Disproportionate Share Hospital Upper Payment Limits

pennsylvania
DEPARTMENT OF HUMAN SERVICES

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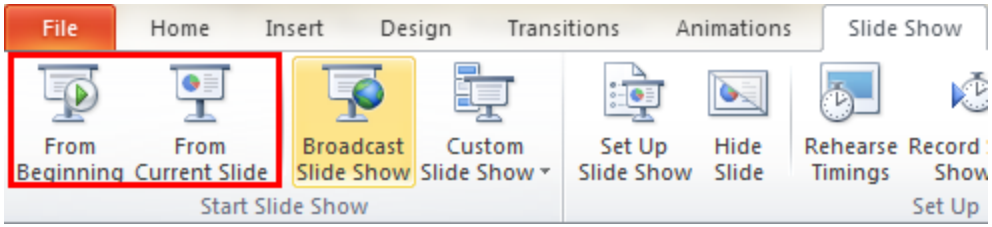

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- You can quickly navigate to any lesson in the course by clicking on the slide number from the Table of Contents (Slide 6)

This training has been designed for use by hospital finance and government reimbursement officers of private Pennsylvania hospitals, and is prepared by the Office of Medical Assistance Programs (OMAP) within the Department of Human Services (DHS).

Office of Medical Assistance Programs…

- Recognizes that the subject of DSH UPL can be confusing and wants to help hospitals to have a better understanding of it
- Wants hospital financial executives to be aware of certain changes to the DSH payment process
- Wants hospitals to understand the importance of properly reporting data used in the determination of DSH payments

Medicaid and Medical Assistance

Throughout this training module, we will refer to both *Medicaid* and *Medical Assistance*, but it is important for you to know that they are NOT synonymous.

- **Medicaid (or Title XIX)**
  - Medicaid is the state-and-federal government program that provides health care coverage for qualifying low-income individuals
  - Medicaid was created legislatively by the addition of Title XIX to the Social Security Act, so the program is sometimes referred to as "Title XIX" (pronounced "Title 19")
    - For example, "Title XIX Days" means strictly Medicaid days

- **Medical Assistance (MA)**
  - This name refers to the governmental program that administers Medicaid **and** General Assistance (GA) coverage in the Commonwealth of Pennsylvania
    - GA is a state-only program for qualifying individuals who are not eligible for Medicaid
    - While "Medical Assistance" includes Medicaid, the terms are not interchangeable
    - When you see the term "Medicaid" or "Title XIX" in this training, it is being used intentionally to refer to the cooperative federal/state program that provides healthcare to qualifying indigent persons (which does not include PA's general assistance program.)

What you will learn in this course:

- About Medicaid DSH UPL
- The importance of DSH UPL and how it can impact your hospital
- How DSH UPL is determined
- Why UPL is calculated twice for the same year
- DSH process timeline
- What important change went into effect recently
- What you can do to report your hospital's data accurately
- Where to go to learn more

Course Agenda:

Lesson 1:
DSH

What you will learn in lesson 1:

- About DSH
- DSH history
- Types of DSH payments
- What is **not** DSH
- Hospital eligibility
- Pennsylvania statistics

What is DSH?

- DSH stands for Disproportionate Share Hospital
- A DSH Hospital is one which serves a disproportionate number of low-income patients with special needs
- DSH is pronounced "dish"…looks like it ought to be a noun, but it's used as an adjective, as in "DSH payments", "DSH limits", and even "DSH hospital"
- There is Medicaid DSH and Medicare DSH. They are completely different programs

This training is ONLY on Medicaid DSH in Pennsylvania, and every reference we make to "DSH" means Medicaid DSH.

DSH history

Medicaid was created in 1965 through Title XIX of the Social Security Act.

It was the 1970's and high-volume Medicaid hospitals were losing money.

"…hospitals rendering high volumes of care to Medicaid recipients often lost money because of historically low Medicaid reimbursement rates."[1]

"They also lost money because these hospitals are often the same facilities that provide high volumes of care to indigent patients, causing them to have high levels of uncompensated care."[1]

In 1981, Congress established the Medicaid DSH program.

The purpose of the Medicaid DSH program is to:

- Provide some financial relief to hospitals serving the poor
- Maintain hospital access for the poor

[1]Coughlin, T.A, Ku, L., and Kim, J.: Reforming the Medicaid Disproportionate Share Hospital Program. *Health Care Financing Review*,22(2):138, 2000.

DSH program design

States have considerable freedom in designing their DSH program…

The level of DSH payments made to individual hospitals

At a minimum, though, Federal law mandates that States must make payments to hospitals that have a Medicaid inpatient utilization rate of at least one standard deviation above the mean for the State or a low income inpatient utilization rate of 25 percent or more

Which hospitals qualify for DSH payments

However, states can go beyond the Federal minimum criteria and make DSH payments to hospitals with Medicaid inpatient utilization rates as low as 1 percent[1]. Because of this flexibility, states' DSH programs vary greatly both in how DSH payments are rendered and the types of hospitals that receive payments.

[1]Hospitals must also meet the Federal Obstetrician requirement as described on slide 18.

Pennsylvania's DSH Payments

There are 19 different DSH payment types in PA, each with its own …

- eligibility criteria
- separate funding
- payment distribution methodology

Each state's DSH programs are funded by both state and federal funds in accordance with approved State Plan.

DSH Payment Programs

	DSH Payment Program Name	Description on Remittance Advice*
1	Inpatient DSH	INP DISPROPORTIONATE SHARE
2	Community Access Fund (CAF)	COMMUNITY ACCESS PMTS
3	Burn DSH	BURN CENTER DSH
4	Critical Access Hospital (CAH)	CRITICAL ACCESS DSH
5	Small/Sole Community Hospital	SMALL/SOLE COMM. HOSP DSH
6	Tobacco DSH	TOBACCO UNCOMP CARE PYMT TOBACCO EXTRAORDY PYMT
7	Trauma DSH	TRAUMA LEVEL I & II TRAUMA LEVEL III

*A Remittance Advice (RA) is the explanation of payment(s) that OMAP provides to each hospital for each time it makes payment(s).

DSH Payment Programs

	DSH Payment Program Name	Description on Remittance Advice
8	Additional Class of DSH	DISPROPORTIONATE SHARE/ UNSPECIFIED
9	Access to Care	DISPROPORTIONATE SHARE/ UNSPECIFIED
10	OB/NICU	OB/NICU DISPROP SHARE PMTS
11	Psychiatric Medical Education	PSYCH MED ED PAYMT
12	Academic Medical Center	ACADEMIC MED. CTR. DSH PYMT
13	General Assistance Claims	Individual Claim Detail
14	Enhanced Payments to Certain DSH Hospitals (beginning with FY13-14)	HOSP ENHANCED DSH

DSH Payment Programs

	DSH Payment Program Name	Description on Remittance Advice
15	Cleft Palate	CLEFT PALATE
16	Impoverished DSH	IMPOVERISHED AREA DSH
17	Rural Academic Med. Ed. DSH	RURAL ACAD. MED. ED. DSH
18	Less Urban Academic Med. Ed. DSH	ACAD MED DSH, LESS URBAN
19	Regional Academic Med. Ed.	REGIONAL ACAD. MED. ED.

Public notices of proposed and final DSH payments programs are published in the Pennsylvania Bulletin.

What is NOT DSH?

These are lump-sum hospital *supplemental* payments – *NOT* DSH payments:

	Description on Remittance Advice
MA Stability	• HOSP MA STABILITY
MA Dependency	• HOSP MA DEPENDENCY
MA Rehab Adjustment	• HOSP MA REHAB ADJ
MCO Payments (Access Capitation Rate)	• n/a (paid through MCOs)
Medical Education	• PASSTHRU DIR MED TEACH COST
Outpatient "DSH"	• OUTPAT DISPROP SHARE PMTS
OP / ER	• HOSP ER & OP ACCESS
Enhanced Payments to Certain DSH Hospitals (through FY12-13)	• HOSP ENHANCED PAYMENT
Augmented Waiver	• HOSP AUGMENTED WAIVER
MA Reliant	• MA RELIANT

Despite the "DSH" in the name, Outpatient is ***not*** true DSH.

Hospital Eligibility

Eligible Hospitals

It depends on the specific DSH payment type, but in general, both private (general acute care, psych, and rehab) and state-owned hospitals, as well as psych, med rehab, and drug & alcohol rehab units of private acute general hospitals are eligible for DSH payments, provided they meet the specific criteria.

This training is focused on private hospitals.

How does a hospital qualify for DSH?

- ✓ Each DSH payment has its own eligibility criteria. For this training, we will not delve into the details of each individual DSH payment program
- ✓ You can find all of the details in Pennsylvania's Medicaid State Plan, which is public information. Details for how to order it on CD are here

Hospital Eligibility: The 2 OB Requirement

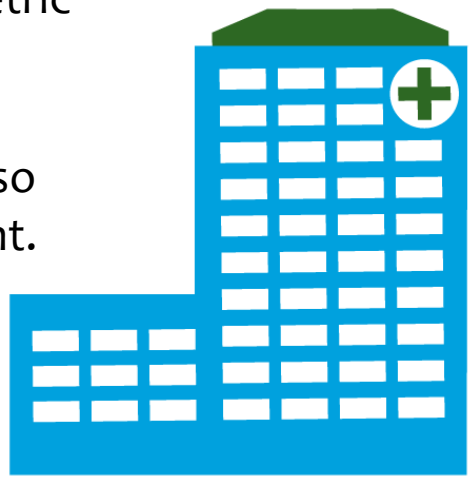
Another federal requirement which is important to note is that a **DSH hospital must have at least two obstetricians (OB)** with staff privileges who have agreed to provide obstetrical care in services to Medicaid-eligible patients on a nonemergency basis

- There are two exceptions to this requirement:
  - Childrens' hospitals
  - Hospitals which did not offer non-emergency obstetrical care on or before December 21, 1987.

