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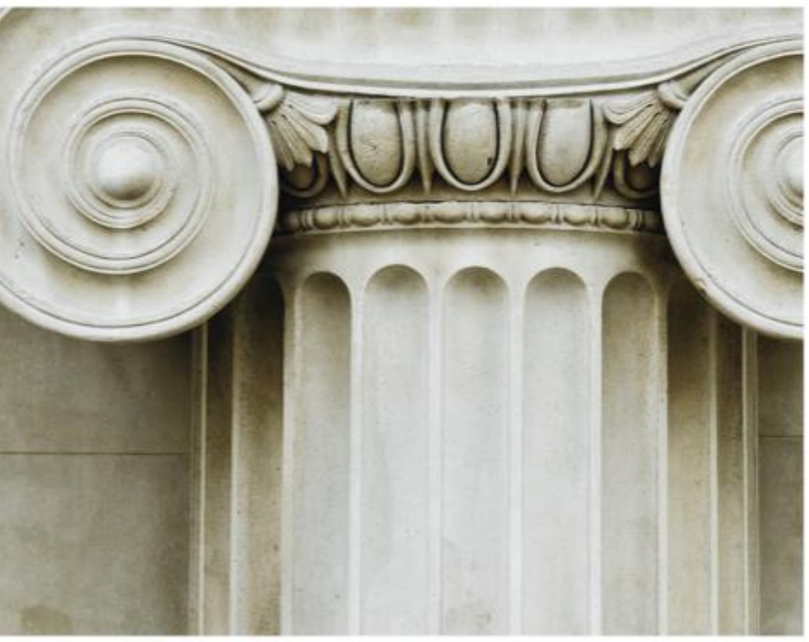
KANSAS DISPROPORTIONATE SHARE HOSPITAL (DSH)

Robyn Pugh
Bridget Bass
Janae Jensen, CPA

DEDICATED TO GOVERNMENT HEALTH PROGRAMS



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OVERVIEW

- Part I – DSH Examination
  - 2014 DSH Examination Update
  - 2015 DSH Examination Reminder
- Part II - SFY 2018 DSH Overview
  - NEW for SFY 2018
  - DSH Year 2018 DSH Survey Process
  - Paid Claims Data Overview
  - Survey Items to Note
  - “Other” Medicaid Eligibles

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OVERVIEW

- Part II - SFY 2018 DSH Overview (cont.)
  - Other Medicaid Payments
  - DSH Survey and Submission Checklist
  - Web Portal
- Part III – General DSH Overview
  - Kansas DSH Calculation Overview
  - DSH Allotment
  - Appeal Process

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PART I
DSH EXAMINATION

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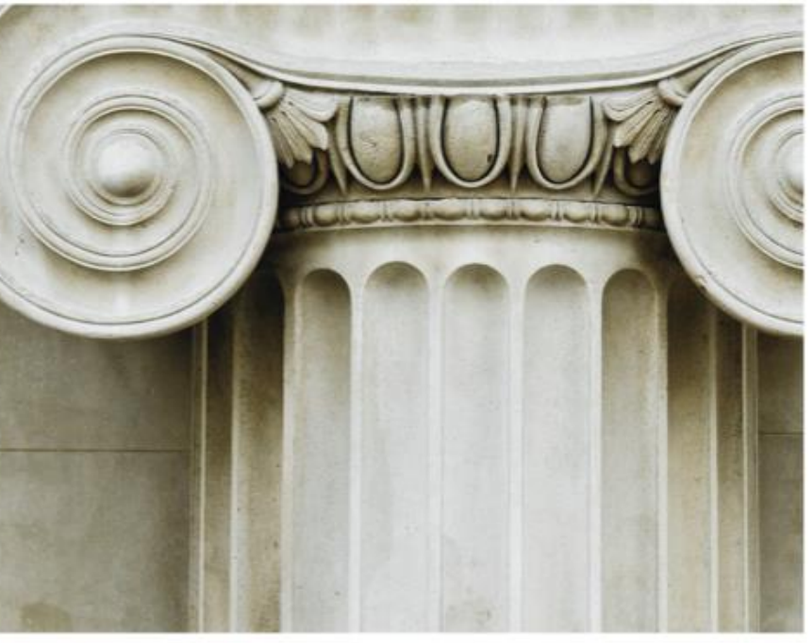

