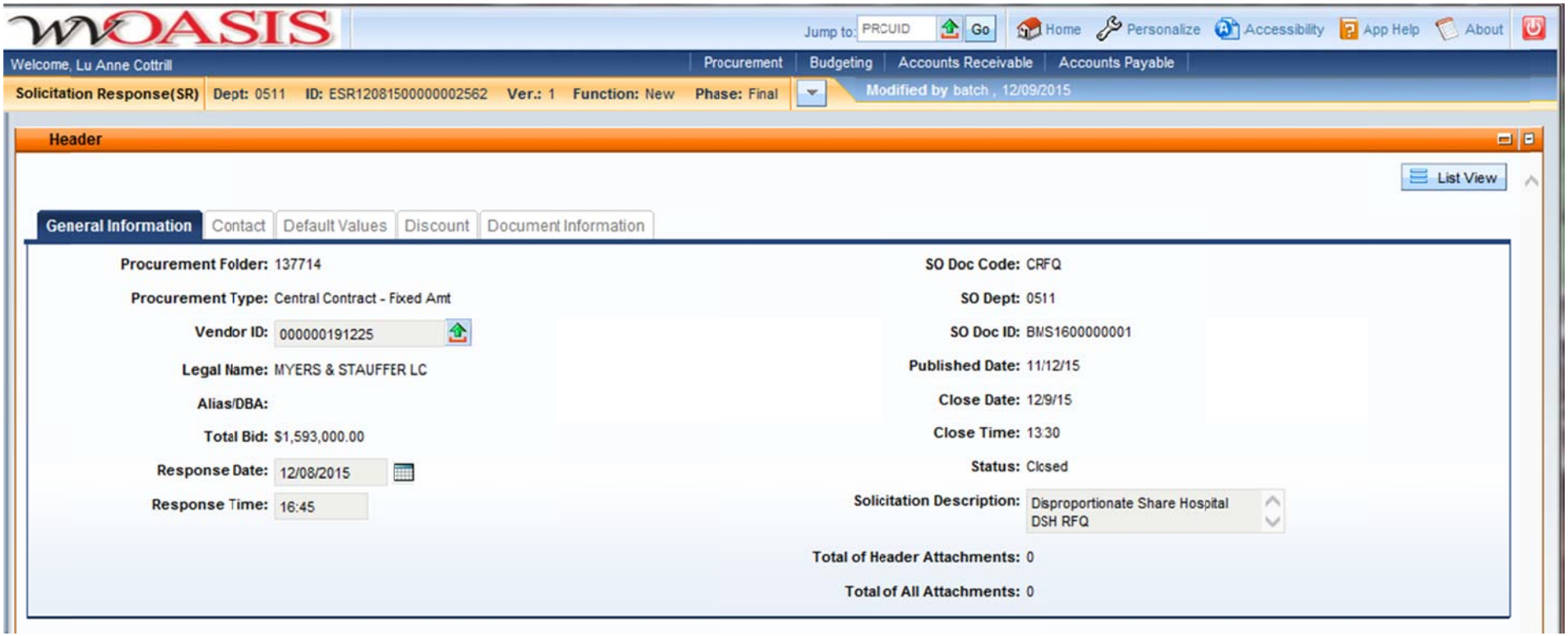
The following documentation is an electronically-submitted vendor response to an advertised solicitation from the *West Virginia Purchasing Bulletin* within the Vendor Self-Service portal at ***wvOASIS.gov***. As part of the State of West Virginia's procurement process, and to maintain the transparency of the bid-opening process, this documentation submitted online is publicly posted by the West Virginia Purchasing Division at ***WVPurchasing.gov*** with any other vendor responses to this solicitation submitted to the Purchasing Division in hard copy format.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Procurement
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Accounts Payable
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Procurement Type: Central Contract - Fixed Amt
Vendor ID: 000000191225
Legal Name: MYERS & STAUFFER LC
Alias/DBA:
Total Bid: $1,593,000.00
Response Date: 12/08/2015
Response Time: 16:45
SO Doc Code: CRFQ
SO Dept: 0511
SO Doc ID: BMS1600000001
Published Date: 11/12/15
Close Date: 12/9/15
Close Time: 13:30
Status: Closed
Solicitation Description: Disproportionate Share Hospital DSH RFQ
Total of Header Attachments: 0
Total of All Attachments: 0

Purchasing Division
2019 Washington Street East
Post Office Box 50130
Charleston, WV 25305-0130

State of West Virginia
Solicitation Response

Proc Folder : 137714

Solicitation Description : Disproportionate Share Hospital DSH RFQ

Proc Type : Central Contract - Fixed Amt

Date issued	Solicitation Closes	Solicitation No	Version
	2015-12-09 13:30:00	SR 0511 ESR12081500000002562	1

VENDOR

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MYERS & STAUFFER LC

FOR INFORMATION CONTACT THE BUYER

Robert Kilpatrick

(304) 558-0067
robert.p.kilpatrick@wv.gov

Signature X **FEIN #** **DATE**

All offers subject to all terms and conditions contained in this solicitation

Line	Comm Ln Desc	Qty	Unit Issue	Unit Price	Ln Total Or Contract Amount
1	Audit Services SFY13				$381,000.00

Comm Code	Manufacturer	Specification	Model #
84111600			

Extended Description : Audit Services

Line	Comm Ln Desc	Qty	Unit Issue	Unit Price	Ln Total Or Contract Amount
2	Audit Services SFY14				$392,000.00

Comm Code	Manufacturer	Specification	Model #
84111600			

Extended Description : Audit Services

Line	Comm Ln Desc	Qty	Unit Issue	Unit Price	Ln Total Or Contract Amount
3	Audit Services SFY15				$404,000.00

Comm Code	Manufacturer	Specification	Model #
84111600			

Extended Description : Audit Services

Line	Comm Ln Desc	Qty	Unit Issue	Unit Price	Ln Total Or Contract Amount
4	Audit Services SFY16				$416,000.00

Comm Code	Manufacturer	Specification	Model #
84111600			

Extended Description : Audit Services

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES BUREAU OF MEDICAL SERVICES

BMS Audit Services – Disproportionate Share Hospital Program

CRFQ 0511 BMS1600000001

Quote Response

December 9, 2015

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

December 9, 2015

Mr. Robert Kilpatrick, Buyer
State of West Virginia
Purchasing Division
2019 Washington Street East
Charleston, West Virginia 25305-0130

Dear Mr. Kilpatrick and Members of the Evaluation Committee:

Myers and Stauffer LC is pleased to present our quotation in response to *Centralized Request for Quotation* (*CRFQ) 0511 BMS1600000001: BMS Audit - Disproportionate Share Hospital (DSH) Program* for the West Virginia Department of Health and Human Resources Bureau for Medical Services (BMS).

Myers and Stauffer's mission is to provide professional accounting, auditing, consulting, data management and analysis services to state and federal governmental health care agencies. Our purpose and vision are to deliver those services to our clients in an efficient, effective and timely manner, and to do so according to the highest levels of integrity and accountability.

Our current and past experience assisting the state has given us a thorough and detailed understanding of your state's Medicaid environment, and prepares us well to meet the requirements of the CRFQ and resulting contract. It would be our great pleasure to continue our work with BMS to support your high expectations and ongoing commitment to serve the state's most vulnerable populations in the most compliant, responsible manner. Myers and Stauffer has 18 offices located nation-wide that collectively manage active engagements with 48 state Medicaid agencies, including engagements with the Department. The vast majority of our client engagements have been continued for greater than five years, a clear indication of our clients' ongoing satisfaction with the services we provide.

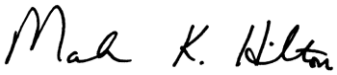
Our exemplary track record has led to the development of a dedicated team of consulting professionals who are committed to providing the highest quality, responsive, personal service while staying abreast of regulatory changes and receiving formal training that exceeds professional requirements. In addition to our extensive regulatory health care experience, utilizing Myers and Stauffer to perform federally mandated independent certified audits of DSH payments will afford the Department an additional level of quality and performance, since certified public accounting (CPA) firms are held to the highest professional standards for integrity, quality and performance.

4400 Cox Rd, Ste 110 | Glen Allen, VA 23060
PH 804.270.2200 | FX 804.270.2300
www.mslc.com

If you require additional information regarding Myers and Stauffer or the contents of our response, please contact me at 800.505.1698 or MHilton@mslc.com. We look forward to continuing our work with the Department to ensure the integrity and fiscal efficiency of your Medicaid program.

Sincerely,

MYERS AND STAUFFER LC



Mark K. Hilton, CPA

Table of Contents

Certification and Signature Page

CERTIFICATIONAND SIGNATURE PAGE

By signing below, or submitting documentation through wvOASIS, I certify that I have reviewed this Solicitation in its entirety; that I understand the requirements, terms and conditions, and other information contained herein; that this bid, offer or proposal constitutes an offer to the State that cannot be unilaterally withdrawn; that the product or service proposed meets the mandatory requirements contained in the Solicitation for that product or service, unless otherwise stated herein; that the Vendor accepts the terms and conditions contained in the Solicitation, unless otherwise stated herein; that I am submitting this bid, offer or proposal for review and consideration; that I am authorized by the vendor to execute and submit this bid, offer, or proposal, or any documents related thereto on vendor's behalf; that I am authorized to bind the vendor in a contractual relationship; and that to the best of my knowledge, the vendor has properly registered with any State agency that may require registration.

Myers and Stauffer LC
(Company)

Mark K. Hilton, Member
(Authorized Signature) (Representative Name, Title)

PH:410-581-4547 Fax: 410-356-0188 12/7/15
(Phone Number) (Fax Number) (Date)

Revised 10/27/2015

Executive Summary

Myers and Stauffer LC is pleased to submit this quotation in response to *Centralized Request for Quotation* (*CRFQ) 0511 BMS1600000001: BMS Audit - Disproportionate Share Hospital (DSH) Program* for the West Virginia Department of Health and Human Resources Bureau for Medical Services (BMS). We are ideally suited to meet and exceed all the requirements of this CRFQ and will demonstrate within this quotation why the selection of Myers and Stauffer is a decision that is both logical and in the best interest of BMS.

Our Understanding of the Project Requirements

Myers and Stauffer has performed health care compliance services — including DSH audits — for BMS since 2010. We, therefore, have a comprehensive understanding of the West Virginia Medicaid reimbursement environment and hospitals, as well as DSH.

In addition to having a specific, detailed understanding of the requested services, other examples of demonstrated value include:

- *As your current contractor, we will have no start up time and can promise efficiencies, a base of knowledge, and hands-on experience that our competition cannot.*
- *A highly qualified project team with complete corporate commitment to the project and extensive historical knowledge specific to West Virginia.*
- *Recognition as a national leader in providing health care audit, reimbursement and consulting services to state Medicaid agencies.*

Our experience with the West Virginia Medicaid program has prepared us well to meet and exceed BMS's needs to perform the DSH audit.

Why Myers and Stauffer Is Best Suited to Serve the Department

Because we are currently performing the services requested in this CRFQ, we feel that Myers and Stauffer is the best-suited vendor for this project. Selection of Myers and Stauffer for these services offers a number of distinct advantages to BMS.