- For rural hospitals, the term "obstetrician" includes any physician with staff privileges at the hospital to perform nonemergency obstetric procedures.

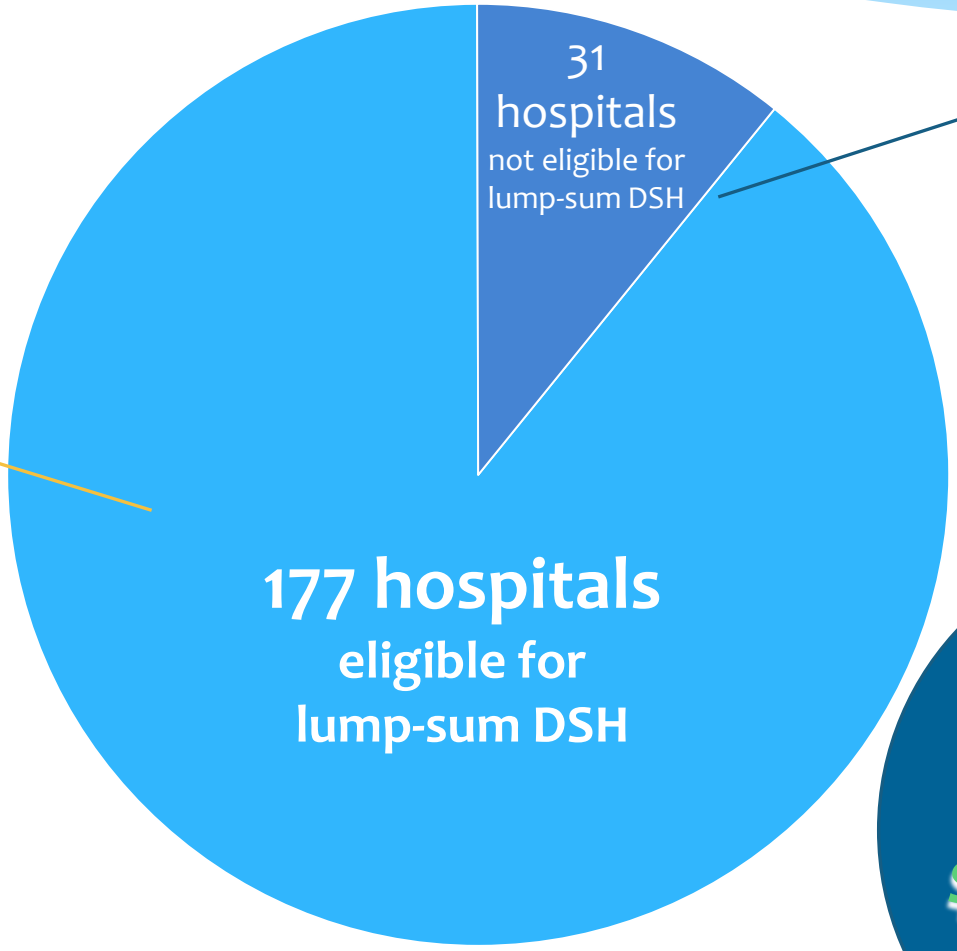
- This information is not collected on the Medicaid Cost Report, so OMAP contacts hospitals to confirm they meet this requirement.

- **Click to view the federal code** (Sec. 1923. [42 U.S.C. 1396r–4] **(d)** REQUIREMENTS TO QUALIFY AS DISPROPORTIONATE SHARE HOSPITAL)



Pennsylvania statistics…

85% of private inpatient hospitals (*acute, psych, rehab*) qualified for lump-sum DSH payments.



Lump-sum?
On this slide, "Lump-sum DSH" refers to all DSH payments except for General Assistance (GA) DSH, which is addressed later. Even hospitals that do not receive lump-sum DSH can receive GA DSH.

Lump-sum DSH allocations totaled nearly **$350 million** (state and federal funds)

Statistics are from FY13-14

Lesson 1 review:

- DSH stands for Disproportionate Share Hospital
- A DSH Hospital is one which serves a disproportionate number of low-income patients
- States have some freedom in designing their DSH program
- There are 19 DSH payment types in PA, each with its own eligibility criteria and payment distribution methodology
- Some lump-sum hospital payments are "supplemental payments," not DSH
- In FY13-14, 85% or 177 private inpatient hospitals qualified for lump-sum DSH in PA

Lesson 2:
UPL and the Prospective DSH Analysis

What you will learn in lesson 2:

- About UPL
- About hospital-specific DSH UPL
- Impact to hospitals
- Federal regulations
- Data sources for DSH UPL analysis
- How DSH UPL is determined
- How DSH UPL is calculated

What is UPL?

- UPL stands for **Upper Payment Limit**

- The term "UPL" can be a source of confusion because there are several different upper payment limits imposed by the federal government with regard to each state's Medicaid expenditures

- **This training is focused solely on the "hospital-specific DSH UPL"**

The Hospital-Specific DSH UPL

The hospital-specific DSH UPL is also referred to as the "**OBRA 1993 hospital-specific DSH limit,**" for the Congressional Act from which it originated.

Federal law limits FFP* for DSH payments through the hospital-specific DSH limit.

Under this limit, **FFP* is not available** for state DSH payments that are **more than the hospital's eligible uncompensated care cost**, which is the cost of providing inpatient hospital and outpatient hospital services to Medicaid patients and the uninsured, minus payments received by the hospital from or on behalf of those patients.

By law, a hospital's DSH payments are not to exceed its UPL.

*FFP means "Federal Financial Participation" and refers to the portion of Medicaid funding that is provided by the federal government.

Other Federal Limits on Medicaid Spending

These limits are sometimes referred to as "UPL".

DSH Allotment

- Federal law establishes an annual DSH allotment for each state that limits Federal Financial Participation (FFP) for total statewide DSH payments made to hospitals. This is sometimes wrongly referred to as the UPL.
- DSH payments to qualifying hospitals may be adjusted so that payments do not exceed the states' annual DSH allotment.

State-wide FFS Cap

- Sometimes, "UPL" is used to refer to the federal cap on a state Medicaid program's total FFS spending for a provider type (i.e. inpatient hospital, outpatient hospital, physicians)
- Typically, Federal Financial Participation (FFP) is authorized only on payments up to what Medicare would have paid facilities (in the aggregate) for the same services
- A number of states have supplemental payment programs which they call "UPL payments" to increase provider reimbursement up to the UPL if there is room between current reimbursement levels and the applicable UPL
- Pennsylvania has supplemental hospital payments, but they are not referred to as "UPL payments"

Why is there a limit?

In the early days of the DSH program, many states became adept at using it to leverage considerably more Federal dollars. Total DSH payments ballooned from $1.4 billion (1990) to $17.5 billion in just two years.[1]

Congress decided that DSH hospitals should not be paid more than the costs they incur to treat Medicaid patients and the unreimbursed costs of treating patients with no source of third-party coverage. (Neither does Congress assure that a hospital will be fully compensated up to its limit.)

[1]Coughlin, T.A, Ku, L., and Kim, J.: Reforming the Medicaid Disproportionate Share Hospital Program. *Health Care Financing Review*,22(2):139, 2000.

Prospective and Retrospective Analyses

Prospective

- OMAP estimates each hospital's DSH UPL for the current State Fiscal Year (SFY) in a process known as the "**prospective DSH UPL analysis**"
  - The prospective analysis utilizes historical data trended forward to the payment year to determine each hospital-specific limit
  - Volume growth, the state-wide transition to Medicaid managed care, and Healthy PA impact are examples of factors that are taken into account
  - The prospective DSH UPL is used by OMAP during the payment year to avoid paying any hospital excess DSH funds

Retrospective

- After a given SFY is completed, and actual, experienced data for that year is gathered, each hospital's DSH UPL is recalculated in a process known as the "**retrospective DSH UPL analysis**"
  - We will discuss the retrospective analysis, as well as the timeline for both analyses later in this training

Impact to Hospitals

- **Your DSH UPL determines whether or not the DSH payments for which you otherwise qualify will be paid to you or not**
- **It can mean millions of dollars to your hospital**
- **Hospitals play a role in determination of DSH UPL by providing accurate, timely data**

Your hospital's UPL is calculated each year with newer data, so it is likely that your UPL will change annually.

How is DSH UPL calculated?

Basically…

a hospital's Medicaid shortfall is added to its uncompensated costs for uninsured patients.

Medicaid Shortfall

\+ **Uninsured Uncompensated Care**

= **Costs eligible for DSH reimbursement**

We will dig a little deeper into each component of the DSH UPL calculation shown here. We will start with Medicaid Shortfall on the next slide.

How is DSH UPL calculated?

Medicaid Shortfall

This is the 1st component of the DSH UPL calculation.

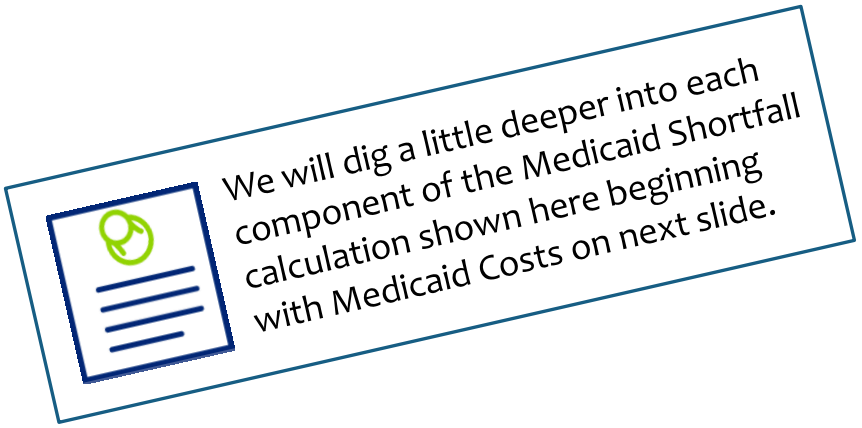
Medicaid Shortfall — Represents a hospital's Medicaid costs that are **not** reimbursed by Medicaid claims payments or non-DSH supplemental payments

How is Medicaid Shortfall calculated?

