We Make Healthcare Reimbursement Easy

Preparing for the Medicaid DSH Examination

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Training Webinar

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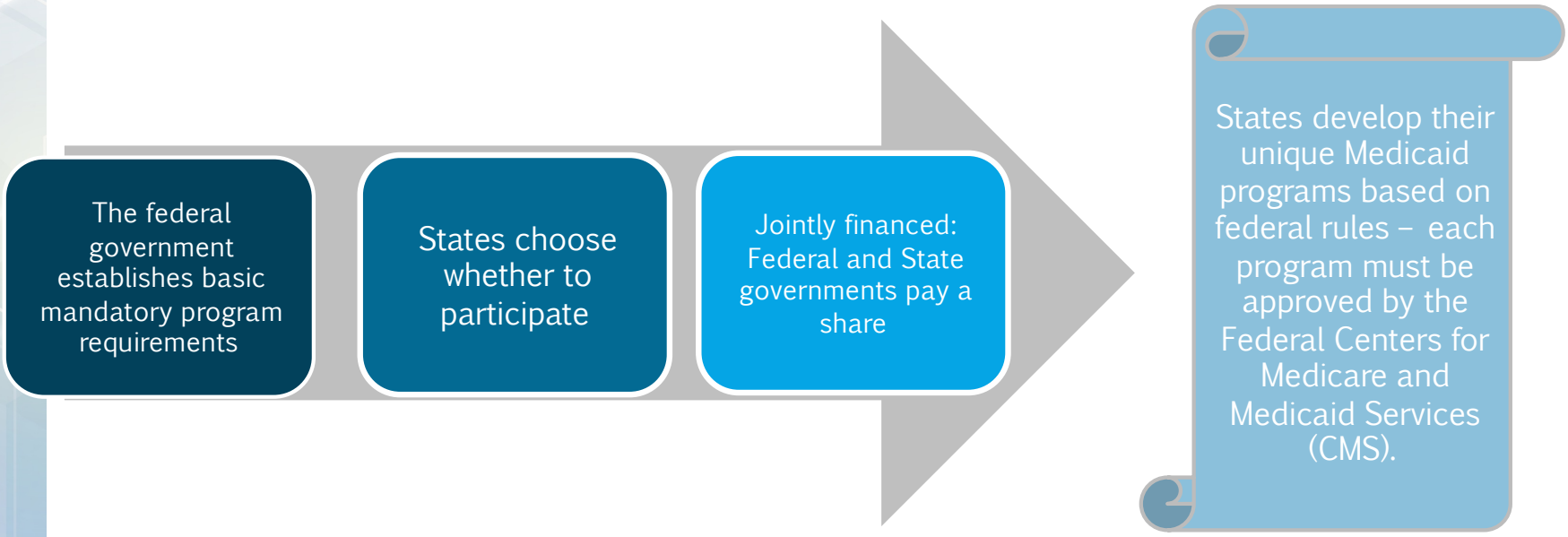
Agenda

- Overview of Medicaid
- Medicaid Reimbursement
- Medicaid Supplemental Payments
- Disproportionate Share Hospital (DSH) Program
- DSH Examination Overview
- Exhibits A-C
- Eligible Patient Accounts
- Preparing for the DSH Examination
- Reinstatement of CMS FAQs 33 & 34
- Consolidated Appropriation Act, 2021
- Questions?

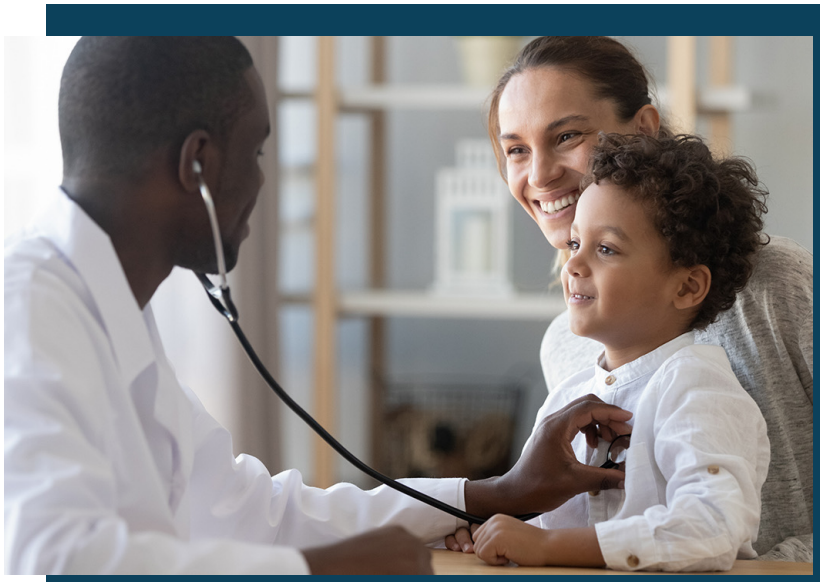
What is Medicaid?

Medicaid is a federal program through which states partner with the federal government to provide health care coverage to low-income children, families, elders, and people with disabilities.



Children's Health Insurance Program (CHIP)

- Provides health coverage to eligible children through Medicaid and separate CHIP programs.
- CHIP is administered by states, according to federal requirements.
- Jointly funded by states and federal government.