- ***In-depth Knowledge of the DSH Audits.*** *Our DSH team has a depth of experience in DSH auditing and consulting – including DSH engagements in West Virginia and 37 other states – that stands out amongst our competition. We will provide you with insight and understanding of DSH programs that other firms simply cannot. We have experience working together to serve DSH clients across the nation. Further, Myers and Stauffer has been actively engaged with Centers for Medicare & Medicaid (CMS), congressional staff, and state Medicaid leaders on DSH auditing since before the Medicare Prescription Drug Improvement and Modernization Act of 2003 was adopted in November 2003. Not only do we have an unsurpassed understanding of the technical requirements, we also possess an unparalleled understanding of the communication process that will be required to be successful in meeting the tight timeline for this effort.*

- ***Knowledge of National and West Virginia Health Care Environment.*** *We maintain dialogues with CMS executives, state Medicaid officials, and industry leaders across the nation in order to provide our clients with guidance and assistance in a manner that other firms simply cannot match. We also closely monitor the activities of the West Virginia Legislature and the national health care regulatory environment regarding Medicaid compliance and program integrity matters to keep a current knowledge base of legislative interests in this area and any relevant inquiries that BMS receives.*
- ***Knowledge of the Department's Operations.*** *We have worked effectively with the Department on various auditing and consulting issues and have established solid working relationships throughout the agency. No other vendor bidding on this CRFQ has the direct experience in providing services to the provider types in West Virginia that are included in this scope of work. Our historical and current work with BMS ensures that we will be able to continue to provide these critical services without any disruption or change for BMS or the hospitals. Through our work, we have learned invaluable lessons that can only be gained through direct experience.*
- ***National Health Care Leadership.*** *Several of our members (partners) have experience as employees of various states' Medicaid agencies. In addition, all of the senior staff on our proposed team have leadership positions within Myers and Stauffer and have extensive experience working with multiple state and local government agencies across the country and with CMS and other federal agencies. Our project leadership team also has extensive experience assisting government agencies to address issues raised by CMS or other federal oversight agencies.*
- ***Practice Focused on Services to Public Agencies.*** *Our business model is designed to exclusively service local, state and federal agencies operating health care programs. Our professionals spend 100 percent of their time working on health care engagements like yours.*
- ***Cost Effectiveness.*** *Because of our risk-based approach and our utilization of experienced professionals, we are capable of providing services in less time without sacrificing quality. Less time on the job translates to lower fees.*
- ***Flexibility.*** *Myers and Stauffer is large enough to meet any state's objectives, yet is structured in a manner that allows our professionals to have the flexibility to design customized audit and consulting solutions. Because Myers and Stauffer has a more than 35-year history of quality work and management with integrity, we are able to balance the profitability of our firm with affordability for our clients.*
- ***Unmatched Team of Professionals.*** *Our proposed team for this engagement is comprised of experienced accountants and other professionals. In addition, we have professionals with certifications including certified public accountants (CPA), certified fraud examiners (CFE), registered pharmacists, medical doctors, registered nurses and certified coders. We also have former CMS and state government directors and managers, policy and other technical staff, former nursing home employees, former hospital accountants, former Medicare intermediary auditors, and former state Medicaid surveillance and utilization review coordinators.*

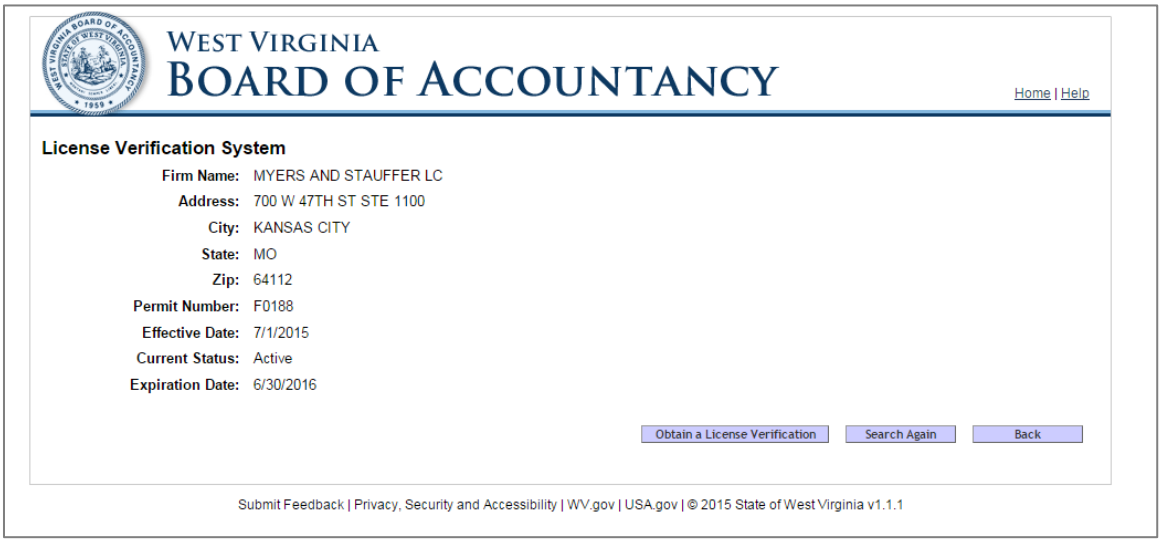
We also consistently surpass minimum contract requirements and exceed our clients' expectations. Our proven team of government health care professionals provides clients with the support they need to effectively and efficiently communicate with the myriad of stakeholders that are impacted by the work we perform. We assist industry leaders, elected officials, program officials, and government staff in obtaining a clear understanding of health care policies, regulatory requirements, and applicable laws that impact them not only today but into the future. Furthermore, the full breadth and depth of our firm's network of professionals is always available to each engagement team and their specific areas of expertise can be accessed when needed.

Myers and Stauffer is the best value vendor that offers to provide the full range of services requested by this CRFQ. We are known nationwide for our superior auditing, consulting, analytical and pricing solutions and our impeccable delivery of services. We will meet the requirements of this contract by applying proven methodologies and subject matter expertise to each core service area to assist the Department in performing necessary due diligence and oversight over your hospitals. Myers and Stauffer has a national reputation for providing high quality services to meet the program needs of our clients, and we are the only vendor which has limited its practice to specializing in work with government health care agencies, thereby minimizing possible conflicts of interest. Our more than 35 years in partnerships with public agencies has established a deep understanding of the exceptionally high degree of integrity, professionalism and accountability that are both expected and required within our firm.

Firm Qualifications (CRFQ Section 3.1)

Firm License (3.1.1)

We are a licensed CPA firm in the state of West Virginia.



Independence (3.1.2)

Myers and Stauffer is a CPA firm that intentionally limits its services to providing audit, rate setting and consulting services to governmental entities managing health care programs. As a result, the firm is independent of the Medicaid agency as defined by the Comptroller General of the United States. Our independence policy applies the Generally Accepted Auditing Standards (GAGAS) Conceptual Framework Approach and we have detailed procedures in our Quality Control Manual to ensure compliance with independence requirements and to avoid other conflicts of interest. Our policies are extensive and designed to meet the requirements of the AICPA, the U.S. Securities and Exchange Commission (SEC), PCAOB, state licensing agencies, and Government Auditing Standards. Some of the key elements of our policies include:

- *Independence training for all professionals.*
- *Annual written representations of independence from all personnel who perform client services.*
- *Extensive client and engagement acceptance and continuance policies.*
- *Requirements for confirming independence of outside accounting firms and independent contractors.*
- *Maintenance of firm wide client list.*

We have included "Chapter 2: Ethical Requirements" of our Quality Control Manual *as Appendix A: Quality Control Manual.*

Hospital Independence (3.1.3)

By signature of this quotation, we attest that we meet all independence standards referenced in C*RFQ Section 3.1.2* and attest that our firm is independent of the West Virginia DSH program and the hospitals listed in *Exhibit 2* of the CRFQ.

Although highly unlikely, should a conflict arise, Myers and Stauffer will first determine if there is any independence impairment under AICPA independence rules. We will also notify BMS of any work performed for a hospital receiving DSH funds. Should an independence impairment or conflict arise, we will subcontract that work to another accounting firm, so as not to conflict with the BMS audit.

Primary Audit Firm (3.1.4)

We have the resources, experience and expertise to perform this engagement as the primary audit firm without the use of subcontractors. Since 2010, we have worked with the West Virginia Department of Health and Human Resources to complete the DSH audit reports for state rate plan years 2005 through 2012 and provided recommendations to improve DSH program procedures.

In addition to our work in West Virginia, the following descriptions provide a brief overview of our relevant DSH experience. All of these contracts and engagements have been completed successfully or are on-going.

Myers and Stauffer is a national leader in assisting states with their DSH programs. We are currently engaged by 38 Medicaid programs to perform the DSH audits as required by the Final DSH Audit Rule published by CMS in the December 19, 2008 Federal Register. In addition, we currently calculate DSH payments on an annual basis for nine state Medicaid programs. We also were instrumental in developing an approach and methodology designed to satisfy the DSH audit requirements set forth by CMS regulations in 2008. Our audit protocol has been reviewed and accepted by CMS.

Our DSH team has arguably the most significant direct experience in the country in performing an actual DSH audit of a state and its implications on the hospitals in that state. We already know what a state will encounter with the audit and what the hospital concerns are with the documentation requirements.

States where we currently perform DSH audits include:

- *Alaska Department of Health and Social Services (2009–present).*
- *Arkansas Department of Health and Human Services (2009–present).*
- *Colorado Department of Health Care Policy & Financing (2010–present).*

- *Connecticut Department of Social Services (2011–present).*
- *Florida Agency for Health Care Administration (2014–present).*
- *Georgia Department of Community Health (2009–present).*
- *Hawaii Department of Human Services (2010–present).*
- *Idaho Department of Health and Welfare (2009–present).*
- *Illinois Department of Health Care and Family Services (2010–present).*
- *Indiana Family and Social Services Administration (1995–present).*
- *Kansas Department of Health and Environment (2009–present).*
- *Kentucky Cabinet for Health and Family Services (2002–present).*
- *Louisiana Department of Health and Hospitals (2013–present).*
- *Maryland Department of Health and Mental Hygiene (2009–present).*
- *Michigan Department of Community Health (2008–present).*
- *Mississippi Office of the Governor (2009–present).*
- *Missouri Department of Social Services (2010–present).*
- *Montana Department of Public Health and Human Services (2009–present).*
- *Nebraska Department of Health and Human Services System (2009–present).*
- *New Hampshire Department of Health and Human Services (2009–present).*
- *New Jersey Department of Human Services (2010–present).*
- *New Mexico Human Services Department (1995–present).*
- *Nevada Department of Health and Human Services (2008–present).*
- *North Carolina Department of Health and Human Services (2009–present).*
- *North Dakota Department of Human Services (2009–present).*
- *Ohio Department of Medicaid (2010–present).*
- *Oklahoma Department of Human Services (2009–present).*
- *Oregon Department of Human Services (2009–present).*
- *Rhode Island Department of Human Services (2010–present).*
- *South Carolina Department of Health and Human Services (2006–present).*
- *Tennessee Department of Finance and Administration (2008–present).*
- *Texas Health and Human Services Commission (2009–present).*
- *Virginia Department of Medical Assistance Services (2006–present).*
- *Washington Department of Social and Health Services (2009–present).*
- *West Virginia Health Care Authority (2010–present).*

- *Wisconsin Department of Health Services (2012–present).*
- *Wyoming Department of Health (2009–present).*

In addition to our DSH auditing engagements, we also perform various DSH consulting services for our clients. Our DSH assistance varies based on the individual state and methodology, and includes services such as sending and receiving survey information (or state-specific alternative), developing and managing databases to calculate DSH eligibility and payment levels, performing desk and on-site reviews of reported uninsured services and payments received, and preparing preliminary DSH payment calculations for the state's review and acceptance. We have assisted in designing DSH payment methodologies, preparing state plan amendments, and communicating DSH methodologies to CMS.

Our state Medicaid DSH payment experience includes:

- *Alabama Medicaid Agency (2008–present).*
- *Georgia Department of Community Health (2009–present).*
- *Idaho Division of Medicaid, Department of Health and Welfare (2009–present).*
- *Indiana Family and Social Services Administration (1995–present).*
- *Kansas Department of Health and Environment (2009–present).*
- *Louisiana Department of Health and Hospitals (2013–present).*
- *Mississippi Division of Medicaid (2009–present).*
- *Nebraska Department of Health and Human Services (2009–present).*
- *New Mexico Human Services Department (1995–present).*

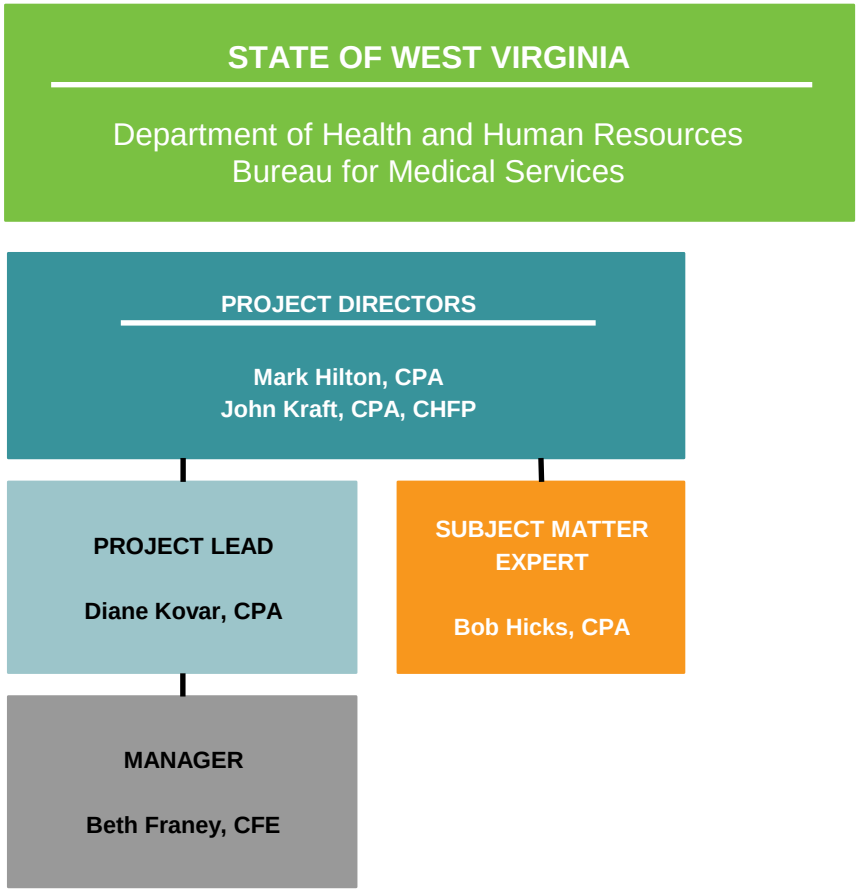
Organizational Chart and Staffing (3.2.1)

Myers and Stauffer is committed to performing this work within the desired time periods established in the CRFQ and have available the resources to efficiently manage this project. Our practice is well-rounded in terms of relevant experience and scope of services provided, and we do not experience the workload compression that other firms might experience during particular busy seasons. This means better client service and closer, personal attention for BMS.

