaid Eligibles ("OME")
    - 2008 DSH Rule: All Medicaid eligibles to be included in UCC
    - Medicaid **not billed** including Commercial Primary/Medicaid Secondary claims
      - Unbilled claims not included in state MMIS data
      - Source of days, charges, and payments is hospital data
        - Submit OME data on Exhibit C
        - Exclude non-Title 19 services (e.g., SCHIP)
      - Based on cost report year

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DSH SURVEY PART II

- Section H: In-State Medicaid Payors (cont.)
  - In-State Other Medicaid Eligibles (cont.)
    - OME population should not include MMP
      - Considered billed to Medicaid when billed to MMP
    - Must include all payments from all payers
    - Allocate days and charges using revenue code crosswalk
      - Exclude non-covered charges from survey
    - In-State Other Medicaid Eligibles Provider Representation form

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DSH SURVEY PART II

- Section H: In-State Medicaid Payors (cont.)
  - In-State Other Medicaid Eligibles (cont.)
    - **Common Issues from Past Examinations**
      - Duplicate claims in Exhibit C and MMIS data
      - Blanket exclusion of dual eligibles from OME
      - Large fluctuations in level of OME claims reported
        - No explanation of operational or billing changes
      - Traditional Medicare/Traditional Medicaid dual-eligibles in OME
      - Traditional Medicaid primary in OME

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DSH SURVEY PART II

- Section H: In-State Medicaid Payors (cont.)
  - Survey form Exhibit C
    - Designed to collect/report Medicaid claims detail (if no paid claims summary)
      - Self-reported OME data (unbilled Medicaid)
      - Out-of-state Medicaid (discussed later)
    - Revenue code level detail required
    - Submit in template format
    - Include all data elements
      - **Patient Medicaid recipient number required**
    - Exclude non-covered Medicaid/non-hospital services
    - Submit separate payor plan listing

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DSH SURVEY PART II

- Section H: In-State Medicaid Payors (cont.)
  - **Update on Treatment of Other Insurance and Medicare Payments**
    - 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).
    - Per April 3, 2017 Final Rule, all Medicare and private insurance payments included in UCC
    - All DSH 2019 cost report periods begin after June 2, 2017
      - Payments no longer prorated

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DSH SURVEY PART II

- Section H: In-State Medicaid Payors (cont.)
  - **COVID-19 Impacts Related to Medicaid Services**
    - Provider Relief Fund (PRF) General and Targeted Distribution payments for Medicaid beneficiaries
      - Exclude PRF payments from DSH HSL
      - PRF restrictions
      - See FAQ 15 for links to federal Covid-19 funding FAQs

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DSH SURVEY PART II

- Section H: Uninsured
  - No source of third party coverage
  - May include exhausted benefits and non-covered services
    - Per December 3, 2014 Final Rule uninsured definition
  - May include state/local-only claims with no Medicare or private insurance
  - Submit uninsured days and charges on Exhibit A
    - Allocate days and charges using revenue code crosswalk
      - Exclude non-covered charges from survey
  - Submit uninsured patient payments on Exhibit B

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DSH SURVEY PART II

- Section H: Uninsured
  - Survey form Exhibit A
    - Designed to collect/report uninsured charges and routine days
    - Based on cost report year using discharge date
    - Revenue code level detail required
    - Submit in template format
    - Include all data elements
    - Exclude non-covered Medicaid/non-hospital services
    - Identify exhausted/non-covered claims in Claims Status column (column R)
      - Report payments as **uninsured** in Exhibit B
    - Submit separate payor plan listing

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DSH SURVEY PART II

- Section H: Uninsured
  - Survey form Exhibit B
    - Designed to collect/report insured and uninsured patient payments (cash basis)
    - Submit in template format
    - Include all data elements
    - Private MCO delivering services to indigent patients
      - MCO payments should offset uninsured cost
      - Subset of Exhibits A and B
    - Report total patient payments on survey Section E
    - Report uninsured patient payments on survey Section H
    - Submit listing of all payment transaction codes

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DSH SURVEY PART II

- Section H: Uninsured
  - **Common Issues from Past Examinations**
    - Duplicate claims in Exhibit C or MMIS data
    - Medicaid claims in uninsured data
    - Uninsured patients in Exhibit A listed as insured in Exhibit B
    - Claims listed as both insured and uninsured in Exhibit B
    - Payor plans inconsistent with claim status
      - Insured payors in Exhibit A not reported as exhausted or non-covered