Medicaid Costs

− **Medicaid Revenue (non-DSH)**

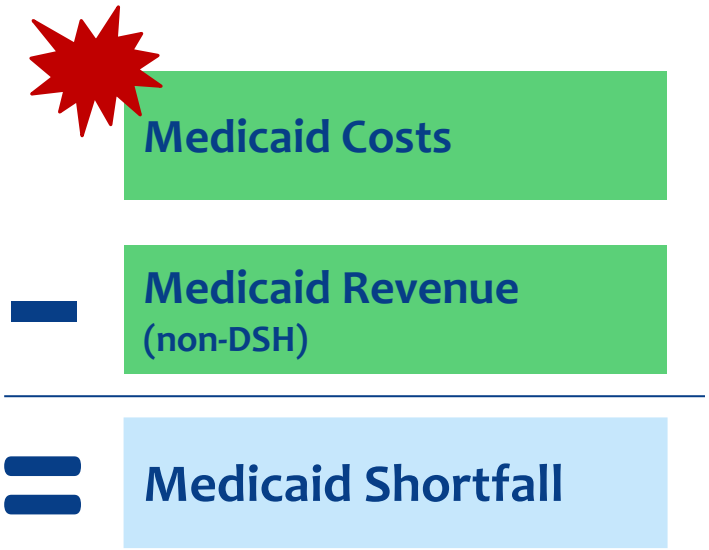
= **Medicaid Shortfall**



How is DSH UPL calculated?

Medicaid Shortfall

Medicaid Costs



- Medicaid charges are converted to costs using the cost-to-charge ratio (CCR) specific to the type of charge
- CCRs are calculated from data within a hospital's Medicaid Cost Report (MA-336). *We will discuss CCRs more on the next slide.*
- Medicaid charges come from different sources depending on the specific type of charge
- Costs are estimated for each type of Medicaid charge. Then, they are added together
- For the prospective UPL, historical hospital costs are trended forward to the year of the DSH UPL calculation using market basket inflationary factors

How is DSH UPL calculated?

Medicaid Shortfall

Medicaid Costs: Cost-to-Charge Ratio (CCR)

- CCRs are unique to each hospital and to each category of claims
- Using MA fee-for-service (FFS) inpatient (IP) acute care as an example, here is the basic calculation to derive its CCR:

MA FFS IP acute care CCR =

$$\frac{\text{Costs attributed to MA FFS IP acute care by the MA-336 hospital cost report (Schedule S1)}}{\text{Charges attributed to MA FFS IP acute care by the MA-336 hospital cost report (Schedule S3)}}$$

- For more details, see Appendix II

The MA-336 hospital cost report includes information for MA which includes Title XIX and General Assistance (GA).

How is DSH UPL calculated?

Medicaid Shortfall

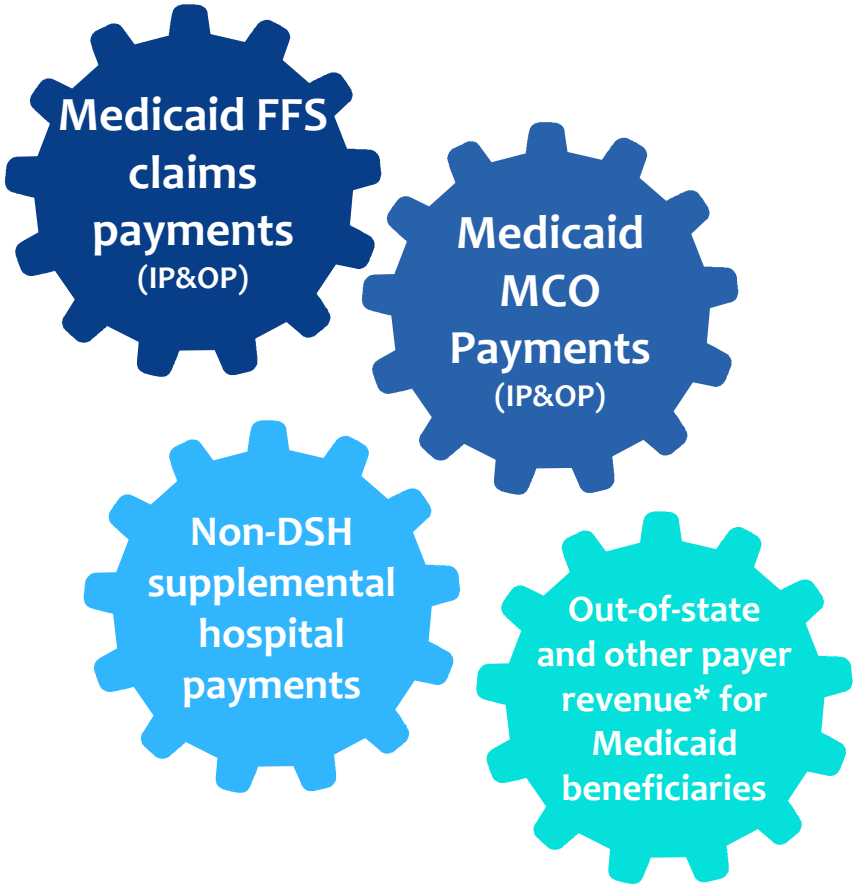
Medicaid Revenue

Medicaid Costs

− Medicaid Revenue (non-DSH)

= Medicaid Shortfall

Here are the types of Medicaid revenue that are included:



*Claim and lump-sum

How is DSH UPL calculated?

Uninsured Uncompensated Care

This is the 2nd component of the DSH UPL calculation.

Uninsured Uncompensated Care

Represents any individual with **no source of third-party coverage** for the hospital services they receive

- Does **not** include Medicaid patients

Who qualifies as "uninsured" as it relates to DSH UPL?

What exactly is "underinsured[1]"?

In general, if the person does not have insurance coverage for the service being provided then the charges for the service should be treated as an uninsured charge and any payment received from the patient (there would be no payment from insurance) should be reported as payment for an uninsured person

[1]CMS' Final Rule effective December 31, 2014 (79 FR 71679-71694) provides a detailed definition of underinsured.

How is DSH UPL calculated?

Uninsured Uncompensated Care

Now that you understand what "uninsured" is, how is it calculated?

Costs to Care for Uninsured

– Any revenue from or on behalf of the uninsured

= Uninsured Uncompensated Care

Revenue for uninsured patients?

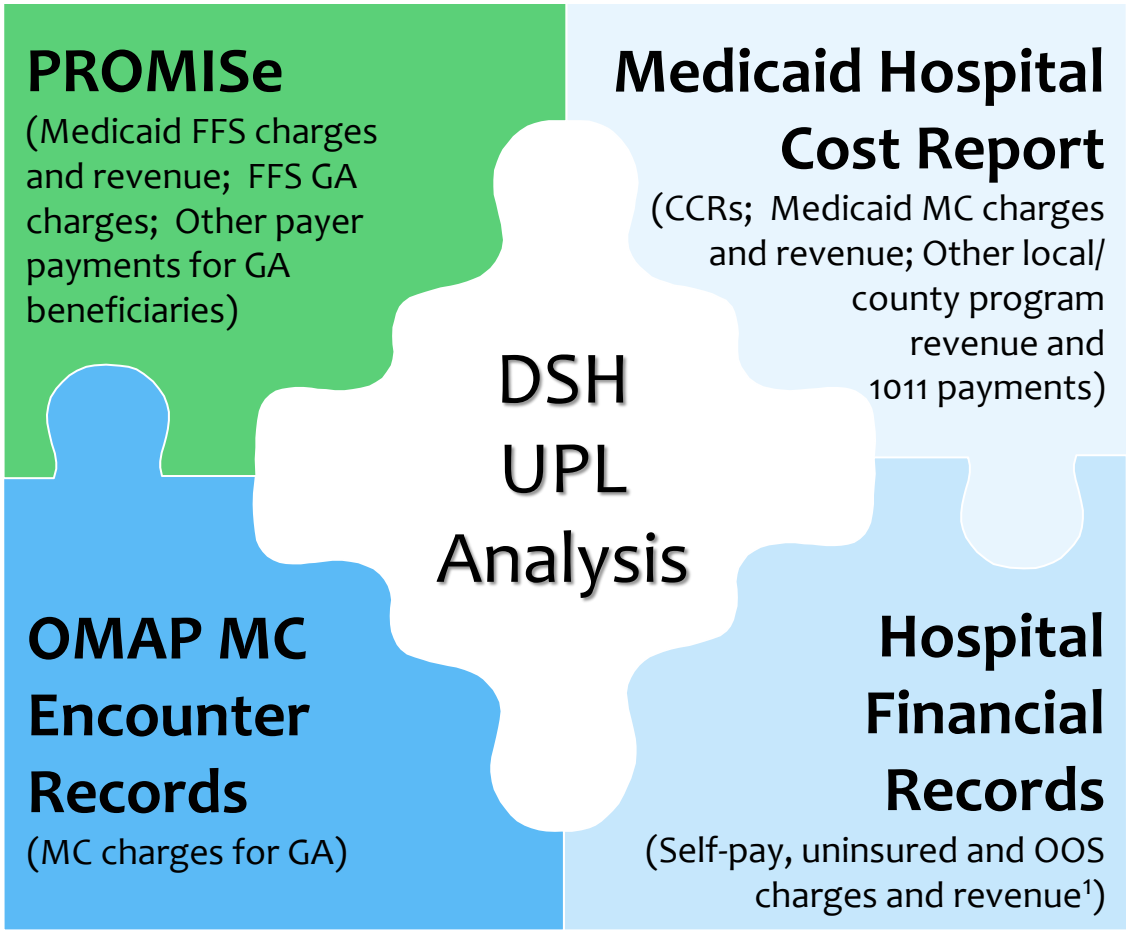
Yes, you may have some revenue from self-pays.

