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DISPROPORTIONATE SHARE HOSPITAL (DSH) YEAR 2021 PAYMENT EXAMINATION OVERVIEW

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

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OVERVIEW

- DSH Examination Policy
- DSH and UC Timeline
- DSH Year 2021 Examination Impact
- Recap of Prior Year Examination (2020)
- Overview of DSH Year 2021 Survey, Exhibits, and Claims Data
- DSH Examination Results and Appeals
- Web Portal

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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, 2013, Final Rule

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RELEVANT DSH POLICY (CONT.)

- CMCS Informational Bulletin Dated December 27, 2013 delaying implementation of Medicaid DSH Allotment reductions 2 years
- April 1, 2014 – P.L. 113-93 (Protecting Access to Medicare Act) delays implementation of Medicaid DSH Allotment reductions 1 additional year
- Additional Information of the DSH Reporting and Audit Requirements – Part 2, clarification published April 7, 2014
- Audit/Reporting implemented in FR Vol. 79, No. 232, Wednesday, 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 DSH reductions until December 1, 2020
- Consolidated Appropriations Act of 2021 delayed DSH reductions until FY 2024

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DSH YEAR 2021 EXAMINATION
UC DY10 RECONCILIATION TIMELINE

- DSH Surveys emailed March 4, 2024
  - Surveys returned by April 3, 2024
- UC Hospitals – Surveys emailed mid-May
  - Surveys returned mid-June
- Draft DSH report to HHSC by September 13, 2024
- Final DSH report to HHSC by November 15, 2024
- Draft UC results to HHSC by December 2, 2024
- Final UC results to HHSC by December 16, 2024

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DSH YEAR 2021 EXAMINATION IMPACT

- The DSH 2021 examination report will be the eleventh 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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RECAP OF PRIOR YEAR EXAMINATION (2020)

- 14 hospitals had DSH payments greater than their UCC.
- Information related to Texas' use of adjudication date as reporting basis of Medicaid billed claims and ongoing legal proceedings and OIG audit were disclosed in the final report.

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CONSOLIDATED APPROPRIATIONS ACT

- In December 2020, Congress passed the Consolidated Appropriations Act (CAA), which changes the calculation of a hospital's DSH limit to only allow the inclusion of costs and payments for services for which the Medicaid state plan or waiver is the primary payor for such services, and the costs and payments for services to the uninsured. Therefore, the Act entirely excludes both the costs and payments for services related to Medicaid dually-enrolled individuals from the UCC.

- Per the final rule published in February 23, 2024, the CAA applies to State Plan Rate Years (SPRY) beginning on or after October 1, 2021. Texas' SPRY begins October 1, therefore, the CAA will not impact the DSH UCC until the state's 2022 DSH examination.

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CONSOLIDATED APPROPRIATIONS ACT

- The Act grants an exception for hospitals meeting certain criteria to continue to include the costs and payments of Medicaid dually-enrolled individuals in the DSH UCC. The final rule indicates the list of hospitals meeting the exception will be published on or before October 1 each year. CMS has not published the list at this time. For DSH 2021, all hospitals will continue to report Medicaid dually-enrolled individuals on the DSH survey.

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CONSOLIDATED APPROPRIATIONS ACT

Impact on DSH 2021 Examination

- Since the majority of hospital cost report periods currently under examination span into DSH 2022 when the CAA changes take effect, we need to ensure that Medicaid primary and Medicaid Secondary claims are appropriately segregated on the DSH Surveys being examined this year. Changes were made to the following areas:
  - Medicaid claims summaries and details (new Medicaid Secondary payor type)
  - DSH Surveys (Other Medicaid Eligible payor types)
  - Exhibit C Templates

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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 or 3 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 (most recent version of the cost report accepted by the MAC; audited if available).
- 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 and Uninsured
  - **Consolidated Appropriations Act Impact to Survey**
    - To prepare for the CAA changes to the DSH limit effective in DSH 2022, In-State Other Medicaid Eligibles (OME) has been split into two buckets:
      - In-State OME Medicaid Secondary (Not Billed + MMIS Secondary)
      - In-State OME Medicaid Primary (Not Billed)
      - Discussed in more detail on later slides

