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Kansas Medicaid DSH Survey: FY2023 Survey Preparation & Review

June 28, 2022

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Meet the Presenters

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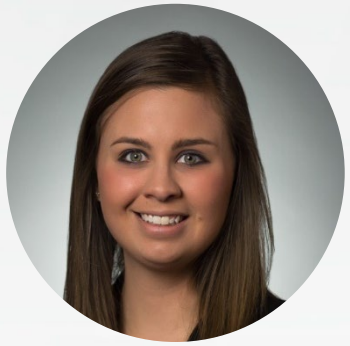

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Key Objectives

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- Discuss the Kansas Medicaid DSH Survey process & eligibility requirements
- Discuss how to appropriately gather requested data & complete requested DSH exhibits
- Discuss common survey issues
- Discuss the DSH examination process

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Agenda

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- SFY 2023 DSH Survey Status
- DSH Eligibility
- Payor Categories
- Common DSH Survey Issues
- DSH Examination Process

Kansas Medicaid DSH Recap

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- Myers & Stauffer will send out DSH survey templates & state data end of June or early July
- 45 days to complete once received
- Once preliminary results uploaded, hospital has 15 days to review for changes
- Data will be used to set the DSH payments for SFY 2023 (quarterly payments)
- Data will be used for the SFY 2020 Medicaid DSH audit
- DSH survey is also used for hospitals to receive UCC/HCAIP payments
  - Many PPS hospitals, even if not receiving DSH payments, will still need to submit
- **No major changes noted for this survey year**

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DSH Ineligible, HCAIP Only

- HCAIP payments calculated using the 2552-10 Medicare Cost Report Worksheet S-10
  - Two tabs in the DSH/UCC survey file
    - + DSH Waiver & MIUR Data
    - + Worksheet S-10
- Hospitals who only submit the survey to receive HCAIP payments do not have to complete the entire DSH survey file!
- All hospitals must complete the new Worksheet S-10 data tab to be considered for HCAIP payment
  - Report only uninsured amounts from S-10
  - If your hospital was not required to complete Worksheet S-10, you must submit equivalent information to be reviewed by Myers & Stauffer (M&S)
- NOTE: Worksheet S-10 data does not come from the same cost report year as the other survey data – be sure to verify dates

Reminder

- Consolidated Appropriations Act
  - Act only allows for the inclusion of costs & payments in the UCC for services for which the MCD state plan or waiver is the primary payor
    - + UCC excludes both costs & payments for services related to dually enrolled individuals
  - May still qualify to include the dually enrolled individuals (costs & payments) in UCC if the hospital is currently under the MCD DSH limit calculations & it results in a higher DSH limit
    - + Hospital must be within the 97th percentile of all hospitals in the number of Medicare SSI days or % of Medicare SSI days to total IP days on its most recent cost report for exception to apply

Kansas Medicaid DSH Recap

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- **Many aspects to completing the survey template**
  - Input cost report data
  - Prepare & input hospital exhibits A, B, & C (templates provided)
  - Complete logic statements
  - Other items to gather for submission

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Additional Items to Gather

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- Copy of your financial statements to support your charity care charges
- Detailed working TB used to prepare the CR (as well as by payor type)
- Revenue code crosswalk used to prepare the CR
- Tax revenue support
- Amount of DSH funds received for the period (& G/L account included in)
- Amount of provider assessment tax paid for the period (& G/L included in), if any
- Out-of-state remittances/PSRs & any OOS DSH payments, if any
- Support for any section 1011 payments (undocumented aliens), if any
- Calculation of ancillary & routine swingbed costs

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Additional Items to Gather

Charity care charge detail (including uninsured bad debts)

Charity Care Information	Includes Charges written off as charity care under the hospital's charity care policy Charges for unpaid Medicaid spend down amounts Charges for uninsured patients written off as bad debt after normal collection efforts Charges for uninsured discounts not billed to a patient Does Not Include Deductible/coinsurance for insured patients written off as bad debt
1. Unpaid charges for patients receiving hospital services where a reasonable collection effort has been made to collect 2. Based upon write-off dates during the cost report period 3. May include bad debt amounts which should be separately identified	

Cost Report

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- What cost report should I use?
  - Most recently available cost report should be used for the period
  - If you have a NPR'd cost report, use this one, not the as-filed
  - For FY 2023 DSH Survey – cost report periods ending *December 31, 2020, through September 30, 2021*
- Reminder: Need to have the previous year cost report available as well for Worksheet S-10 data tab completion