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2014 DSH EXAMINATION

- The 2014 DSH surveys have been received and we have completed approximately 90% of the desk reviews.
- Field visits are schedule for June and July.
- Examination results will be provided to each hospital through the web portal. Hospitals that are overpaid will also receive a certified letter.
- Should expect results in early August.

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2015 DSH EXAMINATION REMINDER

Claims data needs to be submitted in the requested format for Exhibits A – C.

- Myers and Stauffer still has to manually manipulate some of the exhibits, which can lead incorrect assumptions and errors.

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QUESTIONS

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PART II
SFY 2018 DSH PAYMENT

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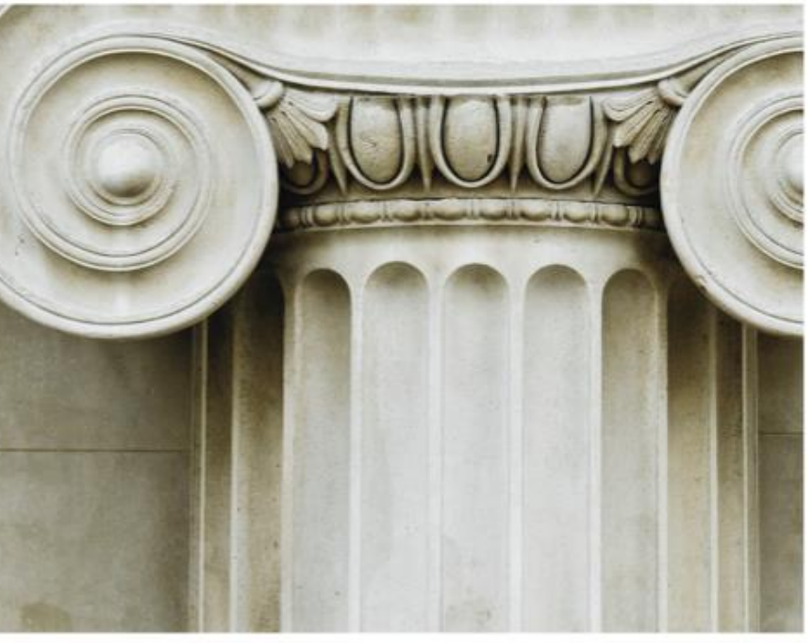

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SUMMARY OF SIGNIFICANT CHANGES

- Survey Updates
  - Additional Payment Lines
    - Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down)
    - Private Insurance (including primary and third party liability)
    - Self-Pay (including Co-Pay and Spend-Down)
    - Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)

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SUMMARY OF SIGNIFICANT CHANGES

- Survey Updates (cont.)
  - Sec. J Provider Tax
    - Provider tax assessment
      - WTB
      - A-8
- Charges

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SUMMARY OF SIGNIFICANT CHANGES

- Data Update
  - Hospital specific PCN
  - Medicare payments

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SURVEY PROCESS

- Period range: cost report year ends between 1/1/2015 – 9/30/2016

- Packet containing a cover letter, claims data, survey, supplemental payments and exhibit template uploaded to the web portal on **5/23/2017**

- 45 days to complete the survey; **Submission deadline 7/07/2017**

- Preliminary results Excel file will be uploaded for all providers

- 15 Days to review

- Final results Excel file will be uploaded for all providers

- Results letters uploaded to web portal or mailed to providers

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SURVEY PROCESS

- Hospitals that participate in the Kansas Medicaid Healthcare Access Improvement Program (HCAIP)
- Based on submitted surveys, MSLC will calculate the hospitals' Uncompensated Care Cost (UCC)
  - Excluding HCAIP and including DSH payments
- UCC calculations will be sent to KDHE to be used for distribution of UC Payments

