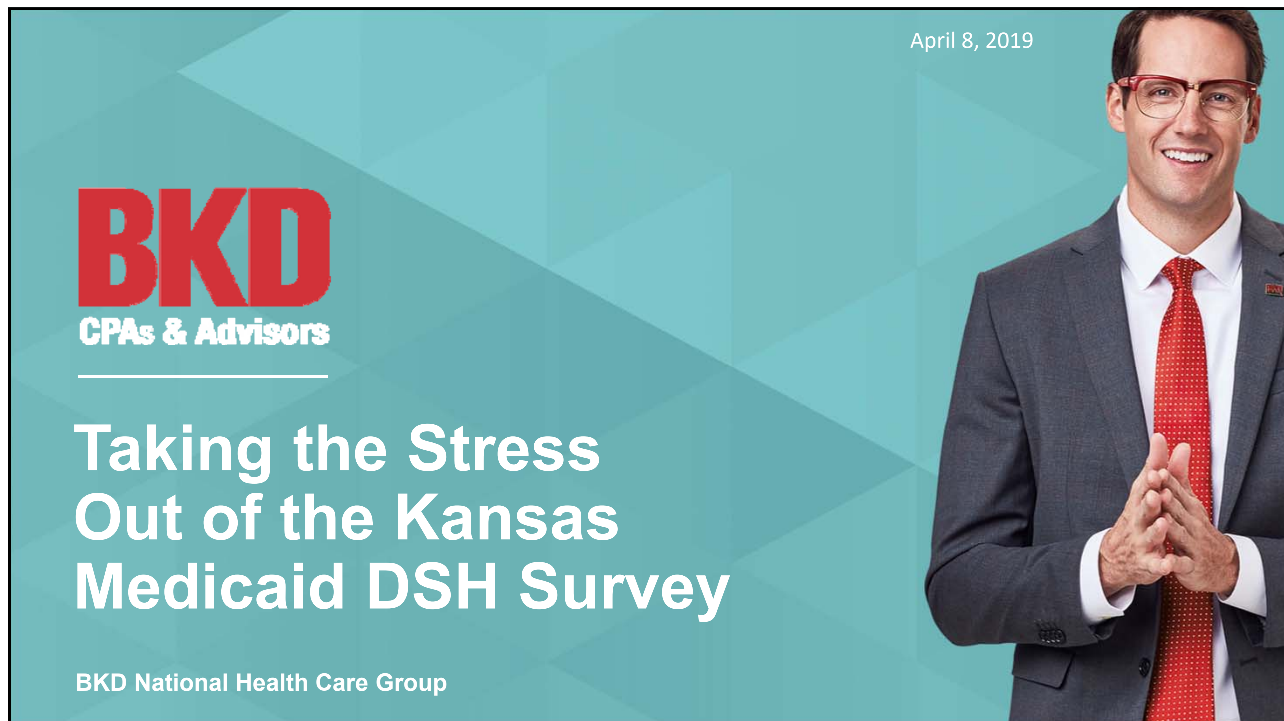

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- **Individuals**
  - Participate in entire webinar
  - Answer polls when they are provided
- **Groups**
  - Group leader is the person who registered & logged on to the webinar
  - Answer polls when they are provided
  - Complete group attendance form
  - Group leader sign bottom of form
  - Submit group attendance form to training@bkd.com within 24 hours of webinar
- If all eligibility requirements are met, each participant will be emailed their CPE certificate within 15 business days of webinar

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Today's Presenter

Casey Johnson, CPA
Senior Managing Consultant
cjohnson@bkd.com
316.768.5185

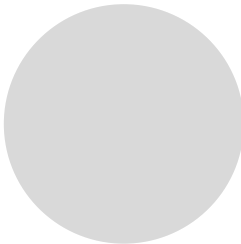
Key Objectives

- Gain a basic understanding of the Kansas Medicaid DSH Survey process & eligibility requirements
- Review potential changes to the SFY 2020 Kansas Medicaid disproportionate share hospital survey
- Discuss how to appropriately gather requested data & complete required DSH exhibits
- Understand the DSH examination process

Agenda

- Kansas Medicaid DSH Recap & Upcoming Changes
- DSH Eligibility
- Payor Buckets
- Common Blunders
- DSH Examination Process

Kansas Medicaid DSH Recap



- Myers & Stauffer to send out DSH survey templates in mid-April
- State detailed data files to be sent out approximately one month later
- Data will be used to set the DSH payments for SFY 2020
- Data will be used for the SFY 2017 Medicaid DSH audit
- **There is plenty to do prior to obtaining the state data files!**
  - Cost report data input
  - Hospital Exhibits A, B & C (templates provided)
  - Logic statements
  - Other items gathered