What about General Assistance (GA) revenue?

Although the cost of treating GA beneficiaries is considered uninsured and therefore is counted as an uninsured cost in the DSH UPL calculation, payments made by OMAP on behalf of GA beneficiaries are not counted here. We will discuss this in more detail later.

How is DSH UPL calculated?

4 Data Sources of the DSH UPL analysis



[1]Uninsured charges and revenue are now being captured on the Medicaid hospital cost report as distinct elements beginning with the FY12-13 MA-336. OOS charges and revenue are targeted to be captured as distinct elements beginning with the FY14-15 MA-336.

How is DSH UPL calculated?

When the various types of patient costs and revenues are considered, it looks like this…

				CHARGES	Conversion to Cost	COSTS	REVENUES
RATE PAYMENTS	Medicaid	FFS	IP		CCR		
			OP		CCR		
			OOS		CCR		
		MC	IP		CCR		
			OP		CCR		
			OOS		CCR		
	GA	FFS & MC	IP & OP		CCR		
	Patients with NSOTPC*		IP		CCR		
			OP		CCR		

GA payments made by OMAP are not counted here.

* NSOTPC = Patients with no source of third-party coverage. Includes self-pays and uninsured.

How is DSH UPL calculated?

In addition to patient costs and revenues, "lump-sum" supplemental payments from Pennsylvania, other states, and any local government must be considered

The spreadsheet on the next slide adds these payments

When the total applicable revenues are subtracted from the total reimbursable costs, the result is the hospital's **DSH Upper Payment Limit**

The DSH UPL analysis then considers the hospital's DSH payments for the year to determine whether it will exceed its DSH Upper Payment Limit

How is DSH UPL calculated?

				CHARGES	Converted	COSTS	REVENUES	DIFFERENCE
				Charges	By Cost-to-Charge Ratio (CCR)	Allowable Costs	Revenues	Costs eligible for DSH reimbursement
	A	B	C	D	E	F=D*E	G	H=F-G
RATE PAYMENTS	Medicaid	FFS	IP		CCR			
			OP		CCR			
			OOS		CCR			
		MC	IP		CCR			
			OP		CCR			
			OOS		CCR			
	GA	FFS & MC	IP & OP		CCR			
	Patients with NSOTPC*		IP		CCR			
			OP		CCR			
LUMP-SUM PAYMENTS	OOS supplemental payments			From local government indigent care programs				
	Other non-state payments							
	PA supplemental payments							
	TOTALS							
	DSH Payments							
	Remaining Room (Excess)							

Includes GA DSH (federalized GA payments)

Subtract DSH payments

The OBRA 1993 hospital-specific DSH limit (the total amount of costs eligible for DSH reimbursement)

Excess or "remaining room"

* NSOTPC = Patients with no source of third-party coverage. Includes self-pays and uninsured.

How is DSH UPL calculated?

Here is a simplified hypothetical example (in millions)

				CHARGES	Converted	COSTS	REVENUES	DIFFERENCE
				Charges	By Cost-to-Charge Ratio (CCR)	Allowable Costs	Revenues	Costs eligible for DSH reimbursement
	A	*B*	*C*	*D*	*E*	*F=D*E*	*G*	*H=F-G*
RATE PAYMENTS	Medicaid	FFS	IP	$10.0	0.250	$2.5	$2.0	$0.5
			OP	$10.0	0.300	$3.0	$2.0	$1.0
			OOS	$3.0	0.250	$0.8	$0.5	$0.3
		MC	IP	$60.0	0.350	$21.0	$14.0	$7.0
			OP	$15.0	0.300	$4.5	$3.0	$1.5
			OOS	$2.0	0.350	$0.7	$0.5	$0.2
	GA	FFS & MC	IP & OP	$10.0	0.300	$3.0		$3.0
	Patients with NSOTPC*		IP	$8.0	0.350	$2.8	$2.2	$0.6
			OP	$7.0	0.250	$1.8	$1.3	$0.5
LUMP-SUM PAYMENTS	OOS supplemental payments						$1.0	-$1.0
	Other non-state payments						$0.5	-$0.5
	PA supplemental payments						$3.0	-$3.0
	TOTALS					$40.0	$30.0	$10.0
	DSH Payments							$11.0
	Remaining Room (Excess)							($1.0)

The DSH UPL

This hospital is projected to be $1 million over its UPL if all DSH payments are made

Lesson 2 review:

- UPL stands for Upper Payment Limit
- Federal law establishes an annual DSH allotment for each state that limits Federal Financial Participation (FFP) for total statewide DSH payments made to hospitals
- Your hospital-specific DSH UPL determines whether or not the DSH payments for which you otherwise qualify will be paid to you or not
- Hospital's DSH UPL will change annually
- DSH UPL is calculated by adding the hospital's Medicaid shortfall to its uncompensated costs for uninsured patients
- Medicaid revenue components in the calculation are FFS (claims) and MCO payments, and Non-DSH supplemental hospital payments
- There are 4 data sources for DSH UPL analysis: PROMISe, OMAP MC encounter records, hospital financial records, and the Medicaid Cost Report

Lesson 3:
Retrospective DSH Analysis

What you will learn in lesson 3:

- Why there is a retrospective analysis
- Who prepares the analysis
- When the analysis is done
- What the difference is between retrospective vs. prospective

About the Retrospective DSH Analysis

Why is there a retrospective analysis?

1. States are required by Federal law to annually submit to CMS a report on Medicaid DSH payments

2. States must also submit an independent certified audit to verify that DSH payments comply with specified DSH program requirements

3. If a state fails to do so, CMS can discontinue Federal Financial Participation

4. The report must identify each hospital that received a DSH payment, and provide any other information the Secretary needs to ensure the appropriateness of the payment amount

The annual certified independent audit includes specific verifications to make sure all DSH payments are appropriate.

About the Retrospective DSH Analysis

The retrospective calculation of DSH UPL is based on actual experience during the payment year (July-June). Those results are independently audited.

The audit is typically conducted by the Bureau of Audits (part of the Commonwealth's Office of the Budget) or by an outside audit entity.

The analysis is done between 2.5 – 3 years after the payment year ends.

The process of finalizing claims, gathering data (via cost reports and hospital financial records), and desk reviewing cost reports for over 200 hospitals is lengthy.

Retrospective vs. Prospective

- Prospective is an estimated calculation of the DSH UPL using historical claims projected to the effective DSH UPL payment year
- Retrospective uses actual experience data (claims, payments, etc.) from the payment year (rather than using prior year data and adjustments)
- Your retrospective UPL will likely be different from your prospective UPL
- In the past, some hospitals were found to have received payments in excess of the retrospective UPL. CMS required audited retrospective reports, but did not require the excess payments to be returned
- That has changed -- which leads us to our next topic….

Lesson 4: The Payment Process and a Few Important Changes

Lesson 3 review:

- Retrospective DSH analysis is required by Federal law
- OMAP does a retrospective calculation of DSH UPL based on actual experience during the payment year and there is also an independent audit assessment of the results
- The analysis is done between 2.5 – 3 years after the payment year ends. The process is lengthy
- The retrospective analysis uses experienced data from the payment year instead of projecting historical data as the prospective analysis does

Lesson 4:
The Payment Process
and a Few Important Changes

What you will learn in lesson 4:

- About the OMAP process for determining and making payments
- About a federally-required change that could affect your hospital
- About recoupments
- About OMAP changes that could also affect your hospital

DSH & Supplemental Payment Process

The OMAP process for DSH payments (as well as the non-DSH supplemental payments) works like this:

For each type of payment, eligibility and hospital-specific payment amounts are determined in accordance with Pennsylvania's State Plan.

Eligibility	Hospital Specific Payments
• Eligibility is determined annually for SOME payment types (ex. Trauma Center DSH and Tobacco DSH) • Eligibility for other payment types was determined at a point in the past, but remains in effect (ex. Community Access Fund and Inpatient DSH)	• The payments are determined annually, based on the total state funds budgeted and the federal matching funds expected for the program • Federal Financial Participation (FFP) varies from year to year, and is determined by the FMAP (Federal Medical Assistance Percentage) • Sometimes, the Commonwealth will adjust the state spend to achieve a flat total spend year-to-year

DSH & Supplemental Payment Process

The process continues…

Hospital payments are made

- Quarterly or annually, depending on the payment program
- Quarterly
  - Examples: Inpatient DSH and Med Ed
  - Some are paid during the payment period while others are paid in the following quarter
- Annually
  - Examples: OB/NICU, Burn, Trauma, and Tobacco
  - Dates vary from program to program, and even from year to year, based on availability of eligibility criteria and other factors

Payments can be reduced

- All DSH and supplemental payments are subject to budgetary constraints, and can be affected by mid-year budget freezes/reductions enacted by the Governor
- Additionally, certain DSH and supplemental payments are subject to reduction by a reconciliation factor that is based on several factors, one of which is any anticipated reduction to the receipts from the statewide hospital assessment.