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SURVEY PROCESS

- DSH Qualifying Hospitals
  - Submitted surveys will be used to calculate DSH payments
  - Survey data also used for the 2015 DSH Examination
    - Be certain to submit Exhibits A, B & C in proper format

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PAID CLAIMS DATA

- Myers and Stauffer has Compiled MMIS Data into Summary and Detail Reports
- Format will be the Same from Prior Year
  - Summary files
  - Details files (zero paid, Title XXI & MediKan claims included)

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PAID CLAIMS DATA

- FFS Medicaid Primary, Managed Care Medicaid Excluding Medicare Crossovers, Traditional Medicare Primary with Traditional Medicaid or Managed Care Medicaid Secondary Paid Claims Data
  - Uploaded to web portal on **May 23, 2017**
  - Reported based on cost report year (using discharge date)
  - Revenue code level
  - Detailed data provided

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PAID CLAIMS DATA

- Medicaid Managed Care Excluding Medicare Crossovers
  - Hospitals may self-report
  - Reconciliation must be submitted between self-reported data and data provided by the state
  - Revenue working trial balance by payor/contract
  - Medicaid managed care crossovers with payor other than Medicare primary
- If submitting internally-generated data, patient detail ***must*** be submitted using the new Exhibit C format (DSH Survey Exhibit A-C Hospital-Provided Claims Data.xlsx on tab Exhibit C)

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PAID CLAIMS DATA

- Traditional Medicare Primary with Traditional Medicaid or Managed Care Medicaid Secondary
- Hospitals may self-report
- Reconciliation must be submitted between self-reported data and data provided by the state
- Revenue working trial balance by payor/contract
- Medicare primary with either FFS Medicaid or managed care Medicaid secondary
- If submitting internally-generated data, patient detail ***must*** be submitted using the new Exhibit C format (DSH Survey Exhibit A-C Hospital-Provided Claims Data.xlsx on tab Exhibit C)

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PAID CLAIMS DATA

- Zero Paid Claims
  - Zero paid claims are included in the summary and detail report of each payor type. There will not be a separate Exhibit C with only zero paid claims
  - There is an 0/1 indicator in column (AA) of detail claims listing with 1 indicating a zero paid claim
  - Hospitals should review all zero paid claims in order to determine if any payments were received for those claims
  - Include all payments received for zero paid claims on the DSH survey in the appropriate payor category

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PAID CLAIMS DATA

- MediKan Claims
  - MediKan claims will now be included in the summary and detail report of each payor type. There will not be a separate Exhibit C with only MediKan claims
  - There is an 0/1 indicator in column (AB) of detail claims listing with 1 indicating a MediKan claim
  - MediKan claims should be **excluded** from the survey
  - MediKan claims are considered to be a public third party insurer and therefore, **cannot** be included in uninsured
  - Exception: if a claim retroactively becomes Title XIX, it may be included on the survey

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PAID CLAIMS DATA

- Title XXI Claims
  - Title XXI claims are included in the summary and detail report of each payor type. There will not be a separate Exhibit C with only Title XXI claims
  - There is an 0/1 indicator in column (AC) of detail claims listing with 1 indicating a Title XXI claim
  - Title XXI claims should be **excluded** from the survey

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PAID CLAIMS DATA

- TPL Payments
  - TPL payments must be verified by the hospital as payments may be misstated in the state's data due to variance in claims submission by providers or 3rd party payors
  - Providers will need to use their own records for TPL payment amounts. The payment logs need to be submitted with the survey. Please note the summary files include co-pay and spenddown in the total TPL amount

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PAID CLAIMS DATA

- Out-of-State Medicaid Paid Claims Data should be Obtained from the State Making the Payment
    - If the hospital cannot obtain a paid claims listing from the state, the hospital should send in a detailed listing in **Exhibit C** format
- Must EXCLUDE CHIP-Title XXI and other non-Title XIX services
- Should be reported based on cost report year (using discharge date)
- In future years, request out-of-state paid claims listing at the time of your cost report filing