We know our clients will not be successful unless we provide them with the highest levels of accuracy, accountability, responsiveness and experience in health care policy and auditing staff. We, as a firm and as individuals, pride ourselves on our professionals' depth of experience and will provide that same level of expertise to the State.

Equally important are the roles and responsibility of each team member. We are confident that our proposed level of staffing will allow us to complete the contract requirements of this CRFQ, while concurrently and effectively addressing any unexpected problems or delays.

Engagement Team Organizational Chart



We understand that the Department must approve our key team members. All individuals indicated in the organization chart are currently employed full-time by Myers and Stauffer, currently working on these exact services, and are ready to continue providing the services requested by this CRFQ.

Overview and Resumes of Your Myers and Stauffer Team

We operate on the principles of “extraordinary client service” and an “unwavering commitment to quality.” We are highly regarded nationwide for our professional objectivity, innovation, quality staff and unparalleled service. Our success has been achieved by providing our clients with excellent service on a timely basis, including those times when clients have made urgent requests with minimal turn-around time. We are committed to serving the Department as effectively and economically as possible, while maintaining the highest levels of integrity, quality and service.

All staff members dedicated to this contract have direct, hands-on experience performing auditing and consulting services for state and local health care agencies or CMS. In addition, we currently

have the team members and resources in-house and will not need to hire any staff to complete this project.

We will staff this project in order to exceed your expectations. The following is a brief summary of our staff and their roles. We have included resumes for all key management staff in *Appendix B: Resumes*. Should we be the successful bidder, these professionals will be the personnel working on the project. In addition, we will assign senior associates and associates from our Baltimore, Maryland office, as needed. We assure BMS that the quality of staff will be maintained over the term of the contract agreement due to the depth of our experience with Medicaid agencies.

Myers and Stauffer: Proposed Key Staff				
Team Member	**Role in Project**	**Health Care Exp.**	**Exp. with WV**	**Qualifications**
Mark Hilton, CPA *Member*	***Co-Project Director/Partner**:* Mr. Hilton, along with Mr. Kraft, will have overall responsibility for all aspects of the project and will ensure total client satisfaction and establish the overall client service approach. He will work with the Project Lead and Project Manager to ensure successful outcomes.	33 years	✓	Mr. Hilton serves as the current project director for the West Virginia DSH audit contract. He also serves as the project director for our DSH audit contracts with the states of Colorado, Tennessee, South Carolina, Connecticut, New Hampshire, Vermont, Oregon, Rhode Island, Tennessee and West Virginia. Mr. Hilton has been an active participant in the development of the protocols that have been developed for applying the DSH Audit Rule. He led in the effort to prepare comprehensive and executive summaries of the final rule when it was published by CMS. He has had face-to-face meetings with the CMS primary author of the DSH rule as well as the CMS personnel responsible for implementing the DSH Final Rule.
John Kraft, CPA *Member*	***Co-Project Director/Partner**:* Mr. Kraft, along with Mr. Hilton, will have overall responsibility for all aspects of the project and will ensure total client satisfaction and establish the overall client service approach. He will work with the Project Lead and Project Manager to ensure successful outcomes	29 years	✓	Mr. Kraft has performed Medicare and Medicaid audit, desk review and rate calculation services. He plays a key role in managing our disproportionate share hospital (DSH) audit contracts with the states of South Carolina, New Hampshire, Connecticut, Oregon, Tennessee, Rhode Island and West Virginia. He also currently manages Medicaid cost settlement audit contracts for the states of South Carolina, New Jersey, Vermont, Georgia and New Hampshire. In addition, he has provided litigation support for our state Medicaid clients' cost report appeals. He also has performed

Myers and Stauffer: Proposed Key Staff				
Team Member	**Role in Project**	**Health Care Exp.**	**Exp. with WV**	**Qualifications**
				various cost report audit services for Carefirst of Maryland, the former Medicare fiscal intermediary. He has also been a key participant in health care litigation support.
Diane Kovar, CPA *Senior Manager*	***Project Lead/Primary Contract Manager:*** Ms. Kovar will work directly with Mr. Hilton and Mr. Kraft to direct the project team, review and sign deliverables and coordinate the professional resources based on the work plan. She will attend project meetings and training, direct the activities of project staff and be available to BMS staff on a daily basis.	17 years	✓	Ms. Kovar has experience working on health care-related audits, fraud investigations, and litigation support services. In addition to being the project manager for West Virginia DSH audits, she has managed DSH audits in Oregon, South Carolina and Connecticut. She has also worked on the DSH engagements in Rhode Island and New Hampshire. Outside of DSH, she has worked on health care engagements with the Maryland Department of Health and Mental Hygiene and CMS.
Beth Franey, CFE *Manager*	***Manager:*** Ms. Franey will be available to serve as a contact for hospitals and assist with directing the work of staff auditors and accountants.	10 years	✓	Ms. Franey has worked in the Medicare and Medicaid audit and investigation arena for over six years. She has performed and reviewed DSH desk reviews for West Virginia, Massachusetts, South Carolina, Tennessee, Connecticut, New Hampshire, Colorado, Oregon, Vermont and Rhode Island and Medicaid cost settlements for South Carolina. She has also performed health care litigation support and fraud investigation in federal health care programs.
Robert Hicks, CPA *Subject Matter Expert*	***Subject Matter Expert:*** Mr. Hicks will be available to assist BMS as a subject matter expert on the technical requirements of the DSH rule.	20 years	✓	Mr. Hicks has extensive experience with hospital cost report auditing, DSH payments, intergovernmental transfers, and creation of analytical reports and models. Mr. Hicks has also is the project director on the firm's DSH audit contracts in Missouri, Louisiana, Kentucky and North Dakota.

Staff Training (3.2.1)

Because our team includes experts in West Virginia's DSH program, the learning curve for training will be significantly reduced. Many of the issues typically encountered during a DSH engagement are not taught in a classroom, nor are they discussed in periodicals, and it takes substantial exposure to the health care reimbursement field to provide the depth of understanding necessary to arrive at supportable conclusions. Myers and Stauffer incorporates an overview of Medicaid systems into its staff development protocol. This includes a review of pertinent federal statutes and regulations, state plan requirements, and state-specific reimbursement requirements. The firm's resource libraries contain all pertinent resource material including professional pronouncements issued by the American Institute of Certified Public Accountants (AICPA).

Our personnel participate in general and industry-specific continuing professional education and development activities. These activities enable staff to satisfy assigned responsibilities and fulfill applicable continuing professional education (CPE) requirements. In addition, we utilize structured and supervised training for specific project tasks. We have implemented firm wide professional development policies that:

- *Encourage participation in professional development programs that meet requirements of the AICPA, state boards of accountancy, and regulatory agencies in establishing the firm's CPE requirements.*
- *Provide orientation and training for new employees.*
- *Develop in-house staff training programs that focus on general and industry-specific subject matter.*

Our professionals routinely attend relevant national health care conferences to stay current with trends and issues. These conferences have included:

- *American Health Lawyers Association: Long Term Care and the Law.*
- *American Health Lawyers Association: Institute on Medicare and Medicaid Payment Issues.*
- *National Association for Medicaid Program Integrity.*
- *National Association of State Human Services Finance Officers.*
- *National Association of Medicaid Directors: Annual Conference.*
- *National Health Care Anti-Fraud Association: Annual Training Conference.*
- *Health Care Compliance Association: Annual Meeting AICPA National Governmental Accounting and Auditing Update Conferences.*

We also conduct local office training sessions that are specific to our Medicaid clients. Recent topics have included:

- *DSH Auditing Updates.*

- *Best Practices in Auditing: Asking the right questions and documenting accurate results.*
- *Appeals Training for Field Staff.*
- *Fieldwork Basic Training.*
- *Field Work Job Set-Up Training Basic Medicaid and Medicare Training for New Hires.*
- *Adjustment Reports and Regulations.*
- *Medicare Cost Reporting 101.*

Our professionals who are CPAs are required to complete 40 hours annually of CPE. In addition, those employees who work on GAGAS engagements are required to complete in excess of 80 hours of CPE every two years. At least 24 hours of the 80 hours must be in subjects directly related to government auditing, the government environment, or the specific or unique environment in which the audited entity operates (Yellow Book). The majority of our CPA-certified staff exceeds these requirements. In addition, all staff receives relevant training throughout the year. We have included CPE documentation for our key staff in *Appendix B: Resumes.*

Finally, all training is managed so that there will be no disruption to the work on our specific contracts. Staff members are assigned to a project team only after they have successfully completed a training program designed specifically to their needs.

Mandatory Requirements *(CRFQ Section 4.1)*

Our Understanding of the Project

The DSH program was established by Congress in 1981 as a provision of the Boren Amendment. It was intended to provide protection for hospitals, specifically hospitals with large caseloads of low-income and uninsured individuals.

Over the years, there has been a series of legislative amendments that have defined, refined, and limited states' use and implementation of the DSH provisions, including:

- *The Omnibus Budget Reconciliation Act of 1986, which stated that HCFA had no authority to limit payment adjustments to DSH hospitals.*
- *The Omnibus Budget Reconciliation Act of 1987, that defined which hospitals, at a minimum, must be included in the DSH program.*
- *The Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991, which established the first upper bounds on DSH payments.*
- *The Omnibus Budget Reconciliation Act of 1993, which sought to better target DSH hospital payments and set limits on the amounts of DSH payments individual hospitals would be allowed to receive.*
- *The Medicare Prescription Drug Improvement and Modernization Act of 2003, which among other changes included a requirement that states submit a detailed annual report and an independent certified audit on their DSH payments to hospitals.*

While efforts at the federal level have been made to control total DSH expenditures, states still have considerable flexibility in designing their reimbursement systems and determining how available funds are distributed. At Myers and Stauffer, we believe DSH payment systems should be managed in conjunction with other hospital payments to ensure state goals and objectives for the entire hospital payment system are realized. As such, we have developed a DSH examination strategy that is fully compliant with the new federal requirements, while also considering the state's data needs and reporting obligations.

The final rule on auditing Medicaid DSH payments published in the Federal Register on December 19, 2008, implements the requirements of Section 1923(j) of the Social Security Act. This section requires two reports from state Medicaid programs on an annual basis:

- *An annual report from state Medicaid programs detailing information relevant to the DSH payments made under the approved state plan, along with any other information the Secretary of Health and Human Services determines necessary.*
- *An independent certified audit of actual uncompensated care cost during the DSH year, along with other data reports (verifications).*

The annual report primarily presents the hospital identification information, the "estimate" of the hospital-specific DSH limit, Medicaid inpatient utilization rate (MIUR) calculations, low income

utilization rate (LIUR) calculations, and the state-defined DSH qualification criteria. The final rule identified the DSH data elements that must be reported in the annual unaudited report to CMS.

The independent certified audit includes elements to be gathered for the audit process, primarily the calculation of the uncompensated Medicaid costs and uncompensated uninsured costs.

Examination Program (4.1.1)

The state of West Virginia is seeking a contractor to provide a series of independent certified audits of hospitals that have received DSH payments from West Virginia Medicaid.