Enrollment

- 76.3 Million People Covered
- 6.9 Million enrolled in CHIP
- 39.2 children enrolled in CHIP or Medicaid program (48.6% of total Medicaid Enrollment)
- As of June 2021
- Enrollment has increased 17.7% since February 2020 as a result of the Public Health Emergency

Enrollment

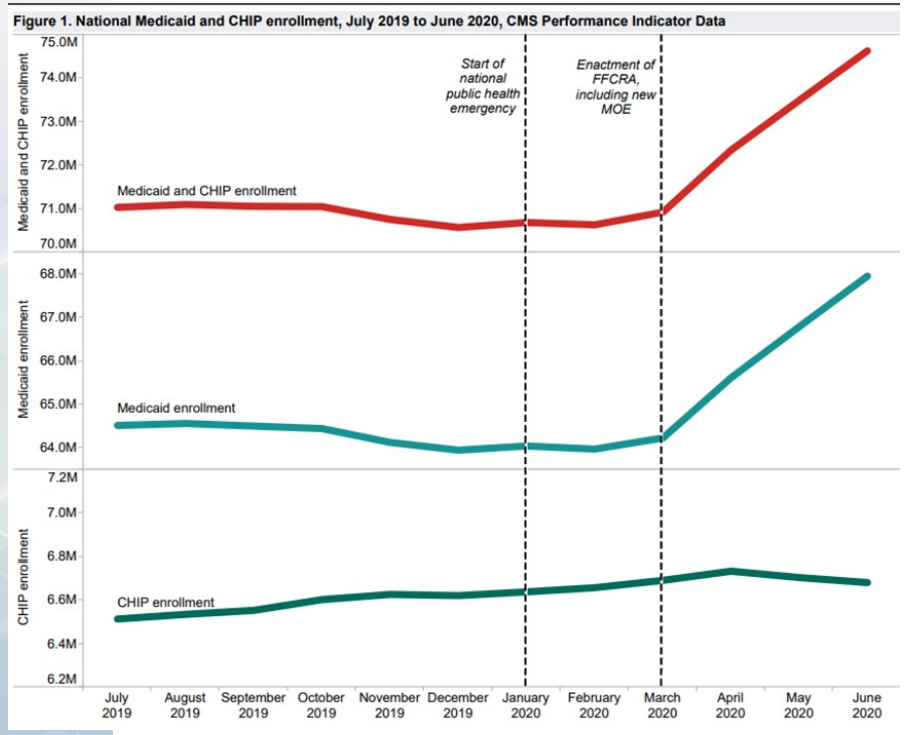


Figure 1. National Medicaid and CHIP enrollment, July 2019 to June 2020, CMS Performance Indicator Data
Medicaid and CHIP enrollment
75.0M
74.0M
73.0M
72.0M
71.0M
70.0M
Start of national public health emergency
Enactment of FFCRA, including new MOE
Medicaid and CHIP enrollment
Medicaid enrollment
68.0M
67.0M
66.0M
65.0M
64.0M
Medicaid enrollment
CHIP enrollment
7.2M
7.0M
6.8M
6.6M
6.4M
6.2M
CHIP enrollment
July 2019
August 2019
September 2019
October 2019
November 2019
December 2019
January 2020
February 2020
March 2020
April 2020
May 2020
June 2020

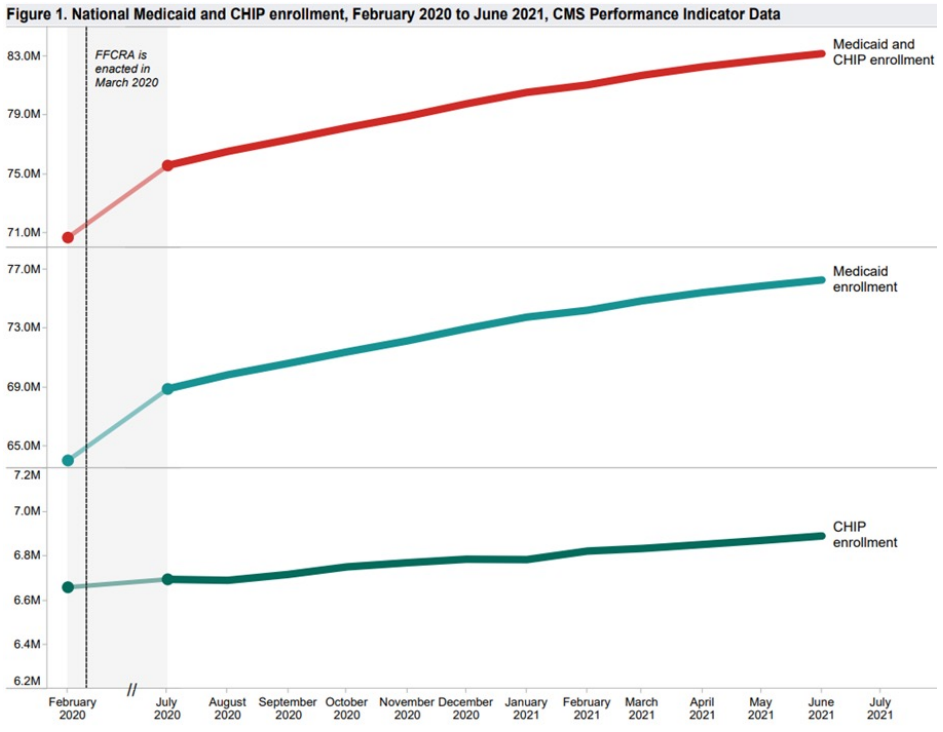


Figure 1. National Medicaid and CHIP enrollment, February 2020 to June 2021, CMS Performance Indicator Data
83.0M
79.0M
75.0M
71.0M
FFCRA is enacted in March 2020
Medicaid and CHIP enrollment
77.0M
73.0M
69.0M
65.0M
Medicaid enrollment
7.2M
7.0M
6.8M
6.6M
6.4M
6.2M
CHIP enrollment
February 2020
July 2020
August 2020
September 2020
October 2020
November 2020
December 2020
January 2021
February 2021
March 2021
April 2021
May 2021
June 2021
July 2021