Payments transmitted

- All DSH and supplemental payments are transmitted electronically (EFT) or by check
  - If your hospital still receives payment by check, click here for information regarding how to switch to EFT
- You receive a Remittance Advice (RA) prior to each payment's transaction. The RA describes what kind of payment is being made and can be used to reconcile hospital records
  - There is a limit to the number of characters in the description on the RA, so some payment names are abbreviated. Please refer to the lists of DSH and supplemental payments included earlier in this training module to see the abbreviated names and associated payment programs

A Federal Change

The CMS 2008 DSH Final Rule requires that, beginning with State Plan Rate Year 2011 (FY10-11 in PA), federal funds used in the overpayments **be recouped (taken back) from the hospitals that received them**, *and be returned to CMS unless the state's Medicaid State Plan prescribes a method for redistributing the funds.*

Recoupments

Is **my** hospital over its limit?	OMAP will notify each hospital found to exceed its retrospective DSH UPL.
When will I be contacted and when will the recoupment take place?	OMAP is in the process of developing a procedure to implement this requirement. The dates are not set. OMAP will provide advanced notice prior to any recoupment.
What if my hospital was withheld payments based on the prospective UPL, but the retrospective UPL is higher? Will we be paid the difference?	These are questions that OMAP is considering as it develops its policy regarding recoupment.

A Data Source Change

Beginning with the FY14-15 prospective DSH UPL analysis, OMAP has changed the primary **data source** and **source year** for the projection

Formerly…..

The prospective DSH UPL process relied almost exclusively on the latest available MA-336 hospital cost report for all data points (typically 2-year old self-reported data).

Beginning with FY 2014-2015…

The Department will prepare the prospective DSH UPL analysis using the **MOST recently available DSH report and audit submitted to CMS as the basis.**

Greater Transparency

Beginning with the FY14-15 prospective DSH UPL analysis, OMAP will provide results to any hospital that requests them.

Formerly…..

Only the hospitals that were found to be over their respective UPLs were provided their prospective results.

Beginning with the FY14-15 results …

Each hospital not identified as exceeding DSH UPL can request a copy of its prospective DSH UPL analysis

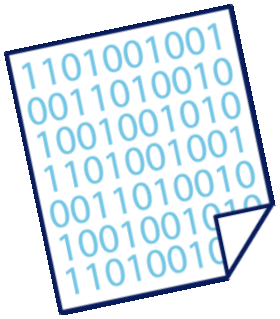
If your hospital is identified to exceed its DSH UPL, OMAP will automatically send your prospective hospital-specific DSH analysis (as before)

Lesson 4 review :

- For each type of payment, eligibility and payment amounts are determined
- Hospital payments are made quarterly or annually, depending on the program
- Remittance Advice (RA) lists all FFS payments, both patient accounting (claims) and lump-sum DSH and supplemental payments
- The CMS 2008 DSH Final Rule requires that, beginning with SFY10-11, federal funds that were used in the overpayments be recouped from the hospitals that received them and be returned to CMS unless the state's Medicaid State Plan prescribes a method for redistributing the funds
- OMAP is making two changes:
  - ✓ OMAP will prepare the prospective DSH UPL analysis using the most recently available DSH report and audit submitted to CMS as the basis
  - ✓ OMAP will prepare and share the prospective results with any DSH hospital that requests them

Lesson 5:
Data Issues

Data Issues – What about _____?



The calculation for each hospital's DSH UPL requires specific data elements.

- Hospitals typically have questions about whether or not certain data are included in the calculation
- The data reported by each hospital on its Medicaid Cost Report impacts the calculation of the UPL
- Let's take a look at some of the areas that are often misunderstood

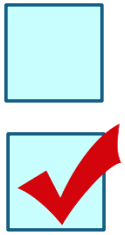
Data Issues – What about bad debt?

Based on what you know so far, do you think your hospital's bad debt should be included as part of the costs for the DSH UPL calculation?

- ☐ Yes, include it
- ☐ No, do not include it

Data Issues – What about bad debt?

Based on what you know so far, do you think your hospital's bad debt should be included as part of the costs for the DSH UPL calculation?



Yes, include it

No, do not include it

"States and hospitals cannot substitute … bad debt data as a proxy for uninsured cost as defined in federal regulations. The definitions of charity care and bad debt may vary significantly from the federal definition of uninsured costs." – CMS[1]

[1]From point #16 in the CMS guidance entitled "Additional Information of the DSH Reporting and Audit Requirements – Part 2"

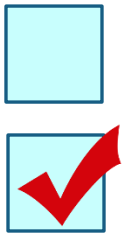
Data Issues – What about physicians' services?

Based on what you know so far, do you think your hospital's physicians' services should be included as part of the costs for the DSH UPL calculation?

- Yes, include it
- No, do not include it

Data Issues – What about physicians' services?

Based on what you know so far, do you think your hospital's physicians' services should be included as part of the costs for the DSH UPL calculation?



☐ Yes, include it

☑ No, do not include it

Physician service costs are NOT to be included in calculating the hospital-specific DSH limit.[1]

[1]See point #14 in the CMS guidance entitled "Additional Information of the DSH Reporting and Audit Requirements – Part 2"

Data Issues – What about the assessment?

Based on what you know so far, do you think your hospital's statewide hospital assessment should be included as part of the costs for the DSH UPL calculation?

- ☐ Yes, all of it is included
- ☐ No, none of it is included
- ☐ A portion of it may qualify to be included

Data Issues – What about the assessment?

Based on what you know so far, do you think your hospital's statewide hospital assessment should be included as part of the costs for the DSH UPL calculation?

- ☐ Yes, all of it is included
- ☐ No, none of it is included
- ☑ A portion of it may qualify to be included

- If you reported the assessment cost correctly on your MA-336, **the MA portion** of your assessment cost was counted as an allowable cost by way of the CCR applied to charges (for years up to and including FY11-12)
  - Prior to FY12-13, if a hospital did not include its hospital assessment cost on the MA-336, the prospective DSH UPL analysis included a method to estimate the MA portion of the assessment cost.
  - The MA-336 was changed, beginning FY12-13, to be in sync with Medicare hospital cost reporting standards. As a result, the method to apportion assessment costs in the DSH UPL analysis may be revised by OMAP.

Data Issues – What about charity care?

You are required to report "charity care charges" on the MA-336. Can your charity care charges be used as uninsured charges in the calculation of the DSH UPL?

- ☐ Yes
- ☐ No

Data Issues – What about charity care?

You are required to report "charity care charges" on the MA-336. Can your charity care charges be used as uninsured charges in the calculation of the DSH UPL?

☐ Yes

☑ No

- Charity care is a term used by hospitals to describe an individual hospital's program of providing free or reduced charge care to those that qualify for the particular hospital's charity care program
- Regardless of a hospital's definition of charity care, States and hospitals must comply with Federal Medicaid DSH law and policy guidance in determining what portion of their specific charity care program costs qualify under the hospital-specific DSH cost limits

To the extent that hospitals do not separately identify uncompensated care related to services provided to individuals with no source of third party coverage, hospitals will need to modify their accounting systems to do so. Also, hospitals must ensure that no duplication of such charges exists in their accounting records.[1]

[1] 73 FR 77910

Data Issues – What about OOS Medicaid patients?

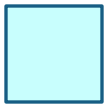
Do you think that your hospital costs and payments related to treating out-of-state (OOS) Medicaid patients should be included as part of the costs and revenues for the DSH UPL calculation?

- ☐ Yes, include them
- ☐ No, do not include them

Data Issues – What about OOS Medicaid patients?

Do you think that your hospital costs and payments related to treating out-of-state (OOS) Medicaid patients should be included as part of the costs and revenues for the DSH UPL calculation?

Yes, include them



No, do not include them

- However, the PROMISe system does not capture OOS FFS claims, and the MA-336 captures only a part of the needed data
- Your managed care charges and revenue for these patients are captured on the MA-336 S7, as part of your total MC Medicaid data; therefore, OOS charges and revenue are included in the DSH Report for the managed care delivery system
- **OMAP needs you to supply OOS FFS IP and OP charges and revenue from your hospital's accounting records.**
  - Retain supporting documentation for audit purposes

Data Issues – What about GA patients?

Do you think that your hospital costs and payments related to treating **General Assistance (GA) patients** are included as part of the costs and revenues for the DSH UPL calculation?

- ☐ Yes, they are included
- ☐ No, they are not included
- ☐ It depends

Data Issues – What about GA patients?

Do you think that your hospital costs and payments related to treating **General Assistance (GA) patients** are included as part of the costs and revenues for the DSH UPL calculation?

- ☐ Yes, they are included
- ☐ No, they are not included
- ☑ It depends

- GA is not Medicaid, even though it might look like Medicaid to hospitals
- GA is a Pennsylvania program for low-income people who do not qualify for Medicaid coverage
- For Medicaid DSH UPL calculation purposes, **GA costs are considered uninsured costs**
- However, **payments** are another story . . .

Data Issues – Payments for GA

- ***Some*** of the Commonwealth's payments for GA services qualify for FFP

- Federal regulations require that **GA payments that have been federalized are considered DSH payments** in the DSH UPL calculation, but GA payments that are state-only[1] should NOT be applied to GA costs

  In other words, if the payment was federalized, it has to be counted as a DSH payment, but if it wasn't federalized, it isn't included in DSH UPL.

- Does a hospital need to know which GA payments are federalized?
  - No, because OMAP identifies which GA payments were federalized through internal budgetary records
  - However, each hospital should know/determine the amount of revenue received on behalf of GA patients in order to properly complete the MA-336 Hospital Cost Report (refer to slide 79 for information on how to determine GA patients versus Medicaid beneficiaries)

[1]This applies to any state-only or local government-only payment toward hospital services for those with no source of 3rd party coverage. Payments from other payers for GA beneficiaries are counted as revenue from or on behalf of uninsured.