Our examination program will comply with 42 U.S.C. Section 1923(j)(2) and will be subject to BMS's approval prior to beginning fieldwork. The examination program will be submitted to BMS for approval a minimum of 30 calendar days prior to the beginning of fieldwork. We will perform all examination procedures in order to render an opinion and examination report. Please see *Section 4.1.4: Work Plan* for more details. Travel and incidental costs shall be include in the all-inclusive, firm fixed price.

Compliance (4.1.1.1)
We understand the audits must meet the CMS requirements as specified in 42 CFR Parts 447 and 455 and CMS guidance and requirements. With over nine years of experience conducting DSH audits – including five years as BMS's contractor for DSH audits – we know the ins and outs of the DSH rule and will be sure that all requirements are met.

Timing (4.1.1.2)
We have very specific timelines that we adhere to in order to ensure that the engagement is completed and reports are issued on or before the CMS guidelines. For SFY 2013, we will complete our work procedures by September 30, 2016. We will then complete a draft report by October 30, 2016 and a final report by November 30, 2016. Please see our Timeline included in *Section 4.1.4: Work Plan*.

Source Documents (4.1.1.3)
To complete our examination, we will utilize the Medicaid State Plan, MMIS payment and utilization data, Medicare 2552 or related cost reports, and hospital audited financial statements and accounting records.

Verifications (4.1.2)

The Final Rule requires six verifications from 42 CFR 455.304 at the state level and we will need to perform examination procedures at the hospital level in order to provide an opinion on those six verifications. The audit and reporting requirements apply to all states that make DSH payments and to each in-state hospital receiving DSH payments. In addition to issuing an independent certified examination report addressing the six verifications and all other requirements set forth in 42 CFR 447 and 455, we will compile the 21 (formerly 18) data elements specified in the regulations for each hospital and for each report. We have addressed this in detail in *Section 4.1.4: Work Plan* and have included a draft format of the schedule in *Appendix C: Hospital Schedule.*

CMS Confirmation (4.1.3)

To the best of our knowledge, all DSH reports that we have compiled for our clients have been accepted by CMS. As confirmation, we have included letters from our state clients in *Appendix D: CMS Acceptance.*

Work Plan (4.1.4)

Overview
Many states, including West Virginia, have made DSH payments to hospitals based upon historical data. The data was used to estimate hospital-specific DSH limits, and other data elements necessary to distribute DSH funds under the approved state plan.

Under the final DSH audit rule published December 19, 2008, states must now measure the actual hospital-specific DSH limit for that state plan year and compare that to the DSH payment received. These requirements also specify that Medicare cost reporting principles must be used to calculate the hospital-specific DSH limit, which contains the net unreimbursed cost of providing care to Medicaid and uninsured individuals.

To accomplish this task, it will be necessary to utilize data from several sources. Sources will include existing Medicare cost reports, hospital financial records and paid claims summaries. In addition, since some data is not readily available or routinely tracked in the hospital's accounting records (e.g., charges and payments attributable to the uninsured), we have developed a detailed survey document for each hospital that received a DSH payment to complete.

We will continue to use our current West Virginia DSH examination approach as follows:

- *Begin the project by meeting with the state to discuss the project and all timelines.*
- *Update our DSH survey tool to reflect any changes needed specific to West Virginia.*
- *Gather necessary data such as MMIS reports, cost reports, state plan, and other data from the state.*
- *Conduct an annual training session for hospitals, to educate them regarding DSH regulations, the examination approach and protocol we follow, and their responsibilities for responding to the DSH examination request.*
- *Send surveys to the hospitals for them to complete and submit to us for examination.*
- *Conduct desk reviews on the surveys.*
- *Using a risk-based approach, select hospitals for expanded procedures.*
- *Complete expanded procedures for hospitals selected.*
- *Perform senior management review of desk reviews and audits.*
- *Prepare a draft examination report and management letter for submission to the state.*
- *Meet with the state to discuss the examination report and findings.*
- *Issue the final examination report for submission to CMS.*

- *We will continue to provide you with continuous communication throughout the examination process. In addition to the entrance and exit conferences, we will hold intermittent status meetings as needed to discuss the detailed project plan and our progress towards completion. Further, we will be available to answer any questions and address any concerns during the course of the examination.*

In addition, it is equally important to maintain open lines of communication with the hospitals. The hospitals must be provided with direction on the examination process and the specific information they will be asked to submit. They must also be afforded an avenue to have their questions answered. We have direct hands-on experience in working through many hospital concerns regarding the significant data requests required by the CMS DSH audit rule. Our significant experience in this area will be used to ease the West Virginia hospital's concerns with providing data and complying with this federally mandated audit.

State Reporting Requirements

Under 42 Code of Federal Regulations (CFR) Section 447.299, states are required to submit to CMS, at the same time as it submits the completed audit required under Section 455.304, the following information for each DSH hospital to which the state made a DSH payment in order to permit verification of the appropriateness of such payments:

1. ***Hospital name.*** *The name of the hospital that received a DSH payment from the state, identifying facilities that are institutes for mental disease (IMD), and facilities that are located out-of-state.*
2. ***Estimate of hospital-specific DSH limit.*** *The state's estimate of eligible uncompensated care for the hospital receiving a DSH payment for the year under audit based on the state's methodology for determining such limit.*
3. ***Medicaid inpatient utilization rate (MIUR).*** *The hospital's MIUR, as defined in Section 1923(b)(2) of the Act, if the state does not use alternative qualification criteria described in Number 5 below.*
4. ***Low income utilization rate (LIUR).*** *The hospital's LIUR, as defined in Section 1923(b)(3) of the Act if the state does not use alternative qualification criteria described in Number 5 below.*
5. ***State defined DSH qualification.*** *If the state uses an alternate broader DSH qualification methodology as authorized in Section 1923(b)(4) of the Act, the value of the statistic and the methodology used to determine that statistic.*
6. ***Inpatient (IP)/outpatient (OP) Medicaid fee-for-service (FFS) basic rate payments.*** *The total annual amount paid to the hospital under the State plan, including Medicaid FFS rate adjustments, but not including DSH payments or supplemental/enhanced Medicaid payments, for IP and OP services furnished to Medicaid eligible individuals.*
7. ***IP/OP MCO payments.*** *The total annual amount paid to the hospital by Medicaid MCOs for IP hospital and OP hospital services furnished to Medicaid eligible individuals.*
8. ***Supplemental/enhanced Medicaid IP/OP payments****. Indicate the total annual amount of supplemental/enhanced Medicaid payments made to the hospital under the State Plan.*

These amounts do not include DSH payments, regular Medicaid FFS rate payments, and Medicaid managed care organization payments.

9. ***Total Medicaid IP/OP payments**. Provide the total sum of items identified in numbers 6, 7 and 8.*
10. ***Total cost of care for Medicaid IP/OP services**. The total annual cost incurred by each hospital for furnishing IP hospital and OP hospital services to Medicaid eligible individuals.*
11. ***Total Medicaid uncompensated care.** The total amount of uncompensated care attributable to Medicaid IP and OP services. The amount should be the result of subtracting the amount identified in number 9 from the amount identified in number 10. The uncompensated care costs of providing Medicaid physician services cannot be included in this amount.*
12. ***Uninsured IP/OP revenue.** Total annual payments received by the hospital by or on behalf of individuals with no source of third party coverage for IP and OP hospital services they receive. This amount does not include payments made by a state or units of local government, for services furnished to indigent patients.*
13. ***Total applicable section 1011 payments.** Federal Section 1011 payments for uncompensated IP and OP hospital services provided to Section 1011 eligible aliens with no source of third party coverage for the IP and OP hospital services they receive.*
14. ***Total cost of IP/OP care for the uninsured.** Indicate the total costs incurred for furnishing inpatient IP and OP hospital services to individuals with no source of third party coverage for the hospital services they receive.*
15. ***Total uninsured IP/OP uncompensated care costs**. Total annual amount of uncompensated IP/OP care for furnishing IP hospital and OP hospital services to Medicaid eligible individuals and to individuals with no source of third party coverage for the hospital services they receive. The amount should be the result of subtracting numbers 12 and 13 from number 14.*
16. ***Total annual uncompensated care costs.** The total annual uncompensated care cost equals the total cost of care for furnishing inpatient IP and OP hospital services to Medicaid eligible individuals and to individuals with no source of third party coverage for the hospital services they receive less the sum of regular Medicaid FFS rate payments, Medicaid managed care organization payments, supplemental/ enhanced Medicaid payments, uninsured revenues, and Section 1011 payments for IP and OP hospital services. This should equal the sum of numbers 9, 12 and 13 subtracted from the sum of Numbers 10 and 14.*
17. ***DSH payments.** The total annual payment adjustments made to the hospital under Section 1923 of the Act.*
18. ***Additional reporting.** The final Medicaid DSH allotment reduction rule published on September 18, 2013, requires additional reporting requirements to include the Medicare provider number, Medicaid provider number and total hospital cost.*

In addition, each state must maintain, in readily reviewable form, documentation that provides a detailed description of each DSH program, the legal basis of each DSH program, and the amount of DSH payments made to each individual public and private hospital or facility each quarter.

If a state fails to comply with the reporting requirements contained in this section, future grant awards will be reduced by the amount of Federal Financial Participation (FFP) that CMS estimates is attributable to the expenditures made to the disproportionate share hospitals as to which the state has not reported properly and until such time as the state complies with the reporting requirements. Deferrals and/or disallowances of equivalent amounts may also be imposed with respect to quarters for which the state has failed to report properly. Unless otherwise prohibited by law, FFP for those expenditures will be released when the state complies with all reporting requirements. We will work with the Department to compile this information in the proper format to comply with the reporting requirements.

We will continue to work with the Department to compile this information in the proper format to comply with the reporting requirements.

DSH Examination Approach

The examination process will encompass auditing data from each DSH hospital for the state fiscal year being audited. To complete the reports, we will gather information for the cost reporting periods that cover the state plan rate year under audit. In cases where the hospital's fiscal year-end may not coincide with the state plan rate year (DSH year), information will be gathered for two or more hospital cost reporting periods. In instances when a change of ownership has occurred, it may be necessary to gather data for three cost reporting periods to cover a single state plan rate year.

We will customize the survey tool we have developed to perform the current West Virginia DSH examination. This survey tool has successfully been used in many states to collect the data necessary to calculate each of the required data elements in accordance with the guidance provided in the final DSH audit rule.

While the methodologies used to calculate the uncompensated care for Medicaid and the uninsured for DSH payment purposes were approved by CMS in the state plan, the final rule requirements specify the cost of caring for Medicaid and the uninsured must be determined using Medicare cost finding techniques. The survey tool will obtain sufficient detail to allow us to calculate the Medicaid and uninsured cost using the routine per diems and ancillary cost-to-charge ratios from the hospitals' Medicare/Medicaid cost reports. As part of the examination process, Myers and Stauffer will continue to perform the following functions as outlined in the final rule:

- ***Review State's Methodology.*** *As part of the DSH examination process, we will review the approved Medicaid state plan for DSH payments. This will include reviewing the methodology for estimating each hospital's DSH limit and the state's DSH payment methodologies.*

  While the main objective of the DSH examination process is to comply with the CMS rule and provide the verifications and reports that are required, there are additional benefits

that can accrue for the Department through this process. By selecting Myers and Stauffer to perform the audit, the state not only selects a contractor skilled in providing Medicaid audit services but also a consultant that has a long history of assisting states with addressing the complexities of their Medicaid DSH programs.

The audit process established by CMS requires the state to recoup any DSH funds that were paid in excess of the hospital specific DSH limits as identified during the DSH audit. It is important that the state select a contractor that is not only able to conduct the audit but is also experienced in designing and implementing DSH payment methodologies. After reviewing the state's methodology for estimating hospitals DSH limits and the state's DSH payment methodologies, our DSH experience will enable us to assist with refining the methodologies to help reduce the possibility of adverse outcomes in future years.