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DSH SURVEY PART II

- Section H: Uninsured
  - **Common Issues from Past Examinations (cont.)**
    - Exhausted/non-covered services reported in uninsured incorrectly:
      - 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
      - Insured claims not paid due to copay/deductible patient responsibility

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DSH SURVEY PART II

- Section H: Uninsured
  - **COVID-19 Impacts Related to Uninsured Services**
    - Payments for uninsured IP and OP hospital services services under these programs should offset uninsured cost:
      - Families First Coronavirus Response Act (FFCRA) Relief Fund for COVID-19 testing and testing-related services
      - Uninsured Relief Fund for COVID-19 care or treatment furnished to uninsured individuals
    - Report on cash basis in Exhibit B (if on claims basis); or
    - Submit additional support
    - **NEW COVID-19 Reimbursement and DSH Reporting Questionnaire**

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DSH SURVEY PART II

- Section H: Additional Edits
  - "Exceed total" error message in far right column of survey
    - If total days or charges by cost center exceed cost report total
    - Hospital should confirm cause of error
      - Adjudication timing
      - Improper mapping
  - Calculated payments as a percentage of cost by payor
    - Payment-to-cost ratios calculated with all payments included
    - Review percentages for reasonableness

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DSH SURVEY PART II

- Section I: Out-of-State ("OOS") Medicaid
  - Similar to Section H
  - Calculate cost and shortfall / longfall for:
    - OOS FFS Medicaid Primary
    - OOS Medicaid Managed Care Primary
    - OOS Medicare FFS Cross-Overs
    - OOS Other Medicaid Eligibles ("OME")

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DSH SURVEY PART II

- Section I: Out-of-State ("OOS") Medicaid
  - Source of OOS Medicaid data should be paid claims listing from other state
  - If no paid claims listing use Exhibit C
    - Should request OOS paid claims listing at the time cost report filing for future years
  - Report based on cost report year
    - Adjudication date if possible
  - Must include revenue code level detail
  - Allocate OOS data using revenue code crosswalk
  - Exclude non-covered charges from survey

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DSH SURVEY PART II

- Sections J and K: Organ Acquisition
  - Calculate organ acquisition cost for In-State and OOS Medicaid and Uninsured
  - Costing data pre-loaded from HCRIS
    - Total organ acquisition cost
    - Total usable organs
  - Organ count and charges self-reported by hospital
    - Supported by summary claims data (PS&R) or similar documents and provider records
  - Reporting basis should mirror that of the related payor
  - Exclude organ acquisition charges and days from Section H & I

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DSH SURVEY PART II

- Section L: Provider Taxes
  - Must be in a locality that is administering LPPF
    - 26 localities/hospital districts have enacted LPPF
  - Section L reconciles provider tax on cost report to actual incurred/paid
  - Self-reported using cost report data and general ledger
    - Identify if cost recorded as expense or contractual
    - Identify where cost is reported on cost report
  - Permissible provider tax added back to Medicaid and uninsured UCC

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DSH SURVEY PART II

- Section L: Provider Taxes (cont.)
  - Should exclude:
    - Association “pool” payments
    - Association fees
    - Non-hospital taxes (e.g., nursing home and pharmacy taxes).
    - Taxes assessed to another (related) hospital/provider.

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DSH SURVEY PART II

- Section L: Provider Taxes (cont.)
  - **Common Issues from Past Examinations**
    - Tax not incurred by the reporting hospital
    - Tax exceeding amount assessed/paid for the current cost report period
    - Tax not removed from cost report on Worksheet A-8
    - Hospitals should reconcile GL/WTB to cost report Worksheet A and Section L

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DSH APPLICATION WEB PORTAL

- Web Portal
  - Common place for handling file submissions
  - Upload and download of PHI
  - Protections based on IP address(es)
  - Only one log-in across projects
  - Two Web Portals – one for each project
    - TX DSH 2019 Examination
    - TX 2022 UC Reconciliation (All DY8)

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DSH APPLICATION WEB PORTAL

- Web Portal (cont.)
  - Web portal page for each period under review
    - **Files must be loaded to the appropriate year**
  - Unique events for every document
    - **Files must be loaded to the appropriate event**
  - Let MSLC know **immediately** of staffing / PHI access changes

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UC FINAL RECONCILIATIONS

- Final Reconciliation of TXHUC Schedules 1, 2 and 3 based on actual cost of services
- DSH hospitals that also received UC distribution for the same year, the results of the DSH examination 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
- Cost calculation closely resembles TXHUC schedules

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UC FINAL RECONCILIATIONS

- IMD cost subject to age (21-64) limitation
  - Exception per Social Security Act Sec. 1905
    - Patients 21 years of age considered “under 21” in limited circumstances
  - Should support limitation with documentation

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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.