Data Issues – What about adultBasic?

Do you think that your hospital costs and payments related to treating **adultBasic patients** are included as part of the costs and revenues for the DSH UPL calculation?

- ☐ Yes, they are included
- ☐ No, they are not included
- ☐ Costs are included, but revenues are not

Data Issues – What about adultBasic?

Do you think that your hospital costs and payments related to treating **adultBasic patients** are included as part of the costs and revenues for the DSH UPL calculation?

- ☐ Yes, they are included
- ☐ No, they are not included
- ☑ Costs are included, but revenues are not

- adultBasic was a state-only program, so the costs are included, but the revenues are not. The adultBasic program ended February 28, 2011, but its costs are figured into the FY 10-11 retrospective DSH report and the FY 14-15 prospective DSH analysis (which is based on the FY 10-11 retrospective DSH report and audit).

Data Issues – What about Healthy PA?

Do you think that your hospital costs and payments related to treating **Healthy PA patients** are included as part of the costs and revenues for the DSH UPL calculation?

- ☐ Yes, they are included
- ☐ No, they are not included
- ☐ Costs are included, but revenues are not

Data Issues – What about Healthy PA?

Do you think that your hospital costs and payments related to treating **Healthy PA patients** are included as part of the costs and revenues for the DSH UPL calculation?

- ☑ Yes, they are included
- ☐ No, they are not included
- ☐ Costs are included, but revenues are not

- Hospital services to beneficiaries enrolled in the Healthy PA program fall under Title XIX (Medicaid). Therefore, both the costs and revenues related to treating Healthy PA patients are included in the calculation.
- The Healthy PA program began January 1, 2015 and is targeted to end August 31, 2015. Medicaid expansion is replacing the Healthy PA and General Assistance[1] programs.

[1]The GA program will continue for eligible legal aliens.

Data Issues – What about these?

Finally, here are some less-common payment types:

- **Section 1011 Payments**
  - These are for "Emergency Health Services Furnished to Undocumented Aliens"
  - These ARE included in the DSH UPL calculation
- **Grants for Medicaid or uninsured hospital care**
  - These ARE included in the DSH UPL calculation[1]
- **State-only or local government-only indigent programs** (other than GA, which we have covered)
  - The costs ARE included, but the revenue is NOT
- **CHIP (Children's Health Insurance Program)**
  - CHIP costs and revenue, which are not Title XIX or uncompensated care, are not included in DSH UPL calculation
- **Prisoner Revenue**
  - Revenue, as well as costs and charges for the treatment of prisoners, is not included in the DSH UPL calculation

[1]See point #41 in the CMS guidance entitled "Additional Information of the DSH Reporting and Audit Requirements – Part 2"

DSH UPL Analysis: Summary of Costs & Payments

	COSTS	PAYMENTS
Patient Services		
PA Medicaid (Title XIX)	Include	Include
OOS Medicaid	Include	Include
Self-Pays	Include	Include
Uninsured	Include	Include
Underinsured (see slide 34)	Include	Include
Healthy PA (program to end in 2015)	Include	Include
FEDERALIZED GA	Include	Include
State-Only GA	Include	***EXCLUDE***
Indigents covered by a state-only or local govt.-only indigent program	Include	***EXCLUDE***
adultBasic (program ended Feb. 2011)	Include	***EXCLUDE***
Special Payments		
DSH Payments		Include
Non-DSH supplemental payments		Include
Section 1011 payments		Include
Grants for Medicaid or uninsured hospital care		Include
Other Considerations		
Bad Debt	**Not Applicable**	
"Charity Care" costs as defined by hospital	**Use Federal standards instead**	
Statewide Hospital Assessment	**Correct portion is already accounted for in the CCR[1]**	
Physicians' Services	***EXCLUDE***	

This table serves as a reference for which costs are included (qualified for reimbursement) and which payments must be used to offset those costs in the DSH UPL analysis.

[1]Applies to years through FY11-12. Beginning with FY12-13, the method by which the apportionment is determined may be revised.

Data Issues – Medicaid Cost Report

Fiscal Year Issues

- Your hospital's fiscal year may be different from the State's fiscal year
- The data you enter into your Medicaid Cost Report must match the State fiscal year (July 1 – June 30)
- For example, if your hospital uses the calendar year as its FY, to complete the FY14-15 MA-336, you will need to use 50% of your costs and charges from your 2014 financial reports, and 50% from your 2015 financial reports
- For more details, see CMS-2198-F ("General DSH Audit and Reporting Protocol")

Data Issues – Medicaid Cost Report

Change to the S7 Schedule

- GA revenues and charges need to be reported separately from self-pay and uninsured revenues and charges in order to appropriately classify the costs and revenues within the DSH UPL calculation
- Through FY11-12, the MA-336 collected the total charges and revenues for GA, self-pays, and the uninsured combined
- That's why your hospital may have received a request from OMAP for additional FY10-11 and FY11-12 data to isolate the GA revenues and charges
- The S7 has been adjusted (FY12-13) to separately capture GA charges and revenue

GA Eligibility – How to Tell

- To determine whether a patient was eligible for the GA program during the specific date of service, please refer to the Eligibility Verification System (EVS)
- For information related to EVS, see Provider Quick Tip #11, http://www.dpw.state.pa.us/cs/groups/webcontent/documents/communication/s_002924.pdf, refer to section 4.5 of the PROMISe Provider Handbook or call the Eligibility Verification Hot Line at 1-800-766-5387
    - (Hours of operation: 24 hours a day, 7 days a week)
    - Website: http://promise.dpw.state.pa.us

Data Issues – Medicaid Cost Report

Reporting the Correct Days

- **Observation Days**
  - Include observation bed days in the calculation of uncompensated care costs
- **"Allowed"/ "Billed" / "Covered" Days**
  - Which type should be used when calculating hospital Medicaid routine costs?
    - "States and hospitals must use covered days for purposes of calculating the hospital-specific DSH limit." [regardless of whether they were billed or paid] – CMS[1]

[1]See point #20 in the CMS guidance entitled "Additional Information of the DSH Reporting and Audit Requirements – Part 2"

Lesson 6:
The Timeline

What you will learn in lesson 6:

- The timeline for the DSH UPL process from beginning to end
- The 5-year process in detail
- DSH timeline by State Fiscal Year

What is the DSH UPL timeline?

Using FY15-16 as an example:

Year 1	Year 2	Year 3	Year 4	Year 5
FY15-16 (Payment Year)	FY16-17	FY17-18	FY18-19	FY19-20

Prospective UPL Calculation → Payments Made → Hospital Financial Records → Medicaid Cost Report → OMAP Data-Gathering & Checking → Retrospect. DSH Analysis → DSH UPL Audit → Report to CMS → Notice and Recoup-ment

Prospective UPL Calculation

- At the start of each payment year (July 1), OMAP gathers historical data needed for the DSH UPL prospective calculation
- The goal is to have a completed analysis in the early months of the new fiscal year
  - Example: FY15-16 UPLs are expected to be done during the first quarter (July – Sept. 2015)
- OMAP will send your prospective hospital-specific DSH analysis if your hospital is identified to exceed its DSH UPL
- Each hospital not identified as exceeding DSH UPL can request a copy of its prospective DSH UPL analysis
- Hospitals are encouraged to review their prospective DSH UPL annually and, if necessary, contact DHS to submit requested changes for DHS consideration.
  - Supporting documentation of requested revisions must be submitted

What is the DSH UPL timeline?

Using FY15-16 as an example:

Year 1	Year 2	Year 3	Year 4	Year 5
FY15-16 (Payment Year)	FY16-17	FY17-18	FY18-19	FY19-20

Prospective UPL Calculation → Payments Made → Hospital Financial Records → Medicaid Cost Report → OMAP Data-Gathering & Checking → Retrospect. DSH Analysis → DSH UPL Audit → Report to CMS → Notice and Recoup-ment

OMAP Makes Hospital Payments

- OMAP distributes DSH and supplemental hospital payments, but is required to withhold any DSH payments that are expected to exceed a hospital's prospective UPL

- NOTE: Non-DSH supplemental payments are counted as Medicaid revenue in the determination of the DSH UPL, but they are not capped by the DSH UPL process, so OMAP does not withhold these supplemental payments

What is the DSH UPL timeline?

Using FY15-16 as an example:

Year 1	Year 2	Year 3	Year 4	Year 5
FY15-16 (Payment Year)	FY16-17	FY17-18	FY18-19	FY19-20

Prospective UPL Calculation → Payments Made → Hospital Financial Records → Medicaid Cost Report → OMAP Data-Gathering & Checking → Retrospect. DSH Analysis → DSH UPL Audit → Report to CMS → Notice and Recoup-ment

Hospital Financial Records for the Payment Year

- To complete your Medicaid Cost Report, you will need to utilize your financial records that pertain to the Commonwealth's Fiscal Year (July 1 through June 30), regardless of the fiscal year your hospital uses
- It is preferred that you use audited records
- A copy of your records should be submitted with your cost report

What is the DSH UPL timeline?

Using FY15-16 as an example:

Year 1	Year 2	Year 3	Year 4	Year 5
FY15-16 (Payment Year)	FY16-17	FY17-18	FY18-19	FY19-20

Medicaid Cost Report for the Payment Year

- The hospital Medicaid cost report in Pennsylvania is also known as the "MA-336"
- About five months after the payment year ends, you receive your new PA Medicaid Cost Report Software (PACRS, which is pronounced like "pacers") and instructions from OMAP
- Your completed report is due several months later, after your Medicare cost report is due

What is the DSH UPL timeline?