- ***Review of State's DSH Audit Protocol.*** *A review of the state's DSH audit protocol will be performed to ensure consistency with inpatient and outpatient Medicaid reimbursable services in the approved Medicaid State Plan.*
- ***Compilation of Cost and Revenue****. Myers and Stauffer has developed a survey tool to be sent to all in-state hospitals that received a Medicaid DSH payment for the state fiscal years under audit. This document includes sections that will enable hospitals to cost out their Medicaid and uninsured claims using Medicare cost report mechanics. The survey tool will compile routine per diem costs and ancillary cost-to-charge ratios from the applicable cost reports. The hospitals will then be responsible for grouping their charges and patient days to the appropriate cost centers for costing purposes. As identified in the survey document, there are multiple patient types that must be included in the calculation of the uncompensated care costs, including:*
    - *In-state Medicaid FFS.*
    - *In-state Medicaid managed care.*
    - *In-state Medicaid FFS cross-over.*
    - *In-state other Medicaid-eligible.*
    - *Uninsured services.*
    - *Out-of-state Medicaid FFS.*
    - *Out-of-state Medicaid managed care.*
    - *Out-of-state Medicaid FFS cross-over.*
    - *Out-of-state other Medicaid-eligible.*

The DSH survey provides the hospitals with the appropriate columns to group the days and charges with each of the above patient types to the appropriate per diems or cost-to-charge ratios. The form also provides the appropriate cells to enter the payments received for each of the patient categories. In addition to having the hospitals complete the survey, we will obtain copies of the cost reports for the appropriate cost reporting periods. As part of the examination process, we will verify that the hospitals have entered the appropriate cost-to-charge ratios and per diems on the survey. We will also test the

reported days and charges back to the supporting documentation (Medicaid MMIS claims runs or hospital generated claims detail).

- ***Compilation of DSH Payments.*** *We will obtain from Department a schedule of DSH payments made for the state fiscal year. Upon contract award, we will confirm with the agency that these are the final DSH payments for the state fiscal year that were claimed as Medicaid DSH payments to CMS. These payments will be compared to the total calculated uncompensated care costs for each hospital.*
- ***Compare Hospital-Specific DSH Limits against Hospital-Specific DSH Payments.*** *The examination report will include a schedule that summarizes all in-state hospitals that received a DSH payment in the state fiscal year under audit. The schedule will also include the adjusted hospital-specific DSH limit (uncompensated care costs) for the period under audit. Hospitals that received DSH funds in excess of their hospital-specific DSH limits will be clearly identified.*

As mentioned previously, Myers and Stauffer will not only provide the required audit report, we will also take additional steps to help ensure the program is able to correct any current deficiencies to prevent problems in future DSH years.

Verification Requirements

Myers and Stauffer's approach to this examination process begins with thoroughly assessing the risk associated with each of the verifications. We will design testing to mitigate risk.

This engagement is unique since the report is to be on a statewide basis, yet the certifications being prepared are at the hospital-specific level. Some level of testing must be completed for each in-state hospital that received a DSH payment. In the final rule, however, CMS acknowledged that a field visit to each hospital receiving a DSH payment is likely not necessary.

Myers and Stauffer will continue a two-phase examination process – the first phase involving a comprehensive desk review of the data elements necessary for the DSH examination process. Then, risk thresholds will be established and if exceeded, the hospital will potentially be selected for expanded procedures review, which is the second phase of the examination process.

Desk Review Process

The initial phase of the process will be to obtain the necessary information from the state agency and the hospitals, organizing each hospital's documents into an electronic work paper. The survey form, central to the entire process, will be checked for mathematical accuracy and completeness. The reported survey elements will be traced to supporting detailed documents, such as Medicaid paid claims summaries, cost report per diems, and cost-to-charge ratios traced to the Medicare cost report (2552) and uninsured charges and payments traced to the claims detail provided by the hospital.

The following data sources will be used for the examination:

- *Approved Medicaid state plan for the Medicaid state plan rate year under audit.*
- *Payment and utilization information from the state's MMIS.*

- *Medicare hospital cost reports.*
- *Audited hospital financial statements and accounting records.*

The detailed data will be reviewed for consistency with the time periods under examination and to identify any improper claims included in the reported data. Myers and Stauffer has also developed a DSH examination application that enables us to "clean" hospital and state detailed DSH claims data. The custom application can review the data for completeness of requested fields, inconsistencies, dates of service, non-covered revenue codes, and duplicate data. The application generates summary reports for use in the DSH examination. Adjustments will be proposed for any incorrect items and adjusted hospital-specific DSH limits will be calculated.

These adjusted hospital-specific DSH limits will be compared to the DSH payments to initially assess examination risk. The primary examination risk is when a hospital's DSH payments exceeded its hospital-specific DSH limit. We will also analyze all data elements reported and used in the uncompensated care calculation. Myers and Stauffer's many years of experience working with Medicaid DSH data will allow us to assess the risk of potential misstatements on the DSH survey and target these data elements for review.

Based on a review of the data elements for all hospitals, a risk threshold will be established and hospitals will be selected for detailed desk reviews or expanded procedure reviews. Once the process is complete, we will evaluate the overall coverage of DSH hospitals selected through the risk assessment process. If insufficient numbers of hospitals have been selected, additional hospitals may be added using selected hospital characteristics or lowering the risk threshold.

Expanded Desk Review Process

Hospitals selected for an expanded procedures review will be contacted to discuss the information needed during the expanded procedures review and methods of providing the needed information. Needed information may include patient financial and medical records, financial statements and supporting general ledgers, as well as charge masters for the period under review. The expanded procedures examination process involves testing the accuracy of the data related to the six verifications.

Myers and Stauffer's approach to the examination process is to thoroughly assess the risk associated with each of the verifications and design testing to mitigate that risk. Each of the required verifications is identified below along with a discussion of the steps that must be taken to examine this verification.

Verification 1: Each hospital that qualifies for a DSH payment in the State is allowed to retain that payment so that the payment is available to offset its uncompensated care costs for furnishing inpatient hospital and outpatient hospital services during the Medicaid State plan rate year to Medicaid eligible individuals and individuals with no source of third party coverage for the services in order to reflect the total amount of claimed DSH expenditures.

Verification 1 involves obtaining assurance that hospitals are allowed to retain the DSH payment received and are not required to return any of the payment to the state or are required by the state to use the DSH funds for specific purposes as a condition for receiving the DSH payment. Our preliminary examination procedures will include a review of the approved state plan, DSH calculation and payment process. We will meet with West Virginia Medicaid officials and confirm hospitals are allowed to retain the entire calculated DSH payment.

We will question hospitals to determine if any hospitals were required to return all or a portion of their DSH payment. Additional testing, if needed, will include tracing the DSH payment into the accounting records and identifying any indications of credits or amounts being returned to the state.

Verification 2: DSH payments made to each qualifying hospital comply with the hospital-specific DSH payment limit. For each Medicaid State plan rate year, the DSH payments made in the Medicaid State plan rate year must be measured against the actual uncompensated care cost in that same Medicaid State plan rate year.

To express an opinion on this verification, it is necessary to obtain data to calculate hospital-specific DSH limits. Data sources include the Medicaid agency, the hospital's cost reports for period(s) under review, as well as data obtained from the hospital's internal financial records.

To obtain hospital internal financial records, we propose to survey each in-state hospital that received a DSH payment from the state.

As indicated in the final rule, it may be necessary to gather data for more than one hospital fiscal year to cover the entire state plan rate year. For this reason, the survey allows the hospital to report multiple years of data.

It is unlikely that all hospitals' fiscal year-ends will coincide with the state plan rate year under audit. CMS indicated in the final rule that it will be acceptable to allocate the calculated hospital-specific DSH limit for each hospital's fiscal year-end to the state plan rate year by the number of months covered. For example, if the state plan rate year under audit ends September 30 and the hospital fiscal year ends December 31, it is acceptable to use three months of the DSH limit calculated for the hospital fiscal year end that covers the start of the state plan rate year and nine

months of the DSH limit calculated for the hospital fiscal year end that covers the end of the state plan rate year.

Verification 3: Only uncompensated care costs of furnishing inpatient and outpatient hospital services to Medicaid eligible individuals and individuals with no third party coverage for the inpatient and outpatient hospital services they received as described in Section 1923(g)(1)(A) of the Act are eligible for inclusion in the calculation of the hospital-specific disproportionate share limit payment limit, as described in Section 1923(g)(1)(A) of the Act.

This verification is met using our DSH survey tool. The survey costs out hospital services for Medicaid eligible individuals and uninsured. Only those costs will be included in the final hospital-specific disproportionate share limit. Please see *Appendix E: DSH Survey Tool* for an example survey.

Medicaid
Medicaid services include Medicaid FFS, Medicaid managed care, Medicare/Medicaid cross-overs, and other Medicaid-eligible patients. The days, charges and payments for all Medicaid categories will be included based on the Agency's paid claims summaries or detailed data and the hospitals' accounting records. The survey tool will calculate a cost for all of these services based on the cost report.

Uninsured
Uninsured days, charges and payments will be provided by the hospitals' accounting records directly. The survey tool will calculate a cost for all of these services based on the cost report.

The final rule created a unique issue in the recognition of payments for the uninsured. CMS, in the comments and responses, indicated that payments received on behalf of the uninsured should be recognized on a cash basis. This basically requires hospitals to gather two data sets related to the uninsured for each hospital fiscal year-end under review.

The first data set will be used to generate the days and charges associated with uninsured individuals who received services during the cost report year. The second data set will identify all payments received during the cost report period from individuals who were uninsured.

Since there are two separate data sets required for the uninsured, the testing will be separated by uninsured charges and uninsured payments. While many of the tests will be similar, it is important to test the validity of both data sets.

Uninsured Charges
On December 3, 2014, CMS published a final rule that is less restrictive in defining uninsured services than the guidance that was provided as part of the December 19, 2008 DSH audit rule. The December 2014 rule clarified and provided additional guidance on what services can be considered uninsured for DSH purposes and reverted back to a service-specific approach. The rule was effective for DSH audits and reports submitted for state plan rate year 2011 and after

which were due to CMS on December 31, 2014. For most states that contracted with Myers and Stauffer to perform the DSH examination, we have been requesting that hospitals include within their DSH reporting the services that met the definitions provided in the proposed rule since it was published in 2012. Our DSH examination program and process is designed in compliance with this rule.

We will begin testing the hospital's representations of uninsured charges by reviewing the information system's extraction criteria with hospital representatives. If discrepancies are noted in the definitions utilized in querying the data, we will discuss the best method to eliminate incorrect data or to obtain any additional data needed to meet the federal definitions of uninsured.

Testing will include reviewing the listing to ensure only services provided within the applicable hospital fiscal year were included in the analysis. If needed, detailed testing of the uninsured charges will be accomplished through sampling the individual patients reported uninsured charges.

For a sample of selected patients, we will request access to the patient's financial records for a sample of selected patients. The files will be reviewed to verify the following:

- *Dates of service were within the service period of the cost report under review.*
- *No evidence of available third party coverage (even if no payments were received from the third party).*
- *Charges included on the claim detail were only for inpatient and outpatient hospital services and did not include items such as physician professional fees, provider-based non-hospital units (skilled nursing facilities, nursing facilities, HHAs, etc.).*
- *Reported charges were the customary charge for that hospital; verified by tracing detailed charges to the hospital's charge master on a sample basis.*
- *Where significant risk for duplicate claims is noted, an electronic match of the data sets may be needed.*
- *Review claims for evidence of large payments that may indicate insurance coverage.*

If exceptions are noted during the testing of uninsured charges, one of two methods will be utilized to eliminate the impact of the exception. It may be possible to eliminate all of the claims that contain the characteristic identified (for example, patients with a billing code of P1, which represent county inmates who should not be included). If so, the specific claims not in compliance with the federal definition of uninsured services will be removed. The second method will utilize statistical extrapolation to adjust known exceptions out of the data. Extrapolation will be used in instances where errors or exceptions were identified but no method of specifically identifying all claims in the claim set that contain that characteristic was available. The extrapolation methodologies being used are properly certified as statistically valid by an independent statistician as required by CMS program integrity manual instructions.

After performing the initial testing procedures, risk will again be evaluated and, if it has not been reduced to an acceptable level, additional testing may be required. Additional testing may include expanding the sample of claims, as well as performing additional detailed insurance eligibility

reviews of the claims sampled. Once risk has been reduced to an acceptable level, the proposed adjustments will be summarized.

Uninsured Payments
Due to the different recognition criteria (cash basis as opposed to accrual) for the uninsured payments, it is necessary to test the hospital's analysis of received uninsured payments. Many testing steps will be the same as the uninsured charges; however, they will be conducted on a different sample of patients.

The testing will begin by reviewing with the hospital the criteria utilized in generating the listing of payments received from the uninsured. If issues are identified in the methodology utilized to query the hospital's financial system, we will identify the most efficient method to acquire the necessary data, either eliminating unnecessary data from the analysis already provided or obtaining a revised analysis from the hospital.

If necessary, detailed testing of the uninsured payments will involve selecting a sample of claims from the self-pay payment analysis provided with the survey. Unlike the uninsured charge sampling, the payment sampling will include all self-pay payments as opposed to only those received from uninsured patients. This is necessary because a hospital may understate its uninsured payments as opposed to overstating them.