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State Data Files

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- Historically after the state data is released, the survey is due in 45 days
  - Typically, M&S will allow for extensions if needed but only a week or two

- M&S does request certain details of these files be reviewed if using for survey completion
  - Read their instructions & correspondence
  - Discuss with your survey preparer

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DSH Eligibility Requirements

Federal Requirements

- Two **federal** requirements to qualify for DSH payment

  1) Must have a greater than 1% Medicaid Inpatient Utilization Rate (MIUR)

  2) Must have two obstetricians with staff privileges at the hospital who have agreed to provide obstetric services to Medicaid individuals

     + Exceptions

       > Inpatient population predominantly less than 18 years of age

       > Facility did not provide nonemergency OB services to general public on December 22, 1987

  Rural hospitals – can be any physician with staff privileges who has agreed to perform nonemergency OB services

Kansas Requirements

- MIUR exceeds the lessor of one standard deviation above the mean for all hospitals receiving Medicaid payments or 25%

OR

Kansas Low Income Utilization Rate (LIUR) is greater than 25%

DSH Eligibility – MIUR

MIUR is calculated as follows

Medicaid Inpatient Utilization Ratio (MIUR):

1	Total Hospital Days per Cost Report (Exclude Swing-Bed)	20,000

Calculation of MIUR

1	Total Medicaid Eligible days per Survey	5,250
2	Total Hospital days per Cost Report	20,000
3	MIUR	26.25%

Medicaid Eligible Days = MCD FFS Days + MCD MCO Days + MCD FFS Crossover Days + MCD MCR Crossover Days + MCD OOS Days

DSH Eligibility – Kansas LIUR

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Medicaid Hospital Net Revenue		$ 500,000	
Hospital Cash Subsidies		650,000	
Total		$ 1,150,000	
Net Inpatient Hospital Revenue		$ 3,500,000	
Kansas Medicaid Fraction (under state plan)		32.86%	A
Net Inpatient Charity Care Charges		50,000	
Net Outpatient Charity Care Charges		100,000	
Inpatient Hospital Cash Subsidies		-	
Unspecified Hospital Cash Subsidies Allocated to Inpatient		170,000	
Adjusted Total Charity Care		(20,000)	
Inpatient Hospital Charges		5,500,000	
Inpatient Charity Fraction		-0.36%	B
Kansas LIUR (under state plan)	(A + B)	32.49%	

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DSH Eligibility

- **What if your hospital qualified when the payment was calculated but does not qualify once the audit is completed?**
  - CMS had indicated in *Additional Information of the DSH Reporting & Audit Requirements – Part 2* that if a hospital no longer qualifies for a DSH payment, it will be treated as a complete overpayment to that hospital & they will be required to pay back funds
  - Alternatively, if a hospital was not initially deemed eligible but is determined to be eligible, the state should make a payment to the hospital in accordance with its state plan

DSH Payor Categories

DSH Payor Categories

- Important changes due to Consolidated Appropriations Act
  - Pay close attention on following slides for underlined changes
    - + Medicaid FFS
    - + Medicaid managed care
    - + Medicaid crossovers & other Medicaid eligible

(refer to slide nine for information)

In-State Medicaid FFS Primary

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- Data source
  - State MMIS data is provided
  - Internal data can be used if reconciled to the state detail. Must be able to explain the variances in the two data sets
- What should be included?
  - All Medicaid FFS primary patients
  - **&** Medicare or private insurance primary with MCD secondary IF primary payor benefits were exhausted or noncovered *(hospital provided)*
- Potential issues
  - Must be sure to exclude any MediKan claims
  - Not all patients who have Medicaid will be in the state's data (or vice versa)
- It is important to discuss with your auditor/preparer what is included

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In-State Medicaid Managed Care (excluding crossovers)

- Data source
  - State managed care data provided
  - Internal data will be allowed if it is reconciled to the state detail. Must be able to explain the variances in the two data sets
- What should be included?
  - All Medicaid managed care primary patients
  - **&** Medicare or private insurance primary with MCD managed care secondary IF primary payor benefits were exhausted or noncovered *(hospital provided)*
- Potential issues
  - Must be sure to exclude any Title XXI claims
  - Managed care bundled payments – exclude professional piece