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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

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SCHEDULE 1 AND 2 SURVEY – COST REPORT YEAR DATA

- Separate workbook from the DSH Survey
- By cost report period end
- Requires best available Medicare cost reports
- Closely resembles TXHUC Schedule 1 and 2 forms and instructions
- One survey per cost report period spanning demonstration year
- **MSLC may revisit spanning survey(s) submitted for DY7 if Schedule 1 cost is required and detailed documentation review was not performed last year**

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SCHEDULE 1 AND 2 SURVEY – COST REPORT YEAR DATA

- Instructions
- Checklist
- Certification

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SCHEDULE 1 – PHYSICIANS AND MID-LEVEL PROFESSIONALS

- Physician/Mid-Level Professional Cost
  - Must agree to best available Medicare Cost Report
  - Reported on Worksheet A
  - Removed via Worksheet A-8 or A-8-2
  - NRCC exception
  - Must be related to direct patient care
    - Time studies
    - Time proxies
    - Contracts
    - NRCC attestation

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SCHEDULE 1 – PHYSICIANS AND MID-LEVEL PROFESSIONALS

- Physician/Mid-Level Professional Cost (cont.)
  - Rural Health Clinic costs may be allowable
    - Subject to same requirements as other reimbursable cost centers
  - **New Schedule 1 Cost Summary template**
    - **Breaks down cost and payments in each cost center by vendor/professional and supporting file(s)**

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SCHEDULE 1 – PHYSICIANS AND MID-LEVEL PROFESSIONALS

- Allocation Statistics
  - If Allocation Statistical Basis is Hospital Charges
    - Cost center specific total charges should agree to the Medicare cost report
    - Total aggregate charges used for cost centers not found on the DSH Survey
      - General Service cost centers
      - Non-Reimbursable Cost Centers (NRCC)
  - If Allocation Statistical Basis is Physician Charges
    - Hospital records used as the source for these statistics

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SCHEDULE 1 – PHYSICIANS AND MID-LEVEL PROFESSIONALS

- Schedule 1 Medicaid and Uninsured Charges
  - If using hospital charges as allocation statistic
    - Part II DSH Surveys used as the source for these charges
    - Should include OME and FFS Crossover charges
      - Submit supporting schedule for combined payors
    - Submit support for routine charge allocations

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SCHEDULE 1 – PHYSICIANS AND MID-LEVEL PROFESSIONALS

- Schedule 1 Medicaid and Uninsured Payments
  - Report all payments received by hospital for services reported on Schedule 1
  - Submit detailed schedule to support payment amounts
  - If no payments are reported:
    - Submit signed attestation – explain billing environment; and
    - Submit copies of related contracts

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SCHEDULE 2 - TEXAS VENDOR DRUG PROGRAM

- Pharmacy costs related to prescription drugs provided by hospitals participating in the Texas Vendor Drug program (TVDP)
  - Not related to services provided by retail pharmacy
  - Not billed to a third party payer under revenue code 253
- Column 1 and 1a must come from the Medicare cost report
- Charges should not be duplicated on DSH Survey
- Allocation statistical basis is hospital departmental charges
  - Need written HHSC approval for alternative basis

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SCHEDULE 1 AND 2 SURVEY – COST REPORT YEAR DATA

- **Common Issues from Past Reconciliations – Schedule 1**
  - Reported Schedule 1 costs not on Worksheet A columns 1 or 2
  - Direct patient care requirement not adequately supported
    - Time studies, time proxies, contracts, NRCC attestation
  - Contract compensation not addressing administrative activities
  - Contradictory professional payment/billing information (attestation vs. contracts)

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SCHEDULE 1 AND 2 SURVEY – COST REPORT YEAR DATA

- **Common Issues from Past Reconciliations – Schedule 2**
  - Schedule 2 costs not pertaining to TVDP
    - Cannot include retail pharmacy costs
  - Duplicate charges on Schedule 2 and DSH Survey

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OTHER INFORMATION

- Inform HHSC 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)

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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).*

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QUESTIONS