We will determine if any payments were received during the cost reporting year under review for the claims sampled in the uninsured charges testing. If payments were received, we will verify the payments are appropriately reflected in the uninsured payments analysis. If needed, the claims sampled from the self-pay payment analysis will be reviewed to determine:

- *Payments were received during the cost reporting period.*
- *All payments received for the patient during the cost reporting period were included on the analysis.*
- *The individual was in fact uninsured during the time services were provided.*
- *Payments for other than inpatient or outpatient hospital services were not included in the analysis. This will include removing the professional portion of any uninsured payments.*
- *Payments shown as "insured" in the self-pay payment analysis were, in fact, insured at the time services were provided.*

Additional testing includes discussing the hospital's policy for selling accounts receivable. If the hospital sells accounts receivable, additional testing will include reviewing contracts associated with the sales to determine if all payments for the uninsured were properly included in the analysis.

Testing will be performed to determine if the hospital has obtained liens against the property of any uninsured individuals. If so, identifying if any payments were received during the cost report year on those liens.

In addition to the self-pay uninsured payments, we will collect illegal alien payments (Section 1011 payments) and compare them to the hospital's financials to the extent necessary. Once risk

has been reduced to an acceptable level, any proposed adjustments to the hospital's uninsured charges and payments will be summarized and included in the subsequent calculation of the hospital-specific DSH limit.

Verification 4: For purposes of this hospital-specific limit calculation, any Medicaid payments (including regular Medicaid fee-for-service rate payments, supplemental/enhanced Medicaid payments, and Medicaid managed care organization payments) made to a disproportionate share hospital for furnishing inpatient hospital and outpatient hospital services to Medicaid eligible individuals, which are in excess of the Medicaid incurred costs of such services, are applied against the uncompensated care costs of furnishing inpatient hospital and outpatient hospital services to individuals with no source of third party coverage for such services.

In calculating the hospital-specific DSH limit, it is required that all Medicaid payments received by the hospital offset the Medicaid cost of providing inpatient and outpatient hospital services to Medicaid eligible individuals. For testing purposes, we will request paid claims detail from the state agency for both fee-for-service and Medicaid managed care (if applicable and/or available) to obtain the payments directly associated with the provided services. In addition, we will request any supplemental or enhanced Medicaid payments (e.g., supplemental payments associated with an upper payment limit program). As part of the survey document sent to hospitals, we will request information on Medicaid services provided to out of state residents, as well as any DSH payments received from other states.

Uncompensated Medicaid costs will be calculated by first costing out the Medicaid hospital services provided utilizing Medicare cost finding principles. The routine cost centers will be costed utilizing Medicaid days multiplied by cost per diems for each applicable cost center from the Medicare cost report. The ancillary services will be costed utilizing Medicaid charges multiplied by the applicable cost-to-charge ratios from the Medicare cost report. The total cost of providing Medicaid services will be reduced by all payments received for providing inpatient and outpatient hospital services. The resulting amount will be netted against the uncompensated costs of providing services to the uninsured. If the calculation of uncompensated Medicaid costs is negative or a gain, the gain must be used to reduce the uncompensated care services to the uninsured.

Verification 5: Any information and records of all of its inpatient and outpatient hospital service costs under the Medicaid program; claimed expenditures under the Medicaid program; uninsured inpatient and outpatient hospital service costs in determining payment adjustments under this section; and any payments made on behalf of the uninsured from payment adjustments under this section has been separately documented and retained by the state.

As part of the examination process, we will gather all necessary documentation to support the claimed expenditures for Medicaid and the uninsured. We maintain our work paper documentation, along with the documents submitted by the hospital, in an electronic format that

enables us to easily and efficiently store the documentation and make it available to others. The documentation will be provided to the state agency upon request at the completion of each year's examination in a format requested by the state.

Verification 6: The information specified in paragraph (d)(5) of this Section includes a description of the methodology for calculating each hospital's payment limit under Section 1923(g)(1) of the Act. Included in the description of the methodology, the audit report must specify how the State defines incurred inpatient hospital and outpatient hospital costs for furnishing inpatient hospital and outpatient hospital services to Medicaid eligible individuals and individuals with no source of third party coverage for the inpatient and outpatient hospital services they received.

A detailed description of the methodology used in calculating the hospital-specific DSH limits will be included in the documentation maintained for the state agency. The description will include the definition of incurred inpatient and outpatient hospital costs. Much of this information will be contained in the instructions and survey documents that are developed and distributed on an annual basis to DSH participating hospitals.

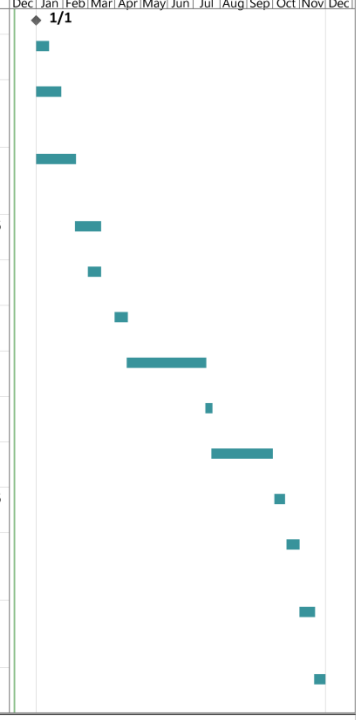
The examination report will contain an Independent Accountant's Report in accordance with GAGAS standards. Following the accountant's report will be the Communication on Internal Control and the schedule of hospital-specific data elements specified by CMS in the final rule, including a comparison of each hospital's actual uncompensated care costs for the examination period and the actual DSH payments made.

The reporting requirements in the final rule also require the examiner to identify any data deficiencies or caveats identified during the examination process. Throughout the examination process, as data issues or caveats arise, they will be fully documented in the examination work papers. Data issues may include missing or incomplete records due to natural disaster, change of ownership, or electronic data retention issues. As issues are identified, alternative procedures will be utilized to verify the data. Any unresolved data issues or caveats will be documented and disclosed in the final examination report as deemed necessary.

Timeline

West Virginia Department of Health and Human Resources, Bureau of Medical Services
Proposed Project Time Line

Task Name	Purpose	Start
Approximate Date Contract Begins		Fri 1/1/16
Meet with state to discuss project and timelines	To explain nature of procedures, answer questions, and obtain initial information	Fri 1/1/16
Update DSH survey tool to reflect any changes needed in the future and obtain necessary state approvals	To ensure appropriate data collection and approvals	Fri 1/1/16
Gather necessary data such as MMIS reports, cost reports, state plan, schedule of DSH payments, and other data from state	To understand nature of payments made and develop examination plan	Fri 1/1/16
Conduct annual DSH hospital training	To educate and provide instructions to hospitals on DSH examination and requested information	Mon 2/15/16
Send DSH surveys to hospitals	Information on which hospital-specific procedures will be performed	Tue 3/1/16
Obtain survey data from the hospitals	Information on which hospital-specific procedures will be performed	Fri 4/1/16
Conduct desk reviews on the surveys	Ensure the data used to determine hospital-specific DSH limits is proper	Fri 4/15/16
Using risk-based approach, select hospitals for expanded procedures	Conduct planning to ensure for an efficient examination with the proper level of coverage	Fri 7/15/16
Completed expanded procedure desk reviews	Ensure the data used to determine hospital-specific DSH limits is proper	Fri 7/22/16
Perform senior management review of desk reviews and expanded desk reviews	To perform independent review of work papers to ensure that quality standards are met	Mon 10/3/16
Prepare draft examination report and submit to state	To allow state the opportunity to review a draft copy of the report and provide comments and/or additional documentation	Mon 10/17/16
Meet with state to discuss draft examination report and findings	Discuss results of procedures with state representatives and allow adequate time for response	Tue 11/1/16
Issue final examination report with state responses for submission to CMS	Summarize findings and comply with the DSH Audit Rule	Fri 11/18/16



Task Milestone

GAGAS Standards (4.1.5)

We will conduct the audit in accordance with GAGAS as defined by the Comptroller General of the United States and the AICPA's Statements on Standards for Attestation Engagements (SSAE).

Deliverables *(CRFQ Section 4.2)*

Examination Report (4.2.1)

We will issue a bound report that expresses an opinion on the six verifications established in the final rule and meet all CMS requirements.

Compliance (4.2.2)

We understand the audits must meet the CMS reporting requirements as specified in 42 CFR Parts 447 and 455 and CMS guidance and requirements. This will include the schedule of 21 (formerly18) data elements for each hospital.

Electronic Examination Audit Report (4.2.3)

We will provide BMS with an electronic version of the final report by November 30 of each year. BMS will transmit the copies of the report to each hospital.

Exit Conference (4.2.4)

We will conduct an exit conference, via web conference, with the DHHR and BMS representatives once a preliminary typed draft of the required engagement report has been accepted by BMS. The exit conference will be scheduled for an agreed upon date after the delivery of the typed draft to allow for adequate time for review and acceptance by BMS.

In addition, we will include the BMS's responses in the final bound report when it is issued.

Management Letter (4.2.5)

We shall give BMS and applicable DSH hospitals an opportunity to provide a written response to management letter comments. BMS's and applicable DSH hospitals' identified contacts will be provided an electronic copy of comments noted during the examination and will be given a minimum of three business days by which responses should be provided. Written responses may be provided in an electronic format. Responses will be reviewed to determine if a revision to the comments is necessary.

Training Program (4.2.6)

The success of our internal training programs and our hands-on training is evidenced through the opportunities that our professionals routinely have to present to national associations, provider groups, state employees, and other stakeholders. In addition, they provide CPE compliant training at internal conferences. Below is a select sample of our 2015 DSH-related training and presentations, including the specific West Virginia DSH training:

DSH Related Training for States			
Training	**Date**	**Audience**	**Outcome**
DSH Audit SFY 2013	9/2015	Ohio Hospitals	
DSH Payment SFY 2016	8/2015	Georgia Hospitals and Association	Our DSH training benefits both the state and the hospitals. We have received repeated positive feedback from the states that the training has increased efficiency in the audit process by reducing individual questions and issues. The hospital staff have expressed that the training allowed them to understand the process and has facilitated the gathering of information. The training has also resulted in more hospitals completing their initial reports correctly and a reduction in reports that must be resubmitted.
DSH Audit SFY 2012	5/2015	Washington Hospitals	
DSH Audit 2012	5/2015	Tennessee Hospitals	
DSH Audit SFY 2012	4/2015	New Jersey Hospitals	
DSH Audit SFY 2012	4/2015	Texas Hospitals	
DSH Payment SFY 2015 2016 and Audit SFY 2012	4/2015	Kansas Hospitals and Association	
DSH Audit SFY 2012	4/2015	Oklahoma Hospitals	
DSH Audit SFY 2012	4/2015	West Virginia Hospitals	
DSH Audit SFY 2012	3/2015	Louisiana Hospitals	
DSH Audit SFY 2012	3/2015	Michigan Hospitals	
DSH Audit SFY 2012	2/2015	North Carolina Hospitals	
DSH Audit SFY 2012	2/2015	Florida Hospitals	
DSH Audit SFY 2012	2/2015	South Carolina Hospitals	
DSH Audit SFY 2012	1/2015	Missouri Hospitals and Association	

In addition, below we have listed a sampling of other relevant presentations given in the past few years:

Other Regulatory Health Care Training		
Training	**Date**	**Audience**
The Importance of Program Integrity	9/2015	National Home and Community Based Services (HCBS) Conference
A Medicaid Director's View of Program Integrity in Managed Care	8/2015	National Association for Medicaid Program Integrity (NAMPI) Annual Conference
Actionable Quality Data: Validating, Aligning and Effectively Using	8/2015	Medicaid Enterprise Systems Conference

Other Regulatory Health Care Training		
Training	**Date**	**Audience**
Forensic Auditing	9/2014	HCBS Conference
Seven Questions You Should Ask About Your Managed Care Program	9/2014	HCBS Conference
RAC'ing Up Recoveries: How Georgia is Partnering with its RAC to Recover Millions and Enhance Program Integrity	8/2014	NAMPI Annual Conference
Medicaid Managed Care: Helpful Hints for Effective Monitoring and Ensuring Compliance	8/2013 8/2012	NAMPI Annual Conference
Certified Public Expenditures Training	12/2012	Tennessee State Representatives
Health Care Fraud: The Government's Response	5/2012	VSCPA Health Care Industry Symposium
Auditing 101	4/2012	CMS Regional Offices

Ensuring Training Objectives (4.2.6.1)
We have developed a comprehensive training program based on our knowledge and experience providing DSH audits to 38 states. In addition, we are constantly revising our program based on feedback, questions and issues raised by our state and hospital audiences. Presenting the training is only a first step to ensuring the understanding of the DSH audit. We provide a copy of the training for states and hospitals to reference as needed, are available to answer further questions, and work with hospitals as the begin their part of the audit.