In-State Medicare/Medicaid Crossovers

- Data source
  - State Medicare/Medicaid crossover data (both MCR/MCD & MCR/MCD Managed Care)
  - Internal generated Exhibit C will be allowed if it is reconciled to the state detail
    - **Note:** If you are a critical access hospital (CAH), it may not be worth taking the time to generate internal data. Medicare pays CAH's at 101% of cost regardless of the data source; once payments are considered the total impact will be very small
- What should be included?
  - Patients with straight Medicare primary/Medicaid secondary (where Medicare is not exhausted or noncovered)
  - Do not include patients with Medicare managed care primary/Medicaid secondary
    - These claims are typically paid at a different rate than straight Medicare, *e.g.*, if they were reported with the crossover claims & you are a CAH, you are not going to be adjusted to a payment rate of 101% on all those claims

Note: Due to CAA changes, all hospitals will continue to report crossovers but are only included for those hospitals who qualify & it results in a higher DSH limit

TPL Payments – State Data Files

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- TPL (third-party liability) payment fields *may* be incorrect for all payor types based on how the claim was submitted by the provider (or third-party payor) and/or how it was entered into the state's system. Hospitals will need to use their own records for TPL payment amounts (and submitted with the survey). Be sure to verify if the summary files include co-pay and spenddown in the total TPL amount within the state files

  - Use internal report of TPL payments if comparable to state data
  - Look up individual patients in system to verify payments
  - Reconcile hospital claims to state claims detail

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Zero Paid Claims – State Data Files

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- Regardless of whether zero paid claims are included in the data files or provided separately, Hospitals should review all zero paid claims in order to determine if any payments were received for those claims. Hospitals should include all payments received for zero paid claims on the DSH survey in the appropriate payor category

Reminder: Any nonhospital charges & associated payments should be *excluded* from the survey! (such as SNF, RHC, HHA)

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Other Medicaid Eligibles

- Data source
  - All data would be internally generated
- What should be included?
  - Any patient who is Medicaid eligible that was not reported elsewhere on the survey
    - + Patients with Medicaid but Medicaid did not pay on the account. Denied for timely filing, no cost sharing … (Note that the patient must have had active Medicaid coverage at the time of service & the service must ordinarily be covered by Medicaid)
    - + Claims with commercial insurance primary/Medicaid or Medicaid managed care secondary where the commercial insurance is NOT exhausted (will want to make sure these are not in the state's data before including here) (generally those with no Medicaid payments will not be in the state's data – must include all payments received on these claims)
- Myers and Stauffer has started to question why there are none reported in surveys as technically we would expect other Medicaid eligibles to be present

Note: Due to CAA changes, all hospitals will continue to report OME but are only included for those hospitals who qualify & it results in a higher DSH limit

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Other Medicaid Eligibles

- "Ordinarily covered by Medicaid"
  - If Medicaid only covered psych services for patients less than 22, then anyone who received psych services could be considered to have received a Medicaid covered service even though Medicaid would not pay for a patient aged 22–64. Because the service is covered for one group of patients, it can be counted for anyone else receiving that service

Uninsured Exhibits

- Data source
  - All data would be internally generated (Exhibit A & Exhibit B)

- What should be included?
  - KEY: If you include it in uninsured charges, you must also include that patient type in the patient payments
  - Self-pay primary with no source of third-party coverage
  - Liability claims where the third-party insurance did not make any payments to the hospital or patient & there is no other source of coverage
  - Patients who do not have coverage for the place of service
    - For example: A patient who only has Medicare Part A, but receives outpatient services could be included as uninsured for the outpatient visit assuming they do not have additional coverage
  - Patients who have insurance, but the insurance never pays because they need additional information from the patient – creditable insurance is never verified

Uninsured

- Patients who meet the definition of uninsured under the December 3, 2014, Final Rule
  - Patients whose lifetime insurance limits have been reached
  - Patients whose benefits have been exhausted
  - Patients whose insurance package does not cover the service received (must still be a Medicaid covered service)
- CANNOT include
  - Denials for timely filing
  - Denials for medical necessity
  - Denials for precertification

Uninsured

- Exhausted benefits
  - Patients who have exhausted benefits prior to obtaining services are uninsured, individuals who exhaust benefits during a stay are insured
- All costs & revenues associated with Medicaid eligibles that have a source of private insurance coverage, including all third-party payor revenues received by hospital on behalf of patient, must be included in calculation of hospital-specific DSH limit
  - CMS justification – exclusion of these claims leads to artificially inflated DSH limits & permits a hospital to be paid twice on the same cost

Uninsured – Exhibit A

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- Uninsured charges – dates of service during DSH period
  - Payment data within Exhibit A *through date data ran*
  - Be sure data in acceptable formats (dates)