Using FY15-16 as an example:

Year 1	Year 2	Year 3	Year 4	Year 5
FY15-16 (Payment Year)	FY16-17	FY17-18	FY18-19	FY19-20

Prospective UPL Calculation → Payments Made → Hospital Financial Records → Medicaid Cost Report → OMAP Data-Gathering & Checking → Retrospect. DSH Analysis → DSH UPL Audit → Report to CMS → Notice and Recoup-ment

OMAP Gathers and Checks Data

- Conducts desk reviews of the MA-336 data submitted, and accepts corrections from hospitals for a time
- Extracts and compiles FFS MA and GA claims data from the PROMISe system and Managed Care data from its MC encounter database
- Gathers the required DSH UPL data elements and supplies them to a vendor to perform the retrospective analysis

What is the DSH UPL timeline?

Using FY15-16 as an example:

Year 1	Year 2	Year 3	Year 4	Year 5
FY15-16 (Payment Year)	FY16-17	FY17-18	FY18-19	FY19-20

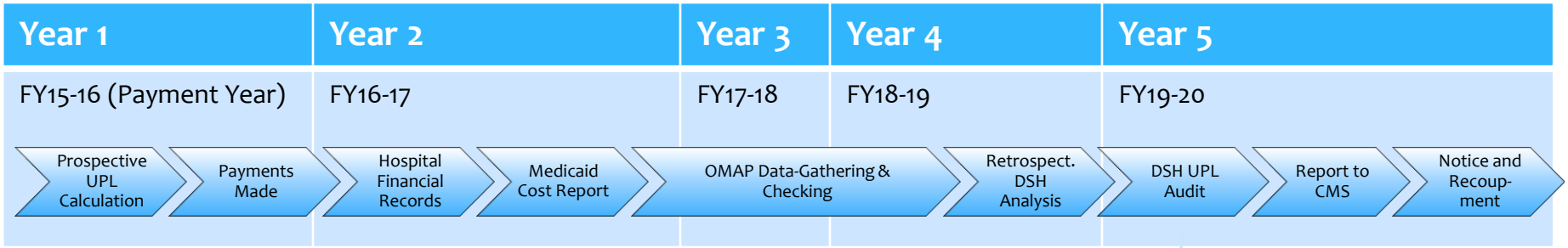
Prospective UPL Calculation → Payments Made → Hospital Financial Records → Medicaid Cost Report → OMAP Data-Gathering & Checking → Retrospect. DSH Analysis → DSH UPL Audit → Report to CMS → Notice and Recoup-ment

Retrospective DSH Analysis

- The calculation is usually performed during the final half of the third SFY following the payment year

What is the DSH UPL timeline?

Using FY15-16 as an example:



Audit of the Retrospective DSH Analysis

- Required by federal law to be completed by the end of the FFY (Sept. 30) three years following the Medicaid State Plan Rate Year (SPRY). (For PA, the SPRY is the same as the SFY, or payment year)

What is the DSH UPL timeline?

Using FY15-16 as an example:

Year 1	Year 2	Year 3	Year 4	Year 5
FY15-16 (Payment Year)	FY16-17	FY17-18	FY18-19	FY19-20

Submission of the Audited Report to CMS

- Must be submitted within 90 days of the completion of the audit. (At the latest, this is Dec. 31, three and a half years following the close of the payment year)
- This report is officially known as the "CMS DSH UPL Report"

What is the DSH UPL timeline?

Using FY15-16 as an example:

Year 1	Year 2	Year 3	Year 4	Year 5
FY15-16 (Payment Year)	FY16-17	FY17-18	FY18-19	FY19-20

Prospective UPL Calculation → Payments Made → Hospital Financial Records → Medicaid Cost Report → OMAP Data-Gathering & Checking → Retrospect. DSH Analysis → DSH UPL Audit → Report to CMS → Notice and Recoup-ment

Notice and recoupment of overpayments

- OMAP will notify each hospital found to exceed its retrospective DSH UPL and will indicate the timing and procedure for any recoupment of overpayment

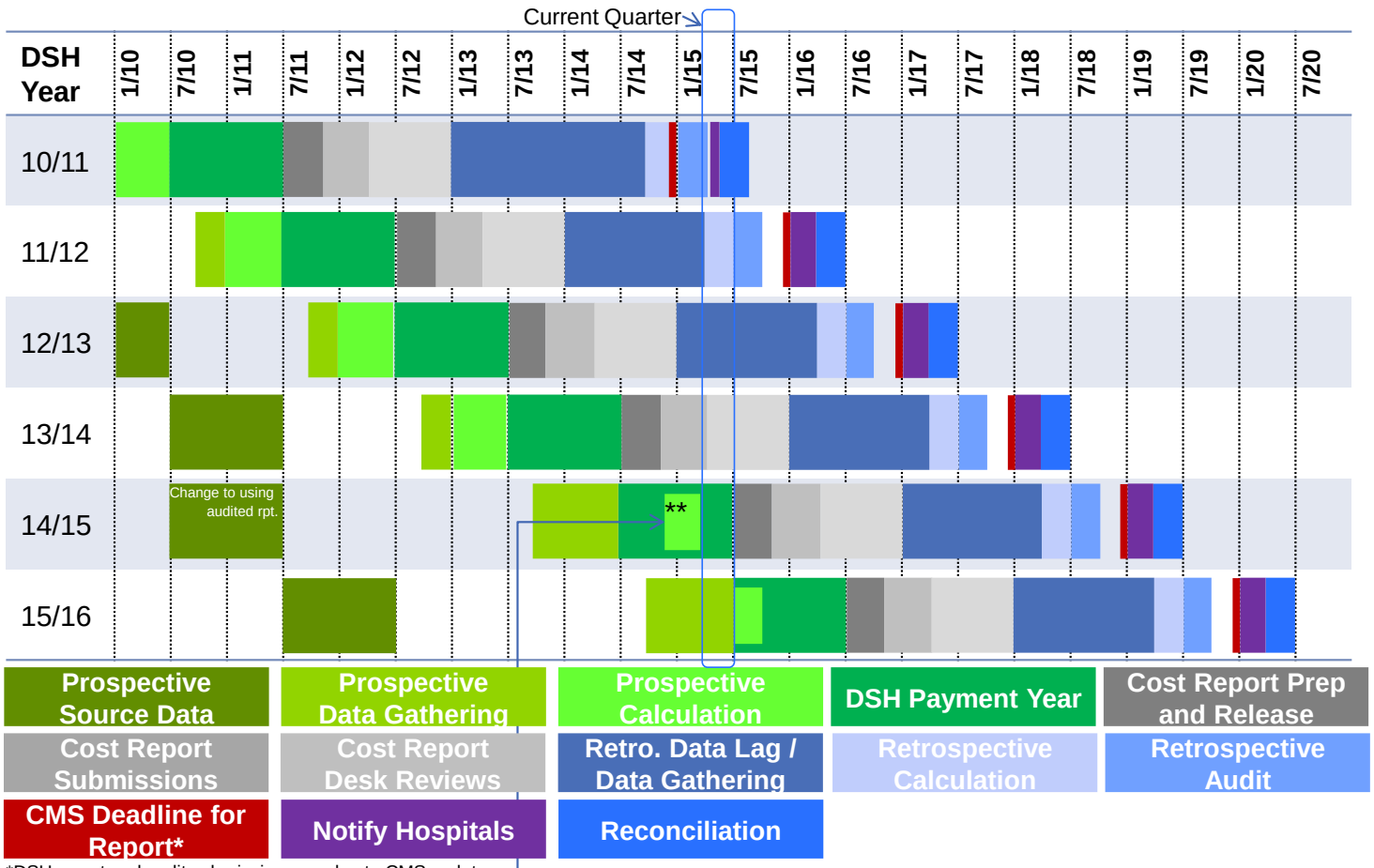
What is the DSH UPL timeline?

At any given time, there are five different payment year DSH UPL processes occurring simultaneously.

The following slide illustrates the overlap…

What is the DSH UPL timeline?

DSH Timeline by State Fiscal Year (SFY)



*DSH report and audit submissions are due to CMS no later than December 31 following three years from the Medicaid SPRY year under audit.

**FY14-15 prospective DSH analysis has been delayed to incorporate audited FY10-11 DSH UPL report as basis (to satisfy CMS request.)

Lesson 6 review:

- DSH UPL is a 5-year process

- Using FY15–16 as an example…
  - ✓ Year 1 – FY15–16
    - OMAP gathers historical data needed for the DSH UPL prospective calculation
  - ✓ Year 2 – FY 16–17
    - Hospitals complete cost reports
  - ✓ Year 3 – FY 17–18
    - OMAP conducts desk reviews of the MA-336 data submitted
  - ✓ Year 4 – FY 18–19
    - OMAP gathers required DSH UPL data elements and supplies them to a vendor to perform the retrospective analysis
  - ✓ Year 5 – FY 19–20
    - Audit commences; OMAP submits report and audit to CMS; OMAP contacts affected hospitals

Lesson 7:
Closing

What you will learn in lesson 7:

- Key takeaways in the course
- Next steps for OMAP…
- Next steps for YOU…
- Hospital reminders
- Where to find more information

After lesson 7, you will find Appendix I, II and III which are the Glossary, CCR, and Contact Information

Course Review

- Each hospital has a hospital-specific UPL that is essentially equal to the sum of its Medicaid shortfall and its uninsured uncompensated care
- Payments to a hospital from or on behalf of Medicaid or uninsured patients may not exceed its UPL
- The prospective DSH analysis creates an estimated UPL for the current payment year by utilizing cost data from a previous year and projecting it forward
- The retrospective DSH analysis calculates a hospital's UPL by using cost and payment data for the payment year itself
- The retrospective DSH analysis is audited and submitted to CMS
- The audited DSH report triggers recoupment of payments found to be in excess of a hospital's UPL