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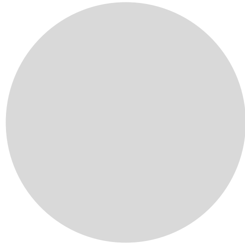
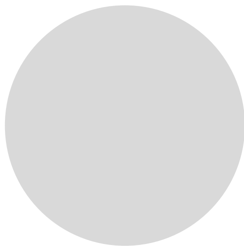
Cost Report



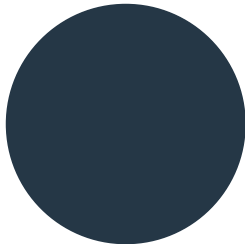
- What cost report should I use?
  - Most recently available cost report should be used for the period
  - If you have a NPR'd cost report, use this one, not the as-filed
  - For FY 2020 DSH Survey – cost report periods from December 31, 2017, through September 30, 2018, should be used

State Data Files



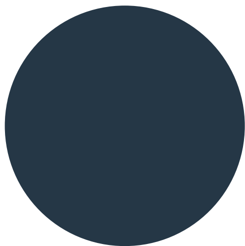
- 45 days to complete survey after receive the state data files
- Historically there have been issues with data files, which may cause delays
- Myers & Stauffer does request certain details of these files be reviewed
  - Read their instructions & correspondence!

Upcoming Changes



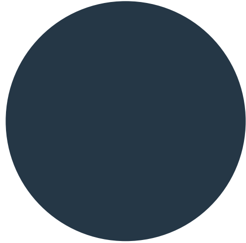
- Withdrawal of FAQs 33 & 34 from the January 2010 *Additional Information on DSH Reporting and Audit Requirements* guidance
  - KDHE has not yet released their plan to address this & are working with legal & their DSH contractor, Myers & Stauffer

Upcoming Changes – DSH Plan Amendment



- KDHE & the DSH Steering Committee have been reviewing changes to the current Kansas DSH State Plan Amendment
- In mid-January KDHE had submitted the revisions of the DSH State Plan Amendment to CMS for a presubmission review
  - CMS replied back with several questions & recommendations – these are currently being reviewed
- KDHE hopes to send in a final DSH plan amendment during the second quarter of 2019 to be effective for the 2020 DSH year

Upcoming Changes – DSH Plan Amendment



- Recommend changes included the following
  - MIUR qualification changes
  - Adding another DSH fund "pool" for large hospitals (500+ beds)
  - CAH transition factor to be eliminated
  - Changes to the three-year transition period
  - Cliff provision eliminated
  - Three-year rolling average hospital burden calculated
  - Percentage rank will no longer be used in the calculation
  - Scaling factor of 150% applied to hospital-specific DSH limits for rural hospitals
  - Eligible CAHs will receive greater of current year DSH or 37% of their DSH limit

Note: these are NOT final & may change based on CMS recommendations & approval

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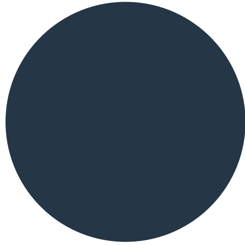
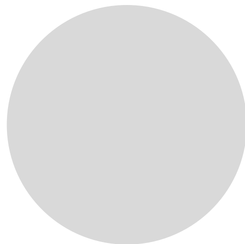
DSH Eligibility Requirements

Federal Requirements



- Two **federal** requirements to qualify for DSH payment
  - Must have a greater than 1% Medicaid Inpatient Utilization Rate (MIUR)
  - Must have two obstetricians with staff privileges at the hospital who have agreed to provide obstetric services to Medicaid individuals
    - Exceptions
      - Inpatient population predominantly under 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

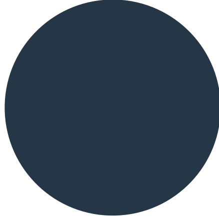


- MIUR greater than one standard deviation above the mean for all hospitals receiving Medicaid payments (prior-year percentage was 28.14% per Myers & Stauffer)

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

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Kansas LIUR

LIUR Calculation:

Part I – Medicaid		
1	Medicaid Net Revenue per Survey	13,285,000
2	Total Hospital Subsidies	100,000
3	Total per Survey	13,385,000
4	Net Hospital Revenue per Cost Report	85,568,063
5	Medicaid Fraction	15.62%
Part II – Charity		
6	Inpatient Charity Care	2,000,000
7	Inpatient Hospital Subsidies	-
8	Unspecified Hospital Subsidies	100,000
8.01	Allocated Unspecified	43,417
9	Adjusted Inpatient Charity Care	1,956,583
10	Total Inpatient Hospital Charges per Cost Report	77,500,000
11	Charity Fraction	2.52%
	LIUR	18.15%

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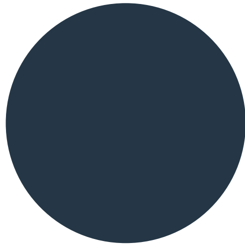
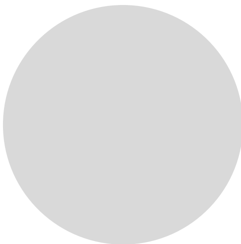
Kansas LIUR vs. Federal LIUR



- Denominator of Medicaid fraction for the federal LIUR is total patient revenue & net IP revenue for Kansas LIUR
- Charity fraction includes IP & OP charity care for Kansas LIUR & only IP charity care for the federal LIUR
- Determination of a deemed hospital is based on federal definition

DSH Eligibility

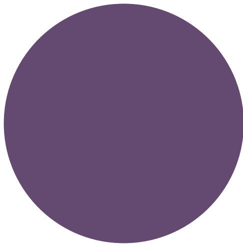


What if your hospital qualified when the payment was calculated but does not qualify once the audit is completed?

- CMS had indicated in *Additional Information of the DSH Reporting and 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

Payor Buckets

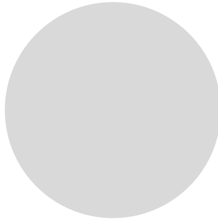
Medicaid FFS Primary (In-State)



- Data source
  - State MMIS data is provided
  - Internal data will only 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 FFS primary patients
- Potential issues
  - Not all patients who have Medicaid will be in the state's data

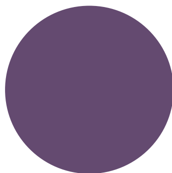
It is important to discuss with your auditor/preparer what is included

Medicaid Managed Care (In-State)



- Data source
  - State managed care data provided
  - Internal data will only 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
- Potential issues
  - Must be sure to exclude any Title XXI claims
  - Managed care bundled payments – exclude professional piece

Medicare/Medicaid Crossovers (In-State)

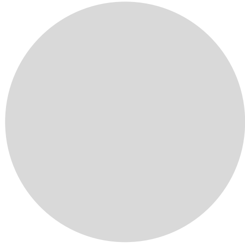


- Data source
  - State Medicare/Medicaid crossover data
  - Internal generated Exhibit C will only be allowed if it is reconciled to the state detail

  Note: if you are a critical access hospital (CAH) it may not be worth taking the time to generate internal data. Medicare pays CAHs 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
  - 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

In SFY 2019, state DSH files contained errors in payments – be sure to review payments

TPL Payments



- **Per Myers & Stauffer**

  "TPL payment fields may be incorrect for all payor types based on how the claim was submitted by the provider (or third-party payor) &/or how it was entered into the state's system. Providers will need to use their own records for TPL payment amounts. The payment logs need to be submitted with the survey"
- Use internal report if 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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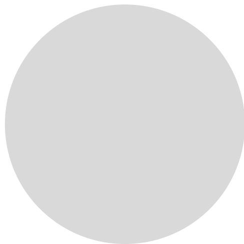
Zero Paid Claims



- **Per Myers & Stauffer**

  "Zero paid claims will be included in the summary & detail reports for each payor type. 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"

Reminder: any nonhospital charges & associated payments should be ***excluded*** from the survey!

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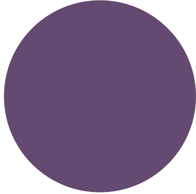
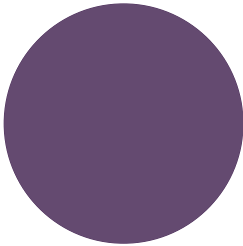
Other Medicaid Eligibles



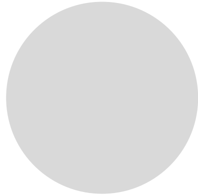
- Data source
  - All data would be internally generated
- What should be included?
  - Any patient who is Medicaid eligible that was not reported elsewhere on the survey
    - Patients with Medicaid, but Medicaid did not pay on the account. Denied for timely filing, no cost sharing … note patient must have had active Medicaid coverage at the time of service & the service must **ordinarily be covered** by Medicaid
    - Claims with Medicare managed care or commercial insurance primary/Medicaid or Medicaid managed care secondary (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)