Eligibility

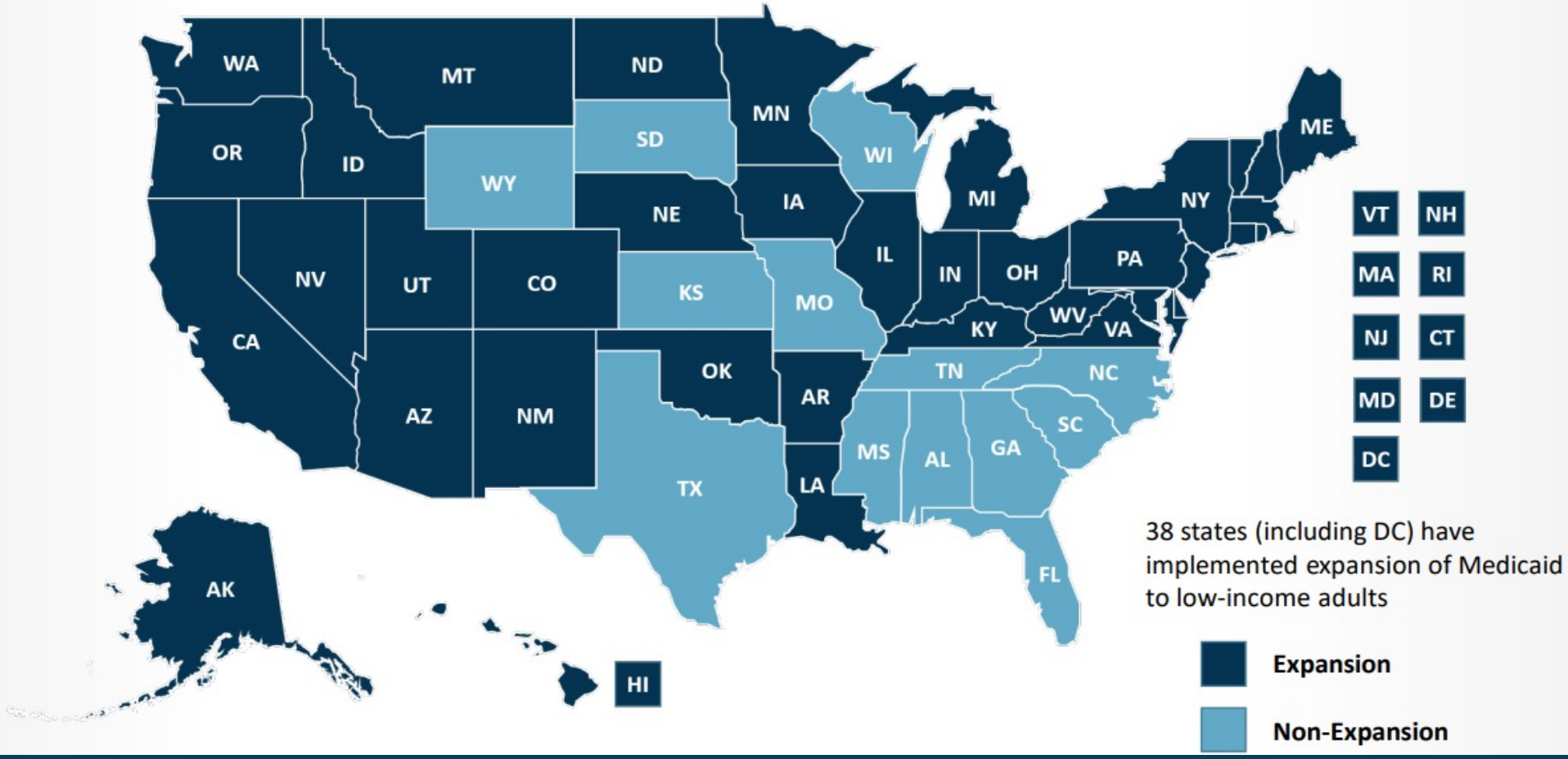
- Mandatory Eligibility Groups
  - Low-income families
  - Qualified pregnant women and children
  - Individuals receiving SSI
- Optional Eligibility Groups
  - Individuals receiving home and community-based services
  - Children in foster care
  - Medically Needy Programs
  - 209(b)

Affordable Cares Act of 2010

- Under the Act, states have the opportunity to expand coverage to nearly all low-income Americans under the age of 65.
- FPL extended to at least 133% for children in every state
- Option to expand eligibility to adults with income at or below 133% of FPL
  - 37 States have expanded
- States can choose to expand at anytime
- Build Back Better – How does this effect states who have not expanded Medicaid?

Adult Coverage Expansion

as of July 2021



Reimbursement

- Medicaid reimbursement varies by state
- Fee-for-service Delivery System
  - Cost Based vs Prospective Payment System (PPS)
- Managed Care Delivery System
- Combination of both
- Medicaid payments have historically been below costs, resulting in shortfalls
  - Supplemental Payments

Fee-For-Service

- Reimbursement to providers comes directly from Medicaid.
- Each service receives a specific reimbursement in exchange for services provided.
- Uses a fee schedule or base rate
- Cost based reimbursement – Medicaid cost reports
- Prospective Payment System
  - Diagnostic Related Groups (DRGs) - Inpatient
  - Enhanced Ambulatory Patient Grouping (EAPG) – Outpatient

Managed Care

- Health care delivery system organized to manage cost, utilization, and quality.
- Provides for the delivery of Medicaid health benefits and additional services through contracted arrangements between state Medicaid agencies and MCOs
- States pay a per-member per-month (capitation) rate to MCOs
- Actuarially sound
- Approximately 70% of Medicaid recipients are currently enrolled in managed care

Benefits of Managed Care

- Reduce program costs
- Better manage utilization of health services
- Improve health plan performance
- Improve health care quality
- Improve outcomes
- Providers negotiate contract with each MCO

What is FMAP?

- The Federal Medical Assistance Percentage (FMAP) is used to calculate the amount of federal share of state Medicaid program expenditures.
  - Varies from state-to-state
  - Updated annually
- The FMAP formula is based on the ratio of the state per capita income to the national per capita income.
- Uses three most recent calendar years for which satisfactory data are available from the Department of Commerce, Bureau of Economic Analysis.
  - The lower the state's average per capita income, the more FMAP and vice versa.
  - All states receive at least 50% FMAP.

Enhanced FMAP

- January 31, 2020: Federal Department of Health and Human Services declared a Public Health Emergency (PHE).
- The CARES Act provides a **6.2 percentage point increase** in federal Medicaid matching funds to help states respond to the COVID-19 pandemic.
- Enhanced FMAP is effective January 1, 2020 through the end of the quarter in which the PHE ends.
- State accepting the enhanced FMAP must provide continuous Medicaid eligibility through the end of the month in which the PHE ends.
  - Applies to people enrolled as of March 18, 2020, or who enroll at any time thereafter during the PHE
- States may request to stop receiving the enhanced FMAP at any time without losing what they claimed previously.