Uninsured – Exhibit B

- Patient payments (cash basis)
  - Include **every patient payment** received during the cost report period (insured & uninsured clearly identified)
  - Must include patient payments received through a collection agency during the year. Would be able to remove from those payments the amount of fees paid to the collection agency on the payments received
- Provided uninsured data (both charges & payments) should be in the Exhibit A & Exhibit B formats as provided by M&S

Out-of-State Medicaid

- Data source
  - If available an out-of-state PS&R should be used; if not available, internally generated data must be used in Exhibit C format
- What should be included?
  - Any patient who has active Medicaid coverage from an out-of-state agency should be included
  - The hospital does not necessarily have to have billed for that stay, but the patient must have active Medicaid coverage & have received a Medicaid covered service
- Item to note: OOS MCD is not included in the payment calculation, but days are included in the MIUR calculation & KS portion of uninsured UCC

Common DSH Survey Issues

Example Issue #1 – Lack of Prior Planning

- **Issue**
  - A system conversion or data purge makes required data unavailable at time of audit or completion of the survey

- **Solution & Result**
  - Plan ahead! If data is not going to be available, work with IT to pull data out of system before it purges
  - Should be able to pull every patient payment received during the period, regardless of service date
  - This ensures you will comply with Medicaid DSH regulations & reduce risk of being unable to support payment received upon examination

Example Issue #2 – Misgrouped Cost Centers

- **Issue**
  - Hospitals have not grouped survey charges in accordance with cost report groupings.
  - Cost report had allocated revenue codes to multiple cost centers but hospital had opted to simplify reporting & did not allocation of charges was not completed

- **Solution & Result**
  - Regroup charges in accordance with the cost report including all department allocations
  - Could potentially increase costs within DSH Survey!

Example Issue #3 – Excluding Allowable Populations

- **Issue**
  - CAH hospital uses the state provided data without reviewing it and a DSH payment of $800,000 is received
  - Upon examination it is found that many of the zero paid claims indeed had payments to the Hospital which resulted in a liability of nearly $300,000 to the Hospital

- **Solution & Result**
  - Be sure to review the state data files, including zero paids, if you intend to use them to report MCD data in the survey
  - This would decrease the liability due back upon examination and avoid issues

Example Issue #4 – Cost Centers Exceed Total

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- **Issue**
  - Routine days or ancillary charges reported in survey exceed total for cost center on cost report

- **Solution & Result**
  - Compare total survey charges to total cost report charges. Verify grouping for any red flags identified
  - Properly group Medicaid & uninsured days & charges in accordance with cost report per DSH instructions

Example Issue #5 – Mismatched Uninsured Data

- **Issue**
  - Patients are included as uninsured in Exhibit B, Patient Payments, with dates of service during year; however, these patients are not included in Exhibit A, Uninsured Charges

- **Solution & Result**
  - Match Exhibit A & Exhibit B data to identify this type of red flag. If they are uninsured on one exhibit, they should be uninsured on the other as well!
  - Have found at times payments that are being included were identified as non-allowable services. These were properly excluded from Exhibit A but should have also been removed from Exhibit B (this would increase the UCC)

Example Issue #6 – Overstating Uninsured Payments

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- **Issue**
  - Patient payments do not specifically apply to hospital or physician charges. Payments can be allocated between two based on charges on patient accounts

- **Solution & Result**
  - When pulling data from the system, include all data elements so this calculation can be completed. (Pull total hospital charges & physician charges for each patient)
  - Removing estimated professional fee payments will result in lower payments & therefore, an increase in net uncompensated care cost (UCC)

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Example Issue #7 – Insurance Status Updates

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- **Issue**
  - Insurance status not updated in patient account system, *e.g.*, a patient comes into hospital & claims to have BCBS. When the EOB arrives, it states coverage terminated prior to admit date. If their insurance status is not updated on the account, this claim may never get included in the uninsured population

- **Solution & Result**
  - Work with patient accounting to update all accounts based on verified financial class/payor plan regularly
  - Easier to identify all allowable claims & comply with DSH regulations
  - Could potentially increase UCC

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Example Issue #8 – Accepting Adjustments

- **Issue**
  - Upon examination audit adjustments exceeded UCC by $500,000, swinging hospital from “underpaid” to “overpaid”
    + M&S had adjusted payments to equal charges from PS&R and crossover payments were 110% of cost (CAH-MCR pays at 101%) in error

- **Solution & Result**
  - If in an overpaid situation upon examination, be sure to review adjustments & submit arguments to correct erroneous adjustments
  - Could potentially decrease or eliminate any liability for the year

Example Issue #9 – Payment Data Accuracy

- **Issue**
  - Payment data is overstated or understated in-state data files causing the hospital UCC to be overstated or understated