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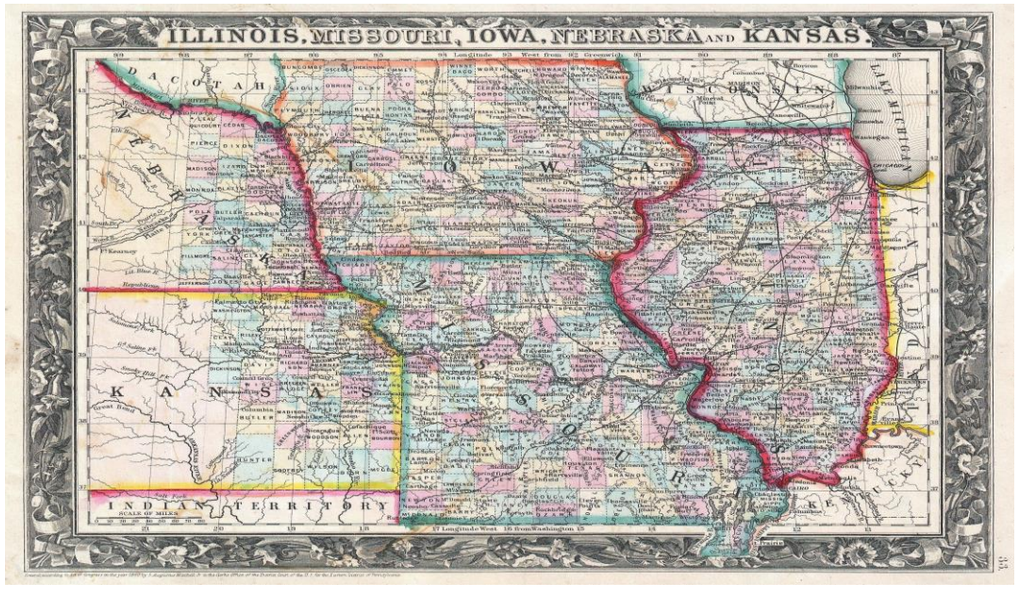
PAID CLAIMS DATA



- Out-of-State Medicaid Paid Claims Data
  - Is not included in the UCC for the payment calculation
  - Days are included in the MIUR calculation
  - Days are used to calculate the Kansas Portion of Uninsured UCC
  - Data is collected for the DSH examination and included in the UCC

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SURVEY ITEMS TO NOTE

- Only DSH appropriate claims can be included on the survey
  - Non-hospital charges and associated payments should be excluded
- Hospital cost should be further reduced by total routine and ancillary swing bed costs
- Routine per diem cost per day and ancillary cost-to-charge ratios should include intern & resident costs and RCE disallowance, if applicable

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"OTHER" MEDICAID ELIGIBLES

- The 2008 DSH rule and January, 2010 CMS FAQ #33 both require that a hospital's DSH uncompensated care cost include all "Other" Medicaid Eligibles

- The 2008 DSH rule specifically states that the UCC calculation must include "regular Medicaid payments, Medicaid managed care organization payments, supplemental/enhanced Medicaid payments, uninsured revenues, and 1011 payments." *FR Vol. 73, No. 245, Friday, Dec. 19, 2008, Final Rule, 77904*

- January, 2010 CMS FAQ #33 issued on January 10, 2010, clarified that the Other Medicaid Eligible population includes patients with private insurance who are dually eligible for Medicaid, and any payments from private insurance must be included in the UCC calculation

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"OTHER" MEDICAID ELIGIBLES

- The hospital must submit Medicaid-eligible services where Medicaid did not receive the claim or have any cost-sharing and are not already included in the state's data on **Exhibit C** for them to be eligible for inclusion in the DSH uncompensated care cost (UCC)
- Providers must include claims with commercial insurance primary and Medicaid secondary, even if Medicaid made no payment on the claim *(Federal Register/Vol. 79, No. 232, December 3, 2014)*