State Share Funding

- General Revenue
- Intergovernmental Transfers (IGTs)
  - Transfer of funds from a governmental entity (other than Medicaid)
  - Counties, Healthcare taxing districts, providers operated by state or local governments
  - Bona fide donation
- Certified Public Expenditures (CPEs)
  - CMS requires cost reimbursement methodologies for providers using CPEs to document actual cost of providing services
    - Statistical time studies, periodic cost reporting, and reconciliation of any interim payments
- Provider Fees/Tax/Assessment
  - Must be uniform and broad based to be allowable by CMS
  - 6% max of net patient revenue
  - Inpatient and Outpatient Assessment

Supplemental Payments

- Payments made to Medicaid providers in addition to the Medicaid reimbursement they received for services provided.
- The state share funding source is generally funded through non-General Revenue funds.
- Authorized by the Legislature either through statute or the General Appropriations Act and approved by the federal Centers for Medicare and Medicaid Services.
- Typically approved by CMS through 1115 Waivers or State Plans

Supplemental Payment Programs

- Disproportionate Share Hospital (DSH) Program
- Uncompensated Care Pools/Low Income Pool Program
- Upper Payment Limits
- Directed Payments Programs (Pass-through Payments)
- Graduate Medical Education
- Medicaid Enhanced Payments
- Emergency Medical Transportation Programs
- School Based Programs

Disproportionate Share Hospital (DSH) Program

- DSH was created under federal law to compensate hospitals that have provided a disproportionate share of Medicaid or charity care services.
- Federal law establishes an annual DSH allotment for each state that limits Federal Financial Participation (FFP) for payments made to hospitals.
- FFP is not available for state DSH payments that are more than the hospital's eligible uncompensated care cost.
- Uncompensated care cost – cost of providing inpatient and outpatient hospital services to Medicaid patients and the uninsured, minus payments received.
- $12.8 Billion total allotment for FY 2020

DSH Audit and Reporting Requirements

- States are required to submit an independent certified audit describing DSH payments made to each DSH hospital.
- Any payments in excess of uncompensated care must be returned to the state.
- States have option to redistribute or return to CMS.
- Myers & Stauffer conducts most audits in the country

DSH Examination Overview

- Today's focus will be on Myers & Stauffer's DSH Examination
- The State/Myers & Stauffer will send out examination letters to each provider required to submit examination surveys.
- Surveys due 30-45 days after letters are sent out.

DSH Examination Surveys

- Hospitals will need to complete 2 surveys
- Completed using Medicare cost report and internal hospital data
- Survey part I
- Survey part II

Survey Part I

- Basic hospital information
- Cost Report Year
- OB Qualifying Questions
- Other Medicaid Payments Received
- Certification/Signature Page
- Checklist of required submission documents

Survey Part II

- Sections D-L
- MIUR/LIUR Calculation
- Myers & Stauffer will prepopulate the data for schedule G using your most recently filed Medicare Cost Report.
  - Uses HCRIS data
  - Did you have an amended cost report?
  - Review data to ensure they are using the correct data
  - Data from Exhibits A-C will be used to complete portion of the survey
- Data from Exhibits A-C will be used to complete sections H-K

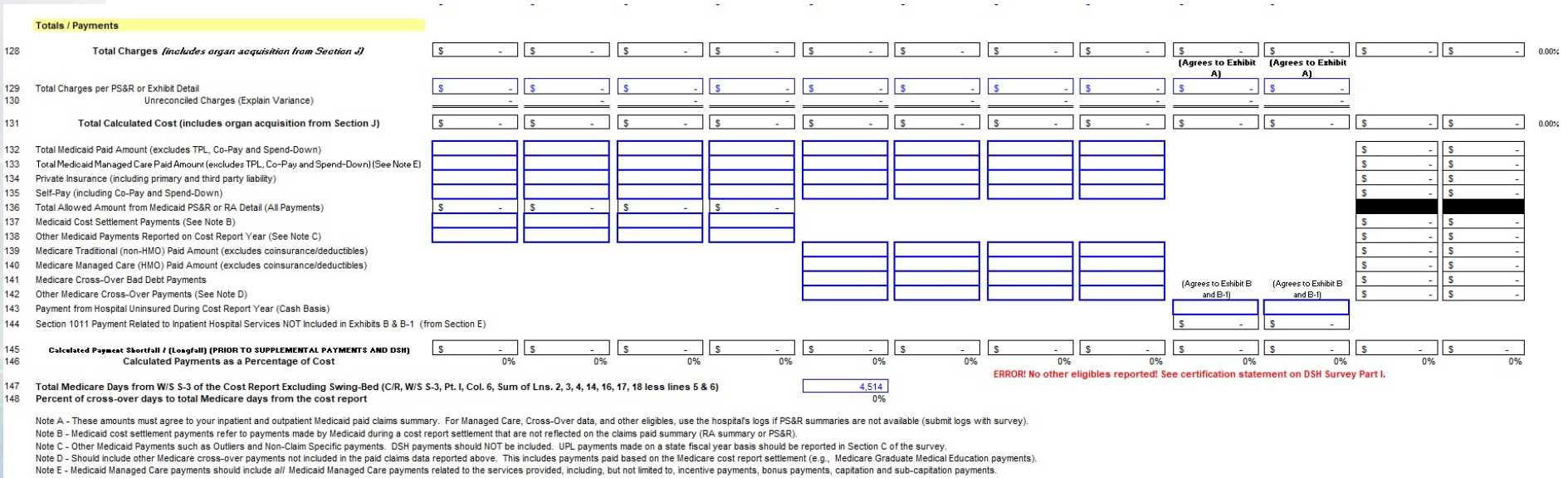
Survey Part II – Schedule H & I

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

Cost Report Year (01/01/2018-12/31/2018)