Other Medicaid Eligibles



- "Ordinarily covered by Medicaid"
  - If Medicaid only covered psych services for patients under 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



- 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, *e.g.*, 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

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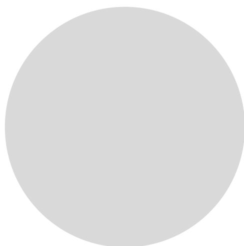
Uninsured



- 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

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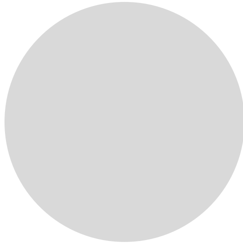
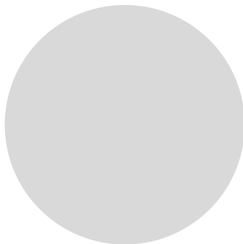
Uninsured



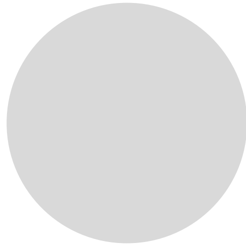
- Exhausted benefits
  - Patients who have exhausted benefits prior to obtaining services are uninsured, individuals who exhaust benefits during a stay are insured
- All costs & revenues associated with Medicaid eligibles that have a source of private insurance coverage, including all third-party payor 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 B



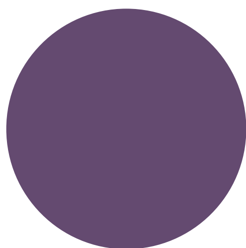
- Patient payments (cash basis)
  - Include **every patient payment** received during the cost report period (insured & uninsured clearly identified)
  - Must include patient payments received through a collection agency during the year. Would be able to remove from those payments the amount of fees 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 Myers & Stauffer

Other Medicaid Eligibles vs. Uninsured



- **Why does this matter?**
  - Only data reported in a Medicaid column will be used to calculate MIUR. Uninsured data is not used in this calculation
  - To qualify to receive DSH payment under federal regulations, a hospital must have a MIUR >1%
  - A hospital can be federally deemed (must receive a DSH payment) based on their MIUR

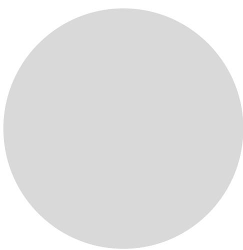
Out-of-State Medicaid FFS



- 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

Common Blunders

Blunder #1 – Misgrouped Cost Centers



- **Issue**
  - Hospital has not grouped survey charges in accordance with cost report groupings. Cost report allocated revenue codes to multiple cost centers but hospital had opted to simplify reporting & did not allocate charges
- **Solution**
  - Regrouped charges in accordance with cost report including all department allocations
- **Result**
  - Costs increased by $165,000!

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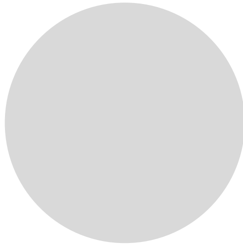
Blunder #2 – Excluding Allowable Populations

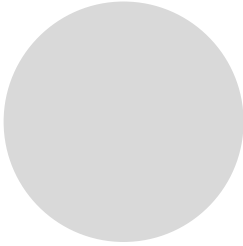


- **Issue**
  - CAH hospital received a DSH payment of approximately $2 million
  - Completed audit & results indicated facility had a liability of nearly $435,000
- **Solution**
  - Identified additional allowable patient populations not previously reported (current year or prior year)
- **Result**
  - Liability reduced to approximately $63,000 – resulting in savings of $372,000!

Blunder #3 – Cost Centers Exceed Total

- **Issue**
  - Routine days or ancillary charges reported in survey exceed total for cost center on cost report
- **Solution**
  - Compare total survey charges to total cost report charges. Verify grouping for any red flags identified
- **Result**
  - Properly group Medicaid & uninsured days & charges in accordance with cost report per DSH instructions

Blunder #4 – Mismatched Uninsured Data



- **Issue**
  - Patients must be included as uninsured in patient payments listing who have dates of service during year; however, these patients are not included in uninsured charges listing
- **Solution**
  - 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!
- **Result**
  - Payments being included were identified as nonallowable services. These were properly excluded from Exhibit A but should have also been removed from Exhibit B