OMAP's Next Steps…

OMAP is planning to send you these DSH-related communications in the next six months of 2015:

May

Your hospital's **FY14-15 prospective** DSH analysis results

- Normally, you would receive the prospective DSH analysis results much earlier in the state fiscal year (SFY)
- This year, preparation was delayed because OMAP needed to gather additional data from hospitals and because it has changed the primary source data to the audited results from the FY10-11 report

July

Your hospital's **FY10-11 retrospective** DSH analysis results

- The FY10-11 retrospective DSH analysis results will include information on the recoupment process

September

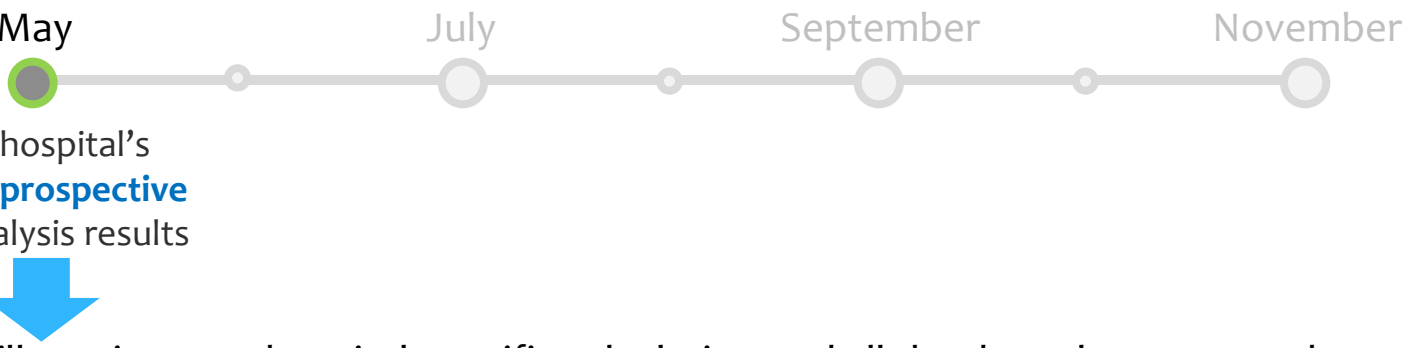
Your hospital's **FY15-16 prospective** DSH analysis results

November

Your hospital's **FY14-15 Medicaid Cost Report** to complete

OMAP's Next Steps…

What details will I receive regarding my FY14-15 prospective analysis?



You will receive your hospital-specific calculation and all the data elements used to calculate your UPL. Your package will include your:

- Summary and Calculation of Excess DSH Payments
- Title XIX (That's Medicaid) Payments and Costs
- Indigent Care/Self-Pay Payments and Costs
- Supplemental Payments and DSH Payments
- Details related to General Assistance
- Details related to Uninsured
- Impact of Managed Care Expansion
- Cost-to-Charge Ratio Calculations
- Cost Growth
- Instructions regarding how to advise OMAP of any corrections you believe are necessary

My Next Steps…

What is a hospital expected to do with the DSH analysis once received from OMAP?

1 Examine it to make sure the data utilized in the calculation is correct

2 Respond to OMAP, according to the instructions included with your materials, to confirm the data or request corrections

3 If your hospital is expected to exceed its UPL, be aware that OMAP will have no choice but to withhold payments that would "put you over the top"

Hospital reminders

Complete MA-336

- Complete MA-336 in a timely and accurate manner
- Use the correct time periods from your hospital's fiscal year to match the state's FY
- Include the correct data!
- Take note of the S-6 and S-7 in particular

Report corrections to submitted MA-336

- Report corrections to your submitted MA-336

Check your prospective UPL analysis

- Respond by the indicated deadline

Understand the DSH process

- Understand the DSH process so that withheld payments or recoupments do not come as a surprise

Where to find more information

Social Security Act, Section 1923(g)

Section 1923(g) of the Act limits Medicaid DSH payments to a qualifying hospital to the amount of eligible uncompensated costs incurred.

2008 DSH Final Rule

On December 19, 2008, a final rule was published by CMS in the Federal Register to implement the reporting and audit requirements within section 1923 of the Act, specifying the elements for the required report and the verifications required for the audit.

There is a correcting amendment here.

CMS Guidance

CMS developed this General DSH Audit and Reporting Protocol and the DSH Report Format to assist States in fulfilling the statutory and regulatory requirements

Additional information from CMS:

- Part 1
- Part 2

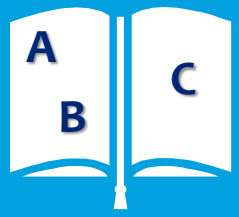
Medicaid DSH Page

Federal Medicaid DSH website

DSH UPL FAQs

Posted on the DHS website

Appendix I
Glossary



Glossary – A – G

CCR	Cost-to-Charge Ratio
CMS	The Centers for Medicare and Medicaid Services, a division of the federal Department of Health and Human Services (HHS)
DHS	The Commonwealth's Department of Human Services. Until 2014, it was called DPW – The Department of Public Welfare
FFP	Federal Financial Participation. The federal government pays a significant portion of qualifying state Medicaid costs. Currently (FFY 2015), it pays 51.82% for typical Medical Assistance services in PA. For more information, please visit this website
FFS	Fee-for-Service
FFY	Federal Fiscal Year. The fiscal year for the U.S. federal goverment begins October 1 and ends September 30
GA	General Assistance, a state program which provides Medical Assistance benefits to eligible individuals that do not qualify for Medicaid under Title XIX. The cost to treat GA individuals is considered an uninsured cost for DSH UPL calculation purposes. Federalized GA payments are DSH payments, while non-federalized GA payments are not considered in the DSH UPL calculation

Glossary – M – P

MA	(say each letter name) Medical Assistance, the name for Pennsylvania's Medicaid program. However, "MA" also includes the General Assistance program (non-Medicaid)
MC	Managed Care. In the context of this training, MC always refers to Medicaid Managed Care
MCO	Managed Care Organization
Medicaid Cost Report	Pennsylvania's Medical Assistance hospital cost report, also known as the MA-336. While commonly referred to as the "Medicaid Cost Report" to differentiate it from the Medicare Cost Report, the MA-336 collects Title XIX and General Assistance data
Medicare Cost Report	The Medicare Hospital Cost Report. (Currently, it is CMS form 2552-10, but it was previously 2552-96 and you will still see many references to those form numbers)
OMAP	(Pronounced as O-Map) The Office of Medical Assistance Programs. Part of DHS that operates Pennsylvania's Medicaid program, including hospital Medicaid claims and hospital payments

Glossary – R – Z

RA	Remittance Advice, statement available to hospitals on a weekly basis. Refer to the Department's website for more information or click the links provided below:
	View the Provider Quick Tip: "Are You Puzzled By Your Remittance Advice Statement? "
	View "Checks, Payments and Remittance Advice Frequently Asked Questions"
	View "How to Save a Remittance Advice to your Computer"
SFY	State Fiscal Year. The fiscal year for the Commonwealth of Pennsylvania runs from July 1 through June 30. The fiscal year that begins on July 1, 2015 is called FY 2015-2016, or FY15-16. References to PA's SFY in this training are simply abbreviated as "FY"
SPRY	State Plan Rate Year. Each state can set its own Medicaid year. Pennsylvania uses its fiscal year as its SPRY, so this training will treat them as synonymous
Title XIX	(pronounced Title 19) Social Security Act Section XIX created the Medicaid program and includes Medicaid federal regulations

Appendix II

Cost-to-Charge Ratios

This table shows the MA-336 worksheet that serves as the source for each CCR's components, as well as the source of the charges to which they are applied

	INPATIENT			OUTPATIENT		
	Source for charges to be converted by the CCR	CCR source -- Costs	CCR source -- Charges	Source for charges to be converted by the CCR	CCR source -- Costs	CCR source -- Charges
Medicaid FFS*	Claims	MA-336: S1	MA-336: S3	Claims	MA-336: S3	MA-336: S3
Medicaid Managed Care	MA-336: S7	MA-336: S3, P1a (IP)	MA-336: S3, P1a (IP)	MA-336: S7	MA-336: S3, P1a (OP)	MA-336: S3, P1a (OP)
Uninsured – GA FFS	Claims	*Use MA FFS CCR (IP)*		Claims	*Use MA FFS CCR (OP)*	
Uninsured – GA MC	Encounter Records	*Use MA MC CCR (IP)*		Encounter Records	*Use MA MC CCR (OP)*	
Uninsured – non-GA	MA-336: S7	MA-336: S3 (total IP)	MA-336: S3 (total IP)	MA-336: S7	MA-336: S3 (total OP)	MA-33: S3 (total OP)
FFS Out-of-State Medicaid	Hospital records	MA-336: S3 (total hosp. IP + OP)	MA-336: S3 (total hosp. IP + OP)	Hospital records	*See IP. There is no separate CCR for OP.*	

*Medicaid FFS inpatient CCR is calculated by specialty (acute care, psych, med rehab, D&A)

Was not captured as a separate element on MA-336 until FY12-13 version

PA does not collect claims for OOS Medicaid patients

Appendix III
Contact Information

Have questions?

If you have DSH UPL questions that were not answered by this training presentation, please email them to:

RA-pwdshpymt@pa.gov

Subject: "[Hospital Name] DSH UPL Training Additional Question(s)"

You have completed this course

You should now be able to:

- Describe Disproportionate Share Hospital (DSH)
- Describe Upper Payment Limits (UPL)
- Explain the origin of DSH and UPL
- Understand the DSH UPL timeline
- Understand DSH and UPL analyses
- Understand how DSH and UPL impacts you
- Know where to go to find more information

END OF COURSE