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"OTHER" MEDICAID ELIGIBLES

- Must EXCLUDE CHIP-Title XXI and other non-Title XIX services
- Should be reported based on cost report year (using discharge date)
- Separately identify each claims' Medicare, Medicare HMO, Medicaid, Medicaid MCO, Private Insurance, and Self-Pay payments on the Exhibit C

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OTHER MEDICAID PAYMENTS

- Included in a Summary File
  - Medicaid Graduate Medical Education (GME)
  - HCAIP Pool Payments (Healthcare Access Improvement Payments)
- Safety Net Care Pool Payments (1/1/13)
  - Large Public Teaching Border City Children Hospital Pool
  - UC Pool (HCAIP) (1.38%)

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EXHIBIT A AND B

- Uninsured charges/days will be reported on Exhibit A and patient payments will be reported on Exhibit B
- Exhibit A should be reported based on cost report year (using discharge date)
- Exhibit B patient payments (uninsured and insured) should be reported based on cash basis (received during the cost report year)

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SUBMISSION CHECKLIST

- Survey completed, signed and dated
- Exhibits A, B and C (must be in excel (.xls or .xlsx) or CSV (.csv) using either a TAB or | (pipe symbol above the enter key)
- Description of logic used to compile exhibits A, B and C (include a copy of all financial classes, payor plan codes and transaction codes utilized during the cost report period)
- Support for Section 1011 (undocumented alien) payments if not applied at patient level in Exhibit B
- Documentation supporting out-of-state DSH payments received
- Financial statements to support total charity care charges and state/local government cash subsidies reported

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SUBMISSION CHECKLIST

- Revenue code crosswalk used to prepare the cost report
- Working trial balance used to prepare the cost report (including revenues)
- Revenue working trial balance by payor/contract
- Electronic copy of cost reports used to prepare the DSH survey
- Documentation supporting cost report payments calculated for Medicaid/Medicare cross-overs (dual eligible cost report payments)
- Documentation supporting Medicaid Managed Care Quality Incentive Payments, or any other Medicaid Managed Care lump sum payments

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WEB PORTAL

- First Time Log-in
  - Click *Forgot Password*
  - Enter email address and click *Send Forgot Password Email*
  - Expect an email with a link to set the password
  - Log-in to the website using email address and new password
  - Review and confirm providers visible on your account

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WEB PORTAL

- Ability to Upload DSH Submission
    - MSLC will review
        - Accept or reject
            - Once document is approved provider is no longer able to upload to that event
                - Will need to notify MSLC of need to revise as-filed documents
- Ability to include notes up to 1,000 characters