- **Solution & Results**
  - Review the state data files as requested by M&S (review zero paid claims, review TPL payments)
  - Review this information, even if it is just spot checked!
  - Could significantly impact the UCC of the Hospital

Example Issue #10 – Missing Data Elements

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- **Issue**
  - Data elements are missing in the hospital internal exhibits

- **Solution & Result**
  - Review your Exhibits A, B, & C compared to the data template examples provided by Myers and Stauffer
  - When the DSH examination is completed, the hospital may be required to go back & complete the missing data elements causing extra time for the facility

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A Few Additional Reminders

- Be sure to reduce hospital costs by both total routine & ancillary swingbed costs, if applicable
- Add back intern & resident costs removed on cost report (Worksheet B part 1, column 25) as well as any RCE limit disallowance (Worksheet C, column 4), if applicable
- Use the Myers and Stauffer portal to download & upload DSH survey & support

DSH Examination Process

DSH Examination

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- Examination files normally come out a few months after the survey is filed (expect 2020 DSH Examination in December 2022 or after)
- Much of the examination file itself is a repeat of the as-filed survey
  - Review & make changes or corrections as needed
- M&S may come back & ask further questions once submitted

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Common DSH Examination Issues

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- Lack of reporting any other Medicaid eligible
- Not all data fields included in exhibits (SS #, MCD #, DOB, etc.)
- Dates not formatted correctly
- Days duplicated within the exhibits
- If change in year-end – could be missing data so would need to report
- Not allocating payments between physician & nonphysician, if physician charges
- Not excluding MediKan or Title XXI charges/payments
- Nonhospital charges are not removed (swingbed, RHC, nursing facility)

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Determining Your Liability

- Hospitals whose year-end differs from the state year have to calculate the state year UCC to compare to the DSH payment
  - Generally, the number of days in the cost report period that overlap the DSH year divided by the number of days in the DSH year times the UCC for that cost report period. May need to use multiple cost report periods to cover the DSH year
  - The sum of these UCC amounts will be reduced by any supplemental payments received & the remainder will be compared to the DSH payment to arrive at the total overpayment or underpayment

Determining Your Liability

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Kansas Medicaid DSH Examination Uncompensated Care Cost (UCC) For State Fiscal Year:				10/1/2018 - 9/30/2019					
	(A)	(B)	(C)	(D)	(E)	(F)	(G)	(H)	(I)
	Cost Report Year Begin	Cost Report Year End	% of Year Applicable to DSH Year	Uninsured / Medicaid Cost	Medicaid and Self-Pay Payments	Medicare Payments	Private Insurance Payments (TPL)	Cost Report Year Adjusted DSH TOTAL Uncompensated Care Cost (UCC) (D)-(E)-(F)-(G)	State DSH Year Adjusted DSH TOTAL Uncompensated Care Cost (UCC) (C) x (H)
Cost Report Year 1 UCC:	1/1/2018	12/31/2018	25.21%	$ 1,710,975	$ 846,566	$ 415,452	$ 12,196	$ 436,761	$ 110,088
Cost Report Year 2 UCC:	1/1/2019	12/31/2019	74.79%	$ 1,618,929	$ 695,168	$ 600,711	$ 40,131	$ 282,919	$ 211,608
Cost Report Year 3 UCC:	-	-	0.00%						$ -
State DSH Year Sub-Totals:				$ 1,642,130	$ 733,329	$ 554,016	$ 33,090		$ 321,697
Less Supplemental Payments (UPL, etc.):									$ -
State DSH Year Adjusted Uncompensated Care Calculation (UCC):									$ 321,697
Out-of-State DSH Payments:									$ -
DSH Payments:									$ 354,100
In-State DSH Payments In Excess of State DSH Year Adjusted UCC:									$ 32,403
DSH Year Low Income Utilization Ratio (LIUR):									5.13%
DSH Year Medicaid Inpatient Utilization Ratio (MIUR):									18.13%

- In-state DSH payments in excess of DSH year-adjusted UCC – if not zero, then this would show the payback amount

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Overpayments

- Why do I have such a large overpayment?
  - Often, the data used to calculate the DSH payment is from two or three years prior to the actual year the payment is for. The DSH audit must compare the DSH payment to the UCC for that state year
  - Significant changes between the year at the hospital can lead to changes in the UCC between years contributing to an overpayment
  - If the data submitted for the payment calculation had errors in it, the DSH payment may have been improperly calculated
  - Or vice versa – the data submitted for the audit could have issues as compared to the data submitted for the payment calculation

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QUESTIONS

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