Line #	Cost Center Description	Medicaid Per Diem Cost for Routine Cost Centers	Medicaid Cost to Charge Ratio for Ancillary Cost Centers	In-State Medicaid FFS Primary		In-State Medicaid Managed Care Primary		In-State Medicare FFS Cross-Overs (with Medicaid Secondary)		In-State Other Medicaid Eligibles (Not Included Elsewhere)		Uninsured		Total In-State Medicaid		% Survey to Cost Report Totals
				Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient (See Exhibit A)	Outpatient (See Exhibit A)	Inpatient	Outpatient	
		From Section G	*From Section G*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From Hospital's Own Internal Analysis*	*From Hospital's Own Internal Analysis*			
Routine Cost Centers (from Section G):				Days		Days		Days		Days		Days		Days		
03000	ADULTS & PEDIATRICS	$ 3,615.70												-		0.00%
03100	INTENSIVE CARE UNIT	$ 5,153.40												-		0.00%
03200	CORONARY CARE UNIT	$ -												-		
03300	BURN INTENSIVE CARE UNIT	$ -												-		
03400	SURGICAL INTENSIVE CARE UNIT	$ -												-		
03500	OTHER SPECIAL CARE UNIT	$ -												-		
04000	SUBPROVIDER I	$ 458.80												-		0.00%
04100	SUBPROVIDER II	$ -												-		
04200	OTHER SUBPROVIDER	$ -												-		
04300	NURSERY	$ -												-		
		$ -												-		
		$ -												-		
		$ -												-		
		$ -												-		
		$ -												-		
		$ -												-		
			Total Days	-		-		-		-		-		-		0.00%
Total Days per PS&R or Exhibit Detail				-		-		-		-		-				
Unreconciled Days (Explain Variance)				-		-		-		-		-				
	Routine Charges			Routine Charges		Routine Charges		Routine Charges		Routine Charges		Routine Charges		Routine Charges		
	Calculated Routine Charge Per Diem			$ -		$ -		$ -		$ -		$ -		$ -		0.00%
Ancillary Cost Centers (from W/S C) (from Section G):				Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	
09200	Observation (Non-Distinct)		0.126462											$ -	$ -	0.00%
5000	OPERATING ROOM		0.063981											$ -	$ -	0.00%
5400	RADIOLOGY-DIAGNOSTIC		0.173902											$ -	$ -	0.00%
6000	LABORATORY		0.352179											$ -	$ -	0.00%
6500	RESPIRATORY THERAPY		0.480107											$ -	$ -	0.00%
6600	PHYSICAL THERAPY		5.317043											$ -	$ -	0.00%
6900	ELECTROCARDIOLOGY		0.473030											$ -	$ -	0.00%
7000	ELECTROENCEPHALOGRAPHY		0.009077											$ -	$ -	0.00%
7100	MEDICAL SUPPLIES CHARGED TO PATIENT		0.265972											$ -	$ -	0.00%
7200	IMPL. DEV. CHARGED TO PATIENTS		0.009077											$ -	$ -	0.00%
7300	DRUGS CHARGED TO PATIENTS		2.127506											$ -	$ -	0.00%
9001	PAIN MANAGEMENT		0.220253											$ -	$ -	0.00%
9002	MULTI SPECIALTY		1.156584											$ -	$ -	0.00%
9100	EMERGENCY		0.629971											$ -	$ -	0.00%
			-											$ -	$ -	
			-											$ -	$ -	

Survey Part II – Schedule H & I



Totals / Payments

128	**Total Charges** *(includes organ acquisition from Section J)*	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ - (Agrees to Exhibit A)	$ - (Agrees to Exhibit A)	$ -	$ -	0.00%
129	Total Charges per PS&R or Exhibit Detail	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -			
130	Unreconciled Charges (Explain Variance)	-	-	-	-	-	-	-	-	-	-			
131	**Total Calculated Cost (includes organ acquisition from Section J)**	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	0.00%
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)											$ -	$ -	
133	Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down) (See Note E)											$ -	$ -	
134	Private Insurance (including primary and third party liability)											$ -	$ -	
135	Self-Pay (including Co-Pay and Spend-Down)											$ -	$ -	
136	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)	$ -	$ -	$ -	$ -									
137	Medicaid Cost Settlement Payments (See Note B)											$ -	$ -	
138	Other Medicaid Payments Reported on Cost Report Year (See Note C)											$ -	$ -	
139	Medicare Traditional (non-HMO) Paid Amount (excludes coinsurance/deductibles)											$ -	$ -	
140	Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)											$ -	$ -	
141	Medicare Cross-Over Bad Debt Payments									(Agrees to Exhibit B and B-1)	(Agrees to Exhibit B and B-1)	$ -	$ -	
142	Other Medicare Cross-Over Payments (See Note D)											$ -	$ -	
143	Payment from Hospital Uninsured During Cost Report Year (Cash Basis)													
144	Section 1011 Payment Related to Inpatient Hospital Services NOT Included in Exhibits B & B-1 (from Section E)									$ -	$ -			
145	**Calculated Payment Shortfall / (Longfall) (PRIOR TO SUPPLEMENTAL PAYMENTS AND DSH)**	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
146	**Calculated Payments as a Percentage of Cost**	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	
147	**Total Medicare Days from W/S S-3 of the Cost Report Excluding Swing-Bed (C/R, W/S S-3, Pt. I, Col. 6, Sum of Lns. 2, 3, 4, 14, 16, 17, 18 less lines 5 & 6)**					4,514								
148	**Percent of cross-over days to total Medicare days from the cost report**					0%								

ERROR! No other eligibles reported! See certification statement on DSH Survey Part I.

Note A - These amounts must agree to your inpatient and outpatient Medicaid paid claims summary. For Managed Care, Cross-Over data, and other eligibles, use the hospital's logs if PS&R summaries are not available (submit logs with survey).
Note B - Medicaid cost settlement payments refer to payments made by Medicaid during a cost report settlement that are not reflected on the claims paid summary (RA summary or PS&R).
Note C - Other Medicaid Payments such as Outliers and Non-Claim Specific payments. DSH payments should NOT be included. UPL payments made on a state fiscal year basis should be reported in Section C of the survey.
Note D - Should include other Medicare cross-over payments not included in the paid claims data reported above. This includes payments paid based on the Medicare cost report settlement (e.g., Medicare Graduate Medical Education payments).
Note E - Medicaid Managed Care payments should include *all* Medicaid Managed Care payments related to the services provided, including, but not limited to, incentive payments, bonus payments, capitation and sub-capitation payments.