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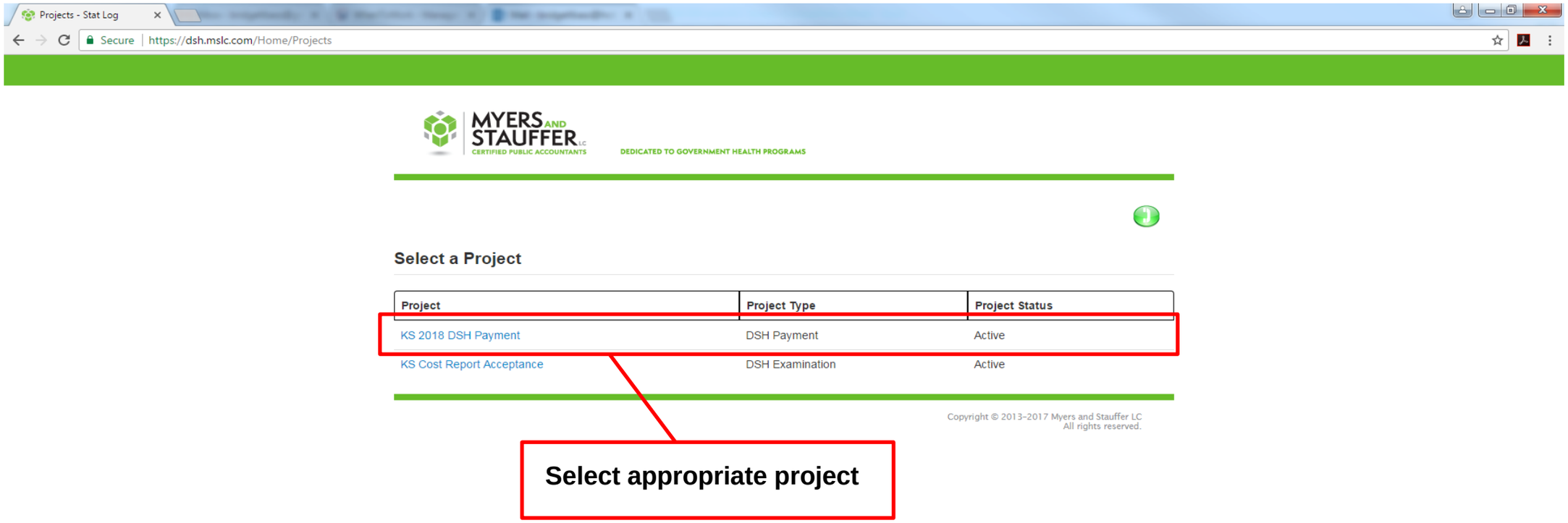
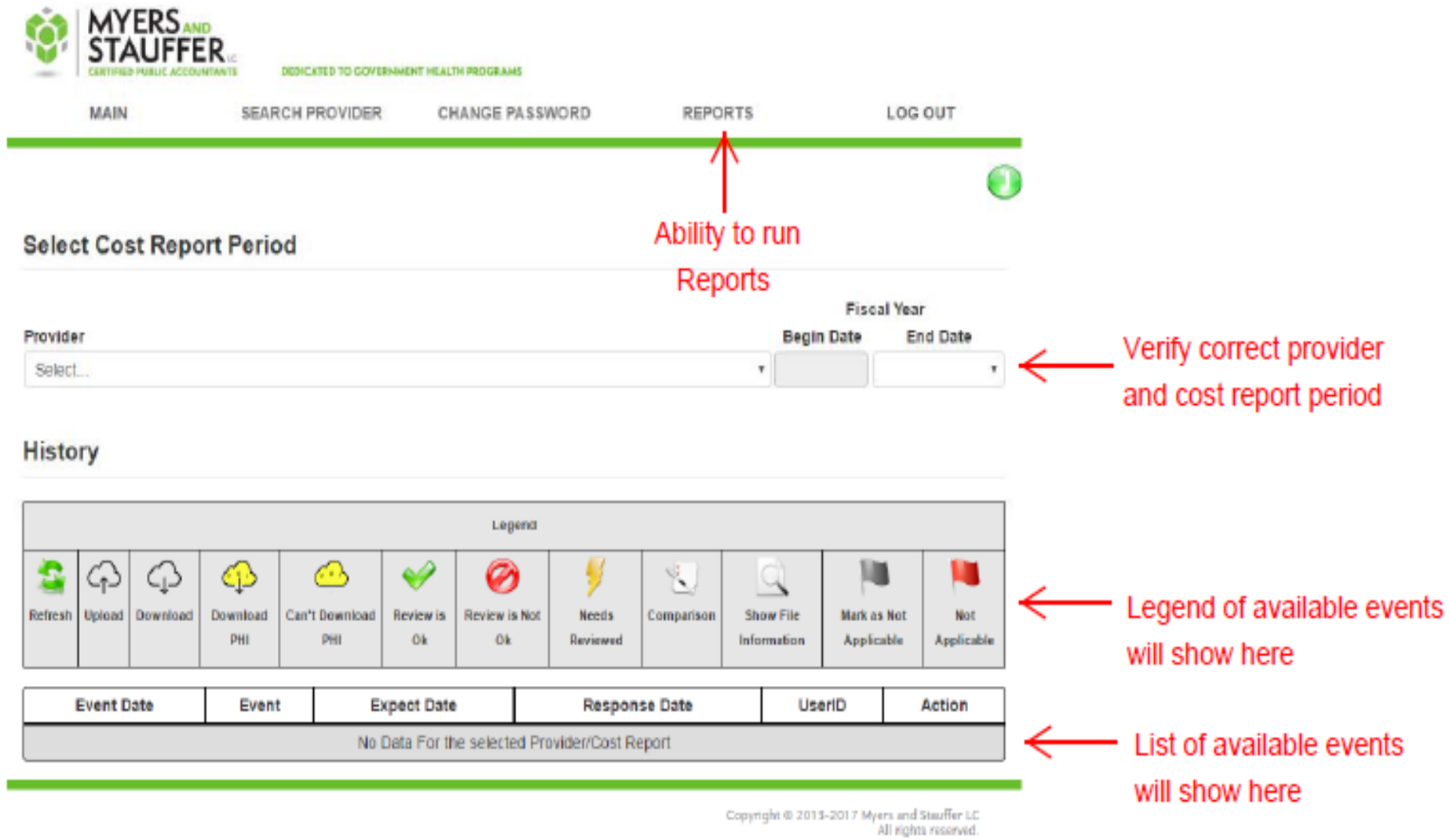
WEB PORTAL