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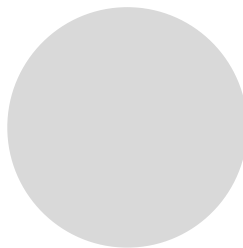
Blunder #5 – Overstating Uninsured Payments



- **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**
  - 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)
- **Result**
  - Removing estimated professional fee payments will result in lower payments & therefore, an increase in net uncompensated care cost (UCC)

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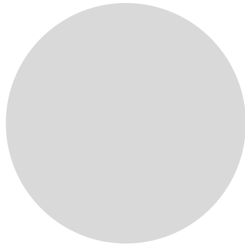
Blunder #6 – Insurance Status Updates



- **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 state is not updated on the account, this claim may never get included in the uninsured population
- **Solution**
  - Work with patient accounting to update all accounts based on verified financial class/payor plan
- **Result**
  - Easier to identify all allowable claims & comply with DSH regulations

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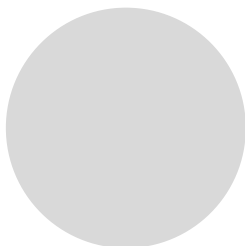
Blunder #7 – Accepting Adjustments



- **Issue**
  - Hospital submitted a DSH survey showing a significant underpayment but audit adjustments exceeded UCC by $500,000, swinging hospital from “underpaid” to “overpaid”
    - Payments adjusted to equal charges from PS&R
    - Crossover payments were 110% of cost (CAH-MCR pays at 101%)
- **Solution**
  - Reviewed adjustments & submitted arguments to correct erroneous adjustments
- **Result**
  - Erroneous adjustments reversed & hospital did not have a liability

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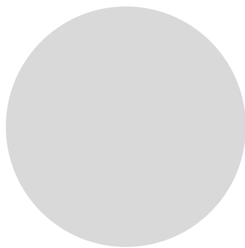
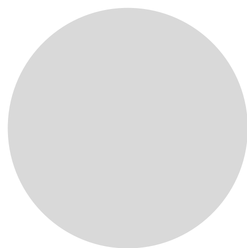
Blunder #8 – Lack of Prior Planning



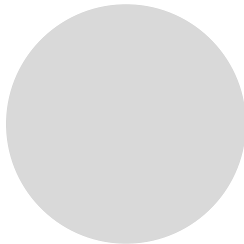
- **Issue**
  - A system conversion or data purge makes required data unavailable at time of audit
- **Solution**
  - Plan ahead! If data is not going to be available, work with IT personnel to pull data out of system before it purges. Also should be able to pull every patient payment received during period regardless of service date
- **Result**
  - Ensures you will comply with Medicaid DSH regulations & reduce risk of being unable to support payment received

Blunder #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**
  - Review the state data files as requested by Myers & Stauffer (review zero paid claims, review TPL payments)
    - SFY 2019 – Medicare/Medicaid crossover file included adjustments within payments, thus overstating payment data (contractual adjustments, etc.)
- **Result**
  - Review this information, even if it is just spot-checked!

Blunder #10 – Missing Data Elements



- **Issue**
  - Data elements are missing in the hospitals internal exhibits
- **Solution**
  - Review your Exhibits A, B & C compared to the data template examples provided by Myers & Stauffer
- **Result**
  - 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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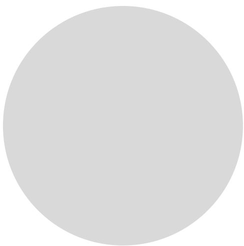
A Few Additional Reminders



- 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 RCH disallowance (Worksheet C, column 4), if applicable
- Use the Myers & Stauffer portal to download & upload DSH survey & support

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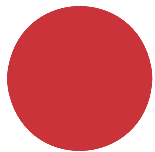
DSH Examination Process



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. Will need to use multiple cost report periods to cover the DSH year
  - The sum of these UCC amounts will be subtracted by any supplemental payments received & the remainder will be compared to the DSH payment to arrive at the total overpayment or underpayment

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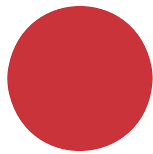
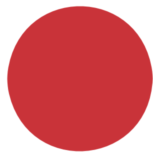


Overpayments

- 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
  - Some states gather data from the hospitals to use in calculating the DSH payment. 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



DSH Examination

- Examination files normally come out at the end of January or early February & are due within a month
- Much of the examination file itself is a repeat of the as-filed survey
  - Review & make changes or corrections as needed
- Myers & Stauffer may come back & ask further questions once submitted

Questions?

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