DSH Exhibits

- The Exhibits will include patient level detail
  - Some of this data will come from the State, and some will need to be pulled from internal hospital records
- Exhibit A – Uninsured
- Exhibit B – Cash Payments
- Exhibit C – Medicaid FFS, Medicaid MCO, Medicaid Other Eligible, Crossover, Out of State

Exhibit A – Uninsured Patients

- Listing of all uninsured patients during cost report year
- Include charges/days by revenue code
- Need to include any patient or third-party payments received
- Must follow Myers & Stauffer template and have minimum data field requirements
- Depending on hospital accounting system, might need additional fields such as GL/Department codes to properly categorize charges by cost report line

Exhibit A – Required Data Fields

a. Claim Type
b. Primary Payor Plan
c. Secondary Payor Plan
d. Hospital's Medicaid Number
e. Patient Identification Number (PCN)
f. Patient's Birth Date
g. Patient's Social Security Number
h. Patient's Gender
i. Patient Name
j. Admit Date (see below for acceptable date formats)
k. Discharge Date (see below for acceptable date formats)
l. Service Indicator (inpatient/outpatient)
m. Revenue Code
n. Revenue Code Charges
o. Routine Days of Care
p. All patient payments (including payments received from collection agencies) received on the claim for services provided from the admit date through the present
q. All private insurance (primary or third party liability) payments received on the claim for services provided from the admit date through the present
r. If the uninsured claim is being claimed as uninsured due to exhausted benefits or meeting lifetime/annual maximums, please enter "Exhausted" in this column. If it is being claimed because it is not a covered service under the insurance package enter "Non-Covered Service" (it must be a covered service under the Medicaid state plan). If neither apply, leave this field blank.

Exhibit A

Claim Type (A)	Primary Payor Plan (B)	Secondary Payor Plan (C)	Hospital's Medicaid Provider # (D)	Patient Identifier Number (PCN) (E)	Patient's Birth Date (F)	Patient's Social Security Number (G)	Patient's Gender (H)	Name (I)	Admit Date (J)	Discharge Date (K)	Service Indicator (Inpatient / Outpatient) (L)	Revenue Code (M)	Total Charges for Services Provided (N)	Routine Days of Care (O)	Total Patient Payments for Services Provided (P)	Total Private Insurance Payments for Services Provided (Q)	Claim Status (Exhausted or Non-Covered Service, if applicable) (R)
Uninsured Charges	Charity	Self-Pay	12345	2222222	1/1/1960	999-99-999	Female	Doe, Jane	3/1/2010	3/11/2010	Inpatient	110	$ 4,000.00	7			
Uninsured Charges	Charity	Self-Pay	12345	2222222	1/1/1960	999-99-999	Female	Doe, Jane	3/1/2010	3/11/2010	Inpatient	200	$ 4,500.00	3			
Uninsured Charges	Charity	Self-Pay	12345	2222222	1/1/1960	999-99-999	Female	Doe, Jane	3/1/2010	3/11/2010	Inpatient	250	$ 5,200.25				
Uninsured Charges	Charity	Self-Pay	12345	2222222	1/1/1960	999-99-999	Female	Doe, Jane	3/1/2010	3/11/2010	Inpatient	300	$ 2,700.00				
Uninsured Charges	Charity	Self-Pay	12345	2222222	1/1/1960	999-99-999	Female	Doe, Jane	3/1/2010	3/11/2010	Inpatient	360	$ 15,000.75				
Uninsured Charges	Charity	Self-Pay	12345	2222222	1/1/1960	999-99-999	Female	Doe, Jane	3/1/2010	3/11/2010	Inpatient	450	$ 1,000.25				
Uninsured Charges	Medicare		12345	4444444	7/12/1985	999-99-999	Male	Jones, James	6/15/2010	6/15/2010	Outpatient	250	$ 150.00		$ 500.00		Exhausted
Uninsured Charges	Medicare		12345	4444444	7/12/1985	999-99-999	Male	Jones, James	6/15/2010	6/15/2010	Outpatient	450	$ 750.00		$ 500.00		Exhausted
Uninsured Charges	Blue Cross		12345	1111111	3/5/2000	999-99-999	Male	Smith, Mike	8/10/2010	8/10/2010	Outpatient	450	$ 1,100.00				Non-Covered Service

Exhibit B – Cash Payments

- Listing of patient payments received during cost report year, regardless of when services were provided.
- Will need to determine if each patient is insured or uninsured
- Only uninsured patient payments will be used to calculate uncompensated care costs

Exhibit B – Required Data Fields

a. Claim Type
b. Primary Payor Plan
c. Secondary Payor Plan
d. Transaction Code
e. Hospital's Medicaid Number
f. Patient Identification Number (PCN)
g. Patient's Birth Date
h. Patient's Social Security Number
i. Patient's Gender
j. Patient Name
k. Admit Date (see below for acceptable date formats)
l. Discharge Date (see below for acceptable date formats)
m. Date of Cash Collection
n. Amount of Cash Collections
o. Indicate if Collection is a 1011 Payment
p. Service Indicator (inpatient/outpatient)
q. Total Hospital Charges for Services Provided
r. Total Physician Charges for Services Provided
s. Total Other Non-Hospital Charges for Services Provided
t. Insurance Status at Time of Service (Must Enter "Insured" or "Uninsured")
u. If the uninsured claim is being claimed as uninsured due to exhausted benefits or meeting lifetime/annual maximums, please enter "Exhausted" in this column. If it is being claimed because it is not a covered service under the insurance package enter "Non-Covered Service" (it must be a covered service under the Medicaid state plan). If neither apply, leave this field blank.
v. Calculated Hospital Collections IF(O) = "Uninsured" or (P)="Exhausted" or (P)="Non-Covered Service", (L)/(((L)+(M)+(N))*(I), 0)