WEB PORTAL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DEDICATED TO GOVERNMENT HEALTH PROGRAMS
MAIN
SEARCH PROVIDER
CHANGE PASSWORD
REPORTS
LOG OUT
Ability to run Reports
Select Cost Report Period
Fiscal Year
Provider
Begin Date
End Date
Select...
Verify correct provider and cost report period
History
Legend
Refresh
Upload
Download
Download PHI
Can't Download PHI
Review is Ok
Review is Not Ok
Needs Reviewed
Comparison
Show File Information
Mark as Not Applicable
Not Applicable
Legend of available events will show here
Event Date
Event
Expect Date
Response Date
UserID
Action
No Data For the selected Provider/Cost Report
List of available events will show here
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OTHER INFORMATION

Please use the **Survey Submission Checklist** when preparing to submit your surveys and supporting documentation

Upload survey and other data to:

https://dsh.mslc.com

Submit questions to:

(800) 374-6858

ksdsh@mslc.com

Note: Exhibits A-C include protected health information and must be sent accordingly (no e-mail)

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QUESTIONS

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PART III
GENERAL DSH OVERVIEW

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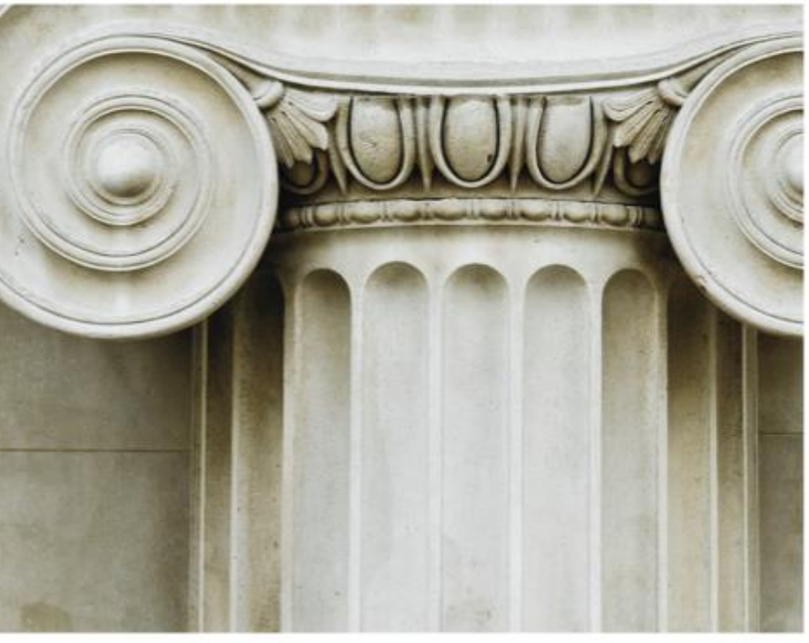

DSH CALCULATION OVERVIEW

Payments to hospitals which are either located in the State of Kansas or located outside of the state, but operates a hospital that is located within the state.