Sample Training Materials (4.2.6.2)
We have provided sample training materials in *Appendix F, G and H: Sample Training Materials*. These materials have been used in our presentations to West Virginia, Oregon and South Carolina.

Training Schedule (4.2.6.3)
For the initial year, we will provide training via Webinar at least two weeks prior to the beginning of field work. For Optional Renewal Periods, we will conduct training at least two weeks prior to the beginning of fieldwork. We will also conduct DSH hospital training on-site for each year. In addition, should any new regulations or CMS guidance/interpretations issued or regulation, guidance orinterpretation changes arise, we will conduct training via Webinar within six weeks of the update for the initial engagement and any Optional Renewal Periods. We agree to also provide assistance and training to BMS represenatives as needed in calculating and processing final DSH settlements.

Externally Driven Changes (4.2.7)

CMS Procedures (4.2.7.1)
We agree to make all adjustments to examination procedures and reporting that impact the scope of the engagement upon future issuance of guidance by CMS, regardless of the timing of such guidance.

Administrative/Expert Witness Services (4.2.7.2)
Should the need arise for any administrative, expert witness, or other services, we will represent BMS. This includes providing services in the event of an audit, DSH hospital appeals, or receipt of questions related to our work. We will provide these services (up to a minimum of 10 years) until all litigation, claims and/or audit findings are resolved with the federal government regardless of whether our contract period has expired. These services shall be provided at no additonal cost.

Contract Award/Pricing Page *(CRFQ Sections 5.1/2)*

We have included our price estimate on the following pages. Our pricing is based on our understanding of your request and our previous experience conducting the DSH audit for BMS since 2010.

Because of the new requirement that we agree to supply all administrative, expert witness and other services necessary to represent the Bureau in the event of an audit, DSH hospital provider appeals or receipt of questions related to our work product up to a minimum of 10 years after the expiration of the contract; at no additional cost, our total pricing to provide the requested services has increased. As the additional required services are not ascertainable at this point in time, we have included an estimated additional amount for these “yet to be determined” services. Please note that we have kept our base audit service pricing in line with the prior year.

Purchasing Divison 2019 Washington Street East Post Office Box 50130 Charleston, WV 25305-0130	**State of West Virginia** **Request for Quotation** **34 — Service - Prof**

Proc Folder: 137714

Doc Description: Disproportionate Share Hospital DSH RFQ

Proc Type: Central Contract - Fixed Amt

Date Issued	Solicitation Closes	Solicitation No	Version
2015-11-12	2015-12-09 13:30:00	CRFQ 0511 BMS1600000001	1

BID RECEIVING LOCATION

BID CLERK
DEPARTMENT OF ADMINISTRATION
PURCHASING DIVISION
2019 WASHINGTON ST E
CHARLESTON WV 25305
US

VENDOR

Vendor Name, Address and Telephone Number:
MYERS AND STAUFFER LC
400 Redland Court, Suite 300
Owings Mills, MD 21117
PH 410.581.4547 (Direct)/PH 800.505.1698 (Main)

FOR INFORMATION CONTACT THE BUYER

Robert Kilpatrick
(304) 558-0067
robert.p.kilpatrick@wv.gov

Signature X Mark K. Hilton **FEIN #** 48-1164042 **DATE** December 7, 2015

All offers subject to all terms and conditions contained in this solicitation

Page : 1 FORM ID : WV-PRC-CRFQ-001

ADDITIONAL INFORMAITON:

The West Virginia Purchasing Division,on behalf of the Agency, the WV Department of Health and Human Resources, Bureau for Medical Services (BMS), is soliciting bids to establish a contract for audit services for the West Virginia Disproportionate Share Hospital (DSH) program, per the attached instructions, conditions, and specifications.

INVOICE TO	SHIP TO
PROCUREMENT OFFICER - 304-356-5052 HEALTH AND HUMAN RESOURCES BUREAU FOR MEDICAL SERVICES 350 CAPITOL ST, RM 251 CHARLESTON WV25301-3709 US	PROCUREMENT OFFICER - 304-356-5052 HEALTH AND HUMAN RESOURCES BUREAU FOR MEDICAL SERVICES 350 CAPITOL ST, RM 251 CHARLESTON WV 25301-3709 US

Line	Comm Ln Desc	Qty	Unit Issue	Unit Price	Total Price
1	Audit Services SFY13	1	1	$381,000.00	$381,000.00

Comm Code	Manufacturer	Specification	Model #
84111600			

Extended Description :
Audit Services

INVOICE TO	SHIP TO
PROCUREMENT OFFICER - 304-356-5052 HEALTH AND HUMAN RESOURCES BUREAU FOR MEDICAL SERVICES 350 CAPITOL ST, RM 251 CHARLESTON WV25301-3709 US	PROCUREMENT OFFICER - 304-356-5052 HEALTH AND HUMAN RESOURCES BUREAU FOR MEDICAL SERVICES 350 CAPITOL ST, RM 251 CHARLESTON WV 25301-3709 US

Line	Comm Ln Desc	Qty	Unit Issue	Unit Price	Total Price
2	Audit Services SFY14	1	1	$392,000.00	$392,000.00

Comm Code	Manufacturer	Specification	Model #
84111600			

Extended Description :
Audit Services

INVOICE TO	SHIP TO
PROCUREMENT OFFICER - 304-356-5052 HEALTH AND HUMAN RESOURCES BUREAU FOR MEDICAL SERVICES 350 CAPITOL ST, RM 251 CHARLESTON WV25301-3709 US	PROCUREMENT OFFICER - 304-356-5052 HEALTH AND HUMAN RESOURCES BUREAU FOR MEDICAL SERVICES 350 CAPITOL ST, RM 251 CHARLESTON WV 25301-3709 US

Line	Comm Ln Desc	Qty	Unit Issue	Unit Price	Total Price
3	Audit Services SFY15	1	1	$404,000.00	$404,000.00

Comm Code	Manufacturer	Specification	Model #
84111600			

Extended Description :
Audit Services

INVOICE TO	SHIP TO
PROCUREMENT OFFICER - 304-356-5052 HEALTH AND HUMAN RESOURCES BUREAU FOR MEDICAL SERVICES 350 CAPITOL ST, RM 251 CHARLESTON WV25301-3709 US	PROCUREMENT OFFICER - 304-356-5052 HEALTH AND HUMAN RESOURCES BUREAU FOR MEDICAL SERVICES 350 CAPITOL ST, RM 251 CHARLESTON WV 25301-3709 US

Line	Comm Ln Desc	Qty	Unit Issue	Unit Price	Total Price
4	Audit Services SFY16	1	1	$416,000.00	$416,000.00

Comm Code	Manufacturer	Specification	Model #
84111600			

Extended Description :
Audit Services

SCHEDULE OF EVENTS

Line	Event	Event Date
1	Technical Questions due by 3:00pm	2015-11-24

	Document Phase	Document Description	Page 4
BMS1600000001	Final	Disproportionate Share Hospita l DSH RFQ	of 4

ADDITIONAL TERMS AND CONDITIONS

See attached document(s) for additional Terms and Conditions

Additional Information *(CRFQ Sections 6-11)*

We will comply with the requirements in the following CRFQ sections:

- *Performance (6)*
- *Payment (7)*
- *Travel (8)*
- *Facilities Access (9)*
- *Vendor Default (10)*
- *Miscellaneous (11): Please note that the primary Contract Manager for the engagement will be as follows:*

  Diane Kovar
  410.581.4544 (phone)
  410.356.0188
  Dkovar@mslc.com

Appendix A: Quality Control

CHAPTER 2 Ethical Requirements

[QC §10.21-10.26; 10.A7-10.A10]

It is the policy of the firm that all personnel be familiar with and adhere to relevant ethical requirements of the AICPA in its *Code of Professional Conduct* and pertinent regulatory agencies, and when applicable to the engagement, Generally Accepted Government Auditing Standards.

Certified Public Accountants (CPAs) must be familiar with and adhere to all relevant *AICPA Professional Standards* and requirements of state boards of accountancy and CPA societies for states germane to one's practice area.

The following is offered to clarify this policy:

1. The firm endeavors to avoid situations that present conflicts of interest. It does not accept providers of health care services as clients. It is the policy of the firm not only to maintain independence in fact and appearance, but also in mental attitude. Although not all-inclusive, the following are considered prohibited transactions:

    a. Investments by the firm or its personnel in a client's or health care provider's business, except indirectly as a passive investor through a mutual fund or retirement plan.

    b. Partnership, joint venture, or joint investment by the firm or its personnel with a client or health care provider, or their personnel.

    c. The firm or its personnel borrowing from or making loans to a client or health care provider, or their personnel.

    d. The firm's personnel accepting cash or gifts from or offering cash or gifts to a client or health care provider, or their personnel (with the exception of non-cash token gifts of nominal value).

    e. Certain close family relationships between the firm's personnel and client or health care provider personnel – consult the Quality Control Committee for a ruling and relevant mitigation steps.

9

f. The firm or its personnel engaging in any activity or undertaking any transaction that may give the appearance that the firm is not independent of a client or a health care provider, or their personnel.

g. The firm or its personnel engaging in any transaction, event, circumstance, or action that would impair independence or violate the firm's ethical policies.

2. When facing situations that raise potential independence threats not specifically addressed by independence rules, one should report the matter to the Quality Control Committee. Such threats will be evaluated by reference to *Conceptual Framework for AICPA Independence Standards* contained in the *AICPA Professional Standards,* Volume 2 ET §100, through professional judgment to determine whether an independence breach exists. When necessary, appropriate authorities from AICPA or state CPA societies are consulted. The firm will take appropriate action to mitigate the threat.

3. Notwithstanding the preceding guidance and list of prohibited transactions, at the Quality Control Committee's discretion, prohibitions can be waived if deemed in the best interest of the firm and if allowed by professional standards.

The firm implements this policy through the following procedures:

Requiring all personnel to sign an Independence, Integrity, and Objectivity Representation when hired, and annually thereafter, that acknowledges familiarity with the firm's relevant ethical requirements policies and procedures, including independence.

Requiring all personnel to promptly notify the Quality Control Committee of any circumstances or relationships that may create a potential threat to independence or an independence breach, so that appropriate action can be taken. To acknowledge these responsibilities, personnel are required when hired, and annually thereafter, to sign the Representation and list known circumstances and relationships that may create a potential threat to independence or violate the firm's ethical requirements policy. The *Code of Professional Conduct* is contained in the *AICPA Professional Standards,* Volume 2 ET and is available in each office. Authoritative resources and advice of the Quality Control Committee should be consulted when one is not sure if a transaction, event, or circumstance may be a violation or should be reported.

Requiring all personnel to determine annually whether their situation (personal and business) involves a prohibited transaction with a state agency or a health care provider or their personnel. If one determines that a prohibited transaction may exist, one is required to review the firm's client list and related health care provider lists. The time sheet program includes a listing of all state agency contracts and is updated regularly. The engagement partner in charge of each

state agency contract maintains a current listing of all health care providers covered under that contract. When hired, and annually thereafter, all personnel are required to sign a representation that confirms this responsibility.

Assigning responsibility for obtaining a signed Independence, Integrity, and Objectivity Representation from all personnel each year to the Quality Control Committee. It is reviewed for completeness and information relating to identified threats to ethical requirements. If a potential threat is identified, the Quality Control Committee communicates relevant information to management so it can take appropriate action to address identified threats. In determining a resolution, refer to paragraph 2 in the clarification above. Documentation of resolution is filed in the employee's personnel folder.

Requiring independence representations from other CPA firms when necessary. During the course of performing an accounting and auditing engagement, the ET may utilize a report prepared by another independent accountant to corroborate the ET's independent findings. Under these circumstances, no independence representation is required from the other auditors. On the other hand, if another auditor performs a segment of our accounting and auditing engagement, a separate independence representation is required from such auditor.

Assigning to the Executive Committee the primary responsibility for determining whether there are unpaid fees by clients that would impair the firm's independence and determine its impact.

Assigning to the Executive Committee the primary responsibility for determining whether actual or threatened litigation has an effect on the firm's independence with respect to a client.

Assigning to the engagement partner the responsibility for promptly notifying the Quality Control Committee when personnel may have violated the firm's independence or other ethics policies or procedures. The engagement partner, in consultation with the Quality Control Committee, may initiate other reasonable steps to mitigate the firm's risk exposure.