Exhibit B

Claim Type (A)	Primary Payor Plan (B)	Secondary Payor Plan (C)	Transaction Code (D)	Hospital's Medicaid Provider # (E)	Patient Identifier Number (PCN) (F)	Patient's Birth Date (G)	Patient's Social Security Number (H)	Patient's Gender (I)	Name (J)	Admit Date (K)	Discharge Date (L)	Date of Cash Collection (M)	Amount of Cash Collections (N)	Indicate if Collection is a 1011 Payment (O)	Service Indicator (Inpatient / Outpatient) (P)	Total Hospital Charges for Services Provided (Q)	Total Physician Charges for Services Provided (R)	Total Other Non-Hospital Charges for Services Provided (S)	Insurance Status When Services Were Provided (Insured or Uninsured) (T)	Claim Status (Exhausted or Non-Covered Service, if applicable) (U)	Calculated Hospital Uninsured Collections If (T)="Uninsured" or (U)="Exhausted" or "Non-Covered Service", (Q)/((Q)+(R)+(S))*(N), 0)
Self Pay Payments	Medicare	Medicaid	500	12345	3333333	2/7/2025	999-99-999	Male	Jones, Anthony	7/12/1995	7/14/1995	1/1/2010	$ 50	No	Inpatient	$ 10,000	$ 900	$ -	Insured		$ -
Self Pay Payments	Medicare	Medicaid	500	12345	3333333	2/7/2025	999-99-999	Male	Jones, Anthony	7/12/1995	7/14/1995	2/1/2010	$ 50	No	Inpatient	$ 10,000	$ 900	$ -	Insured		$ -
Self Pay Payments	Medicare	Medicaid	500	12345	3333333	2/7/2025	999-99-999	Male	Jones, Anthony	7/12/1995	7/14/1995	3/1/2010	$ 50	No	Inpatient	$ 10,000	$ 900	$ -	Insured		$ -
Self Pay Payments	Medicare	Medicaid	500	12345	3333333	2/7/2025	999-99-999	Male	Jones, Anthony	7/12/1995	7/14/1995	4/1/2010	$ 50	No	Inpatient	$ 10,000	$ 900	$ -	Insured		$ -
Self Pay Payments	Blue Cross		150	12345	9999999	9/25/1979	999-99-999	Male	Smith, John	9/21/2000	9/21/2000	9/30/2009	$ 150	No	Outpatient	$ 2,000	$ -	$ 50	Insured	Exhausted	$ 146
Self Pay Payments	Blue Cross		150	12345	9999999	9/25/1979	999-99-999	Male	Smith, John	9/21/2000	9/21/2000	10/31/2009	$ 150	No	Outpatient	$ 2,000	$ -	$ 50	Insured	Exhausted	$ 146
Self Pay Payments	Blue Cross		150	12345	9999999	9/25/1979	999-99-999	Male	Smith, John	9/21/2000	9/21/2000	11/30/2009	$ 150	No	Outpatient	$ 2,000	$ -	$ 50	Insured	Exhausted	$ 146
Self Pay Payments	Self-Pay		500	12345	7777777	7/9/2000	999-99-999	Male	Cliff, Heath	12/31/2009	1/1/2010	5/15/2010	$ 90	No	Inpatient	$ 15,000	$ 1,000	$ -	Uninsured		$ 84
Self Pay Payments	Self-Pay		500	12345	7777777	7/9/2000	999-99-999	Male	Cliff, Heath	12/31/2009	1/1/2010	5/31/2010	$ 90	No	Inpatient	$ 15,000	$ 1,000	$ -	Uninsured		$ 84
Self Pay Payments	United Healthcare		500	12345	5555555	2/15/1960	999-99-999	Male	Johnson, Joe	9/1/2005	9/3/2005	11/12/2010	$ 130	No	Inpatient	$ 14,000	$ 400	$ 50	Insured	Non-Covered Service	$ 126

Exhibit C – All other patient types

- Similar to the Exhibit A, patient level detail by revenue code
- Required for all payer types that require internal hospital data
- Need to include all payments received for patient
  - This needs to be broken down by payer type
  - Medicaid FFS, Medicaid MCO/HMO, Medicare FFS, Medicare HMO, other third party payment, patient payments
- Depending on hospital accounting system, might need additional fields such as GL/Department codes to properly categorize charges by cost report line
- Payer Types – Separate Exhibit for each
  - Medicaid FFS
  - Medicaid MCO/HMO
  - Medicaid Other Eligible
  - Crossover

Exhibit C – Requires Data Fields

a. Claim Type
b. Primary Payor Plan
c. Secondary Payor Plan
d. Hospital Medicaid Number
e. Patient Identification Number (PCN)
f. Patient's Medicaid Recipient Number
g. Patient's Birth Date*
h. Patient's Social Security Number*
i. Patient's Gender*
j. Patient Name
k. Admit Date (see below for acceptable date formats)
l. Discharge Date (see below for acceptable date formats)
m. Service Indicator (inpatient/outpatient)
n. Revenue Code
o. Revenue Code Charges
p. Routine Days of Care
q. Medicare Traditional Payments (all payments received for the services provided from the admit date through the present)
r. Medicare HMO Payments (all payments received for the services provided from the admit date through the present)
s. Medicaid Payments (all payments received for the services provided from the admit date through the present)
t. Medicaid MCO Payments (all payments received for the services provided from the admit date through the present)
u. Private Insurance (primary or third party liability) Payments (all payments received for the services provided from the admit date through the present)
v. Self-Pay payments (all payments received from patients for the services provided from the admit date through the present)
w. Total Payments received on the claim (sum of all payments listed above)