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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 and extended through March 31, 2022
        - 1% sequestration reduction in effect from April 1, 2022 to June 30, 2022
        - 2% sequestration reduction resumed as of July 1, 2022

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DSH SURVEY PART II

- Section H: In-State Medicaid Payors (cont.)
  - **NEW: In-State Other Medicaid Eligibles (OME) Medicaid Secondary (Not Billed + MMIS Medicaid Secondary)**
    - Source of OME Medicaid Secondary days, charges, and payments may be a **combination** of
      - MMIS data, and
      - Hospital data
    - **MMIS Data Component**
      - Refer to the "MCD Secondary" tabs of the MMIS summary
      - Based on cost report year (adjudication date)

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DSH SURVEY PART II

- Section H: In-State Medicaid Payors (cont.)
  - **NEW: In-State Other Medicaid Eligibles (OME) Medicaid Secondary (Not Billed + MMIS Medicaid Secondary)**
    - **Self-reported Component**
      - Unbilled Medicaid secondary claims not included in state MMIS data
      - Submit self-reported OME data on Exhibit C
      - OME self-reported population should not include MMP
        - Considered billed to Medicaid when billed to MMP
      - Must include all payments from all payors
      - Exclude non-Title 19 services (e.g., SCHIP)
      - In-State OME Provider Representation form

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DSH SURVEY PART II

- Section H: In-State Medicaid Payors (cont.)
  - **NEW: In-State Other Medicaid Eligibles (OME) Medicaid Secondary (Not Billed + MMIS Medicaid Secondary)**
    - Exclude non-covered charges from survey
    - Allocate days and charges using revenue code crosswalk

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DSH SURVEY PART II

- Section H: In-State Medicaid Payors (cont.)
  - **NEW: In-State Other Medicaid Eligibles (OME) Medicaid Primary (Not Billed)**
    - Medicaid-eligible patient services where Medicaid is primary, but did not receive the claim would not be included in the state's data.
    - Source of OME Medicaid Primary days, charges, and payments is hospital data
      - Based on cost report year
      - Submit OME primary data on Exhibit C
      - Excludes non-Title 19 services (e.g., SCHIP)
    - Allocate days and charges using revenue code crosswalk

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DSH SURVEY PART II

- Section H: In-State Medicaid Payors (cont.)
  - **NEW: In-State Other Medicaid Eligibles (OME) Medicaid Primary (Not Billed)**
    - Volume is expected to be limited
      - Valid billed Medicaid claims should be in MMIS data
      - Not intended to be for claims where Medicaid was billed, but did not pay, or Medicaid primary claims that were not billed because services are not Medicaid covered services.
      - Primarily restricted to IMD Medicaid primary claims subject to the IMD age 21-64 exclusion

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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.)
  - 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.)
  - 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

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DSH SURVEY PART II

- Section H: In-State Medicaid Payors (cont.)
  - Survey form Exhibit C
    - 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.)
  - Survey form Exhibit C
    - **Consolidated Appropriations Act Impact to Exhibit C**
      - NEW Column X: indicate whether the claim has any coverage other than Medicaid FFS/Managed Care.
      - Essential hospital correctly indicates “yes” or “no” in column X to ensure claims are reported in the correct payor bucket (Medicaid Primary vs. Medicaid Secondary).
      - NEW Column Z is optional; available to input any explanations as to why a claim should be considered Medicaid primary.

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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
      - Denied 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
    - **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 Medicaid Secondary ("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
    - 28 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 EXAMINATION RESULTS AND APPEALS

- Ten business days to review initial results and request/review workpapers
- Appeal limitations:
    - Adjustments made by MSLC during current examination only
        - No appeals on prior year examination adjustments
    - New costs cannot be added during appeal
    - Documentation must be received by appeal deadline
    - No appeal deadline extensions
    - Appeal rights acknowledged on DSH Survey Part I signed certification

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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 2021 Examination
    - TX 2024 UC Reconciliation (All DY10)

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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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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 when preparing to submit your DSH 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