- 2 Obstetricians
  - Exceptions
- Medicaid Inpatient Utilization Rate (MIUR)
  - One standard deviation above the statewide mean
- Low Income Utilization Rate (LIUR)
  - Greater than 25%

* Kansas Medicaid State Plan – Attachment 4.19-A

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DSH CALCULATION OVERVIEW

- Kansas LIUR vs. Federal LIUR
    - Denominator of Medicaid Fraction for The Federal LIUR is Total Patient Revenue and Net IP Revenue for Kansas LIUR
    - Charity Fraction includes IP and OP Charity Care for Kansas LIUR and only IP Charity Care for the Federal LIUR
    - Determination of a deemed hospital is based on Federal Definition

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DSH CALCULATION OVERVIEW

- Lost Eligibility Payment
  - Hospitals that lose eligibility in any given year, that were eligible for DSH in each of the **preceding 2 years**
  - Receive the LESSER of 50% of their previous year's payment or their current UCC
  - Must meet the OB requirements and have at least 1% MIUR
- CAH Transition Payment
  - Increase in DSH will receive 100% of increase from previous year
  - Decrease in DSH will receive the lesser of their 2007 payment or their facility specific DSH limit
  - Must meet the OB requirements and have at least 1% MIUR

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DSH CALCULATION OVERVIEW

- Limitations on DSH Payments
  - Limited to the Federal DSH Allotment
  - Hospitals are limited to no more than their UCC
    - Total Facility Specific DSH Limit (Hospital's UCC)
      - Kansas Portion of Uninsured Uncompensated Care Cost + Kansas Medicaid Short (Long) Fall

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DSH CALCULATION OVERVIEW

- Non-Institutes for Mental Disease (IMDs) Distribute DSH Based upon each Hospital's Burden %
  - Burden % = Hospital's Uncompensated Care Cost (UCC)/Hospital's Total Cost (excluding any SNF, NF, rural health clinics, Swing-bed costs, etc.)
  - Rank % = (Facility's Burden-Lowest % Burden of DSH Eligible Facilities)/(The Average of the Three Highest % Burdens of DSH Eligible Hospital- Lowest % Burden of DSH Eligible Facilities)
    - This cannot exceed 100% to ensure the facility's UCC is not exceeded
    - Incrementally raised or lowered until the entire Federal DSH allotment has been allocated
  - DSH Payment = Rank % * UCC

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DSH CALCULATION OVERVIEW

- IMD Payment Calculation
  - Divide each eligible IMD hospital's UCC by the total UCC for all DSH eligible IMD hospitals
  - Percentage calculated * IMD portion of Federal Allotment
  - Receive the lower of the calculated amount or their UCC

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DSH ALLOTMENT

- Allocation of DSH Funds: Based on Burden of UCC relative to their peers
- DSH Funds Limited for the Following Hospital Types (in-order)
  - Institutes for Mental Disease (IMD)
    - Limited to 33% of the Federal DSH Allotment
  - Out of State Hospitals
    - Limited to up to 10% of the Federal DSH Allotment
  - State Owned or Operated Teaching Facility
    - Limited to up to .25% of the Federal DSH Allotment
  - Non-IMDs
    - Remaining Funding

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2017 PRELIMINARY DSH ALLOTMENT

- Total Approximately $80 Million
- IMD Approximately $26.5 Million
- Non-IMD Out-of-State Approximately $5 Million
- State-Owned/Operated Teaching Approximately $64,000
- Non-IMD Other In State Approximately $47 Million

Note: Allotment reduction has been delayed even further until federal fiscal year 2018, through the Protecting Access to Medicare Act (P.L. 114-10). The total reduction amount was increased to $2,000,000,000.

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APPEAL PROCESS

- Appeal Rights
  - If hospital is not determined eligible for DSH, may request in writing a review of the determination within **15 days** from the notification of the final payment notice
  - Limited to errors in the DSH formula and errors that may result in material overstatement of DSH based on data submitted in the provider's DSH form

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