Exhibit C

Claim Type (A)	Primary Payor Plan (B)	Secondary Payor Plan (C)	Hospital's Medicaid Provider # (D)	Patient Identifier Number (PCN) (E)	Patient's Medicaid Recipient # (F)	Patient's Birth Date (G)	Patient's Social Security Number (H)	Patient's Gender (I)	Name (J)	Admit Date (K)	Discharge Date (L)	Service Indicator (Inpatient / Outpatient) (M)	Revenue Code (N)	Total Charges for Services Provided (O)	Routine Days of Care (P)	Total Medicare Traditional Payments for Services	Total Medicare HMO Payments for Services	Total Medicaid Payments for Services Provided (S)	Total Medicaid MCO Payments for Services	Total Private Insurance Payments for Services Provided (U)	Self-Pay Payments (V)	Sum of All Payments Received on Claim (Q)+(R)+(S)+(T)+(
Medicaid MCO	Healthcare USA	BCBS Blue Advantage	12345	888888	123456789	1/1/1960	999-99-999	Male	James, Samuel	9/1/2009	9/4/2009	Inpatient	120	$ 1,200	3	$ -	$ -	$ -	$ 1,500	$ 50	$ -	$ 1,550
Medicaid MCO	Healthcare USA	BCBS Blue Advantage	12345	888888	123456789	1/1/1960	999-99-999	Male	James, Samuel	9/1/2009	9/4/2009	Inpatient	206	$ 1,500	1	$ -	$ -	$ -	$ 1,500	$ 50	$ -	$ 1,550
Medicaid MCO	Healthcare USA	BCBS Blue Advantage	12345	888888	123456789	1/1/1960	999-99-999	Male	James, Samuel	9/1/2009	9/4/2009	Inpatient	250	$ 100	-	$ -	$ -	$ -	$ 1,500	$ 50	$ -	$ 1,550
Medicaid MCO	Healthcare USA	BCBS Blue Advantage	12345	888888	123456789	1/1/1960	999-99-999	Male	James, Samuel	9/1/2009	9/4/2009	Inpatient	300	$ 375	-	$ -	$ -	$ -	$ 1,500	$ 50	$ -	$ 1,550
Medicaid MCO	Healthcare USA	BCBS Blue Advantage	12345	888888	123456789	1/1/1960	999-99-999	Male	James, Samuel	9/1/2009	9/4/2009	Inpatient	450	$ 1,500	-	$ -	$ -	$ -	$ 1,500	$ 50	$ -	$ 1,550
Medicaid MCO	Family Health Partners		12345	666666	978654321	7/12/1985	999-99-999	Female	Johnson, Sandy	6/30/2010	6/30/2010	Outpatient	250	$ 100	-	$ -	$ -	$ -	$ 900	$ -	$ 75	$ 975
Medicaid MCO	Family Health Partners		12345	666666	978654321	7/12/1985	999-99-999	Female	Johnson, Sandy	6/30/2010	6/30/2010	Outpatient	300	$ 375	-	$ -	$ -	$ -	$ 900	$ -	$ 75	$ 975
Medicaid MCO	Family Health Partners		12345	666666	978654321	7/12/1985	999-99-999	Female	Johnson, Sandy	6/30/2010	6/30/2010	Outpatient	450	$ 1,500	-	$ -	$ -	$ -	$ 900	$ -	$ 75	$ 975
Medicaid MCO	BCBS	Self-Pay	12345	555555	654321978	3/5/2000	999-99-999	Female	Jeffery, Susan	2/28/2010	2/28/2010	Outpatient	300	$ 375	-	$ -	$ -	$ -	$ 1,000	$ 100	$ -	$ 1,100
Medicaid MCO	BCBS	Self-Pay	12345	555555	654321978	3/5/2000	999-99-999	Female	Jeffery, Susan	2/28/2010	2/28/2010	Outpatient	450	$ 1,500	-	$ -	$ -	$ -	$ 1,000	$ 100	$ -	$ 1,100

Preparing for the DSH Examination

- There are some things that you can do now
- Start gathering all financial documents that will be used to complete the surveys. These will also need to be submitted with the surveys.
  - Financial Statements
  - Listing of other Medicaid Supplemental Payments
  - Working Trial Balance
  - Medicare Cost Report
  - Logical statements
- Review prior year results
  - Are you including all eligible accounts?
  - Were any adjustments made in prior years?

Preparing for the DSH Examination

- Look at your hospitals staffing capabilities and any upcoming PTO/Vacation Requests
- Schedule a meeting with your IT department
  - Determine if prior year search queries captured all eligible accounts
  - Do they have the staffing capabilities to complete the request timely?
- Request the data as soon as possible
  - This can be done before you receive the letter from Myers & Stauffer

Consolidated Appropriations Act, 2021

- Creates new supplemental payment reporting requirements for States
- Changes the calculation of hospital specific DSH limits, effective October 1, 2021
- Eliminates reduction in FY 2021
- Also delays remaining 4 years of cuts until FY 2024

	FY 2021	FY 2022	FY 2023	FY 2024	FY 2025	FY 2026	FY 2027
Previous Reduction Amounts	$4 billion[2]	$8 billion	$8 billion	$8 billion	$8 billion	-	-
Modified Reduction Amounts	-	-	-	$8 billion	$8 billion	$8 billion	$8 billion

DSH Rule – Reinstatement of CMS FAQs 33 & 34

- On April 30, 2017 CMS issued final rule On April 30, 2017 CMS issued final rule, withdrawing FAQs 33 & 34 from the Medicaid DSH guidance that was issued in January 2010 titled "Additional Information on the DSH Reporting and Audit Requirements"
- Uncompensated costs include only those costs for Medicaid eligible individuals that remain after accounting for all payments received, including Medicare and other third party payments.
- As of December 30, 2018 FAQs 33 and 34 are no longer operative
- States had option to revise DSH audits to remove third party payments for services provided before June 2, 2017
- August 13, 2019 final rule reinstated for services provided on or after June 2, 2017
  - Third party payments will now be included in the calculation of uncompensated care (UC) costs.
  - This will reduce UC costs
- How will this effect your hospitals DSH limits?

Medicaid Services Provided by TRG

- DSH/Uncompensated Care Pool Audits
- Supplemental / Enhanced / Pool Payment Optimization
- Settlement and Upper Payment Limit Issues
- Prospective Payment Rates
- Special Designation Requests
- Medicaid Appeals
- Charity Care/Financial Assistance Optimization

Questions?