Requiring notification of breach. If a breach of independence or other ethics issue is identified, all parties that know of a possible breach in Ethical Requirements should promptly notify the Quality Control Committee. The committee should determine the facts and circumstances and promptly notify the Executive Committee of the incident and recommended action. Recommended action for each incident is determined by facts and circumstances and may include eliminating a personal impairment, requiring additional training, drafting a reprimand letter, or even termination.

Assigning to the Executive Committee resolution of breaches in ethical requirements. The committee confirms its resolution to the Quality Control Committee and notifies other affected parties.

Table of Selected Rules in the AICPA Code of Professional Conduct
(These rules apply to all personnel.)

Description of Rule	Location in Professional Standards*
Article I Responsibilities	ET §52
Article II The Public Interest	ET §53
Article III Integrity	ET §54
Article IV Objectivity, Independence	ET §55
Article V Due Care	ET §56
Article VI Scope, Nature of Services	ET §57
Rule 101 Independence	ET §101.01
Rule 101 Interpretations	ET §101.02-.19
Rule 102 Integrity and Objectivity	ET §102.01
Rule 102 Interpretations	ET §102.02-.07
Ethics Rulings	ET §191.001-.229

* From *AICPA Professional Standards*, Volume 2

Appendix B: Resumes

MARK HILTON, CPA

Mr. Hilton has more than 33 years of audit and consulting experience relating exclusively to performing health care related services and applying Medicare and Medicaid principles of reimbursement including cost report audits. He is part of the firm wide leadership serving as the Partner-In-Charge of the Cost Report Attest and DSH Audit engagement team.

His relevant experience includes:

Oregon Health Authority (2009-present)

- Project director responsible for overseeing the contract to perform audit procedures on the DSH Payment Program. Responsibilities include modification of audit program, scheduling, reviewing completed engagements, supervising staff, interaction with state and hospital representatives.

West Virginia Department of Health and Human Resources (2010-present)

- Project director responsible for completion of DSH Audits for the State Fiscal Years 2005 through 2011.

Colorado Department of Health Care Policy and Financing (2010-present)

- Project director responsible for completion of DSH Audits for the State Fiscal Years 2005 through 2011.
- Project director responsible for completion of Hospital, FQHC, RHC cost report audits.

South Carolina Department of Health and Human Services (2006-present)

- Project director responsible for overseeing the project to perform audit procedures on the state of South Carolina DSH Payment Program. Responsibilities include modification of audit program, scheduling, reviewing completed engagements, supervising staff, interaction with state and hospital representatives. Project director responsible for performing Medicaid cost settlements on South Carolina hospitals. Responsibilities include cost settlement program development, scheduling, reviewing of completed work papers, supervising staff, and interaction with state and hospital representatives.

Mark Hilton , *CPA*

Member (Partner)

EDUCATION

B.S., Accounting, Liberty University

EXPERIENCE

33 years of professional experience

CORE COMPETENCIES

health care auditing and accounting on Medicaid DSH

health care auditing and accounting with an emphasis on Medicaid and Medicare reimbursement

health care consulting with an emphasis on fraud investigation and litigation support

New Hampshire Department of Health and Human Services (2009-present)

- Project director responsible for overseeing the contract to perform audit procedures on the state of New Hampshire DSH Payment Program. Responsibilities include modification of audit program, scheduling, reviewing completed engagements, supervising staff, interaction with state and hospital representatives.

U.S. Department of Justice (DOJ) (1997-present)

- Project director responsible for the oversight of the FBI Headquarters' Health Care Fraud Unit subcontract involving litigation support and the investigation of health care fraud cases across the United States. Provide litigation support assistance to FBI Special Agents, FBI Financial Analysts, Assistant United States Attorneys, U.S. DOJ Commercial Litigation Trial Attorneys, State Attorneys, Chief Investigators of Medicaid Fraud Control Units, U.S. Department of the Treasury Special Agents, U.S. Department of Treasury Intelligence Analysts, U.S. Food and Drug Administration Office of Criminal Investigations Special Agents, U.S. Department of Health and Human Services Office of Inspector General Special Agents, National Insurance Crime Bureau Agents, and Government Statisticians and Medical Experts.
- Project director responsible for providing litigation support services to the Department of Justice Assistant United States Attorneys and attorneys representing the Commercial Litigation Branch of the U.S. Department of Justice Civil and Criminal.

CERTIFICATIONS

Certified Public Accountant

PRESENTATIONS

"Medicare and Community Mental Health Centers," Colorado Mental Health Center and Clinics Association.

"Medicare and Reimbursable Bad Debts," and "Medicare Graduate Medical Education," District of Columbia Hospital Association.

"Medicaid Disproportionate Share Audits," Mississippi Hospitals for the Mississippi Medicaid Division.

"Medicaid Disproportionate Share Audits," National Association of State Human Service Finance Officers.

"Medicaid Disproportionate Share Audits," New Hampshire Hospitals for the New Hampshire Medicaid Division.

AFFILIATIONS

American Institute of Certified Public Accountants
Maryland Association of Certified Public Accountants

Mark Hilton CPE (Yellow Book) 2013-present			
Program	**Completion Date**	**Sponsor Name**	**Credits**
Excel Macros - Advanced	6/8/2015	The Business Learning Institute	8
Institute on Medicare and Medicaid Payment Issues 2015	3/27/2015	American Health Lawyers Association	22
Webcast: Ethics: It's Not Just What You Do, but How You Do It!	12/1/2014	The Maryland Association of CPAs	4
Lessons Learned from Healthcare Fraud Investigations for Virginia Program Integrity Division	10/15/2014	Myers and Stauffer LC	2
Institute on Medicare and Medicaid Payment Issues 2014	3/28/2014	AHLA	21
Ethics for OR CPAs - ETHXOR	6/6/2013	PASS Online	4
Audit/Attest Training	5/24/2013	Myers and Stauffer LC	14
Institute on Medicare And Medicaid Payment Issues 2013	3/22/2013	AHLA	23.5
DSH Payment Examination Update	2/5/2013	Myers and Stauffer LC	6.5
DSH Payment Examination Update	2/5/2013	Myers and Stauffer LC	3
Credits Per Year: 2013 - 51 credits, 2014- 27 credits, 2015 - 30 credits		**Total Credits**	**108**

JOHN KRAFT, CPA

For the past 29 years, Mr. Kraft has performed Medicare and Medicaid audit, desk review and rate calculation services. He plays a key role in managing our disproportionate share hospital (DSH) audit contracts with the states of South Carolina, New Hampshire, Connecticut, Oregon, Tennessee, Rhode Island and West Virginia. In addition, he has provided litigation support for our state Medicaid clients' cost report appeals. He also has performed various cost report audit services for Carefirst of Maryland, the former Medicare fiscal intermediary. Most recently, he has been a key participant in health care litigation support.

John Kraft, *CPA*

Member (Partner)

EDUCATION

B.S., Accounting and Economics, Towson University

EXPERIENCE

29 years professional experience

CORE COMPETENCIES

health care auditing and accounting with an emphasis on Medicaid and Medicare reimbursement

health care consulting with an emphasis on fraud investigation and litigation support

RELEVANT EXPERIENCE

DSH Program Audits-States of Connecticut, Massachusetts, New Hampshire, Oregon, Rhode Island, Vermont, West Virginia, Tennessee and the District of Columbia (2010-present)

- Manages completion of DSH audits and related reports, oversees development of standard procedures and workpapers; manages audit teams and sets workload objectives and deadlines; advises clients on complex DSH issues.

Medicaid Cost Settlement Audits - States of Georgia, New Jersey and Vermont (2009-present)

- Manages and reviews field audits and desk reviews of Medicaid cost reports for hospitals, FQHCs and RHCs; manages tentative settlement and interim rate calculations; provides appeal and litigation support; oversees development of standard workpapers, procedures and workload objectives.

State of South Carolina - DSH Program and Hospital Cost Settlements (2006-present)

- Manages and reviews field audits and desk reviews of hospital Medicare cost reports and DSH statistical data. Key participant in developing DSH and Medicaid cost settlement audit and desk review programs and engagement planning guides. Developed Microsoft Excel spreadsheets to calculate Medicaid cost settlements, and to summarize hospital uncompensated care costs, hospital-specific DSH payment limits and DSH qualification criteria. Experienced with HFS Medicare cost reporting software.

U.S. Department of Justice (DOJ) (1999-present)

- Provides litigation support services for healthcare fraud investigations. Analyzes and researches complex reimbursement issues and provides support for damage calculations. Entities investigated include hospitals, clinics, pharmacies, medical transcription agencies, durable medical equipment suppliers, among others. Experienced with Microsoft Access in developing and analyzing large financial and statistical databases. Provides assistance with

witness depositions including development of questioning strategy, analysis of witness testimony and preparation of exhibits. Experienced with maintaining and managing large inventories of case documents.

State of Maryland Department of Health and Mental Hygiene - Medicaid Program (1986-2006)

- Managed and reviewed field audits and desk review verifications of hospitals, ICF/MRs, residential treatment centers, alcohol/drug treatment centers, home health agencies, federally qualified health centers and nursing homes. Established departmental objectives and managed the workload of a large staff of audit professionals. Developed detailed audit, desk review and interim rate calculation programs and engagement planning guides for a number of provider types. Monitored Medicare and Medicaid regulatory environment and updated programs and procedures. Reviewed TEFRA target rate adjustment requests for Maryland Medicaid providers.

State of Maryland Department of Health and Mental Hygiene - Medicaid Program (1993-2011)

- Provided litigation support services for Medicaid cost report appeals. Analyzes appeal issues, prepared hearing exhibits, provided hearing testimony and assisted with settlement negotiations. Testified as expert witness in healthcare accounting and Medicare and Medicaid reimbursement before the state of Maryland Office of Administrative Hearings. Researched and prepared position papers for presentation to the state of Maryland Hospital Appeal Board.

Centers for Medicare & Medicaid Services (CMS) (1990, 1997-1999)

- Reviewed and evaluated financial audit work of the Tennessee, Massachusetts and Pennsylvania state Medicaid programs in conjunction with CFO Act.
- Key participant in the State Performance Evaluation and Comprehensive Test of Reimbursement Under Medicaid (SPECTRUM) of the state of New York for CMS.

PRESENTATIONS

”Disproportionate Share Hospital Auditing,” State of Massachusetts Medicaid and Hospital Personnel
”Disproportionate Share Hospital Auditing,” State of Rhode Island Medicaid and Hospital Personnel

AFFILIATIONS

American Health Lawyers Association
American Institute of Certified Public Accountants
Association of Government Accountants
Maryland Association of Certified Public Accountants

John Kraft CPE (Yellow Book) 2013-present			
Program	Completion Date	Sponsor Name	Credits
Identifying Fraudulent Financial Transactions: A Framework for Detection	11/15/2015	AICPA	1
Annual Accounting and Auditing Workshop: FASB Accounting Standard Updates	11/8/2015	AICPA	2
4725J Ethics and Professional Conduct for Vermont CPAs	11/3/2015	Professional Education Services, LD	4
Audit Sampling: Substantive Audit Sampling - An Introduction	11/1/2015	AICPA	1
Audit Sampling: Attribute Sampling for Tests of Controls	11/1/2015	AICPA	1.5
Audit Sampling: Monetary Unit Sampling	10/25/2015	AICPA	1
Audit Sampling: Classical Variables Sampling Techniques; Selecting a Representative Sample; Questions and Answers	10/25/2015	AICPA	1.5
Financial Statement Analysis: How to Conduct an Analysis, Users of Financial Statements, Case Study, and Forecasting Bankruptcy	10/18/2015	AICPA	1
Audit Sampling: Introduction to Basic Sampling Concepts and Terms	10/18/2015	AICPA	1
Identity Theft Preventing, Detecting and Investigating Identity Theft	10/4/2015	AICPA	2
Audit Workpapers: Conducting the Review; Typical Shortcomings	10/4/2015	AICPA	1
Audit Workpapers: Basics	10/4/2015	AICPA	1
Governmental Accounting and Reporting: Preparing the Government-Wide Financial Statements, Footnote Disclosures and Other Information	9/27/2015	AICPA	2
Governmental Accounting and Reporting: Foundations and Budgetary Accounting	9/27/2015	AICPA	1
Ethics: Megatron Corp. - You are the Corporate Controller/AA&C LLP - You are a Member of the Practice Development Committee	5/8/2015	AICPA	2
Ethics: Pointer Electronics, Inc. You are the Engagement Quality Review (Concurring) Partner	5/8/2015	AICPA	1
Institute on Medicare and Medicaid Payment Issues 2015	3/27/2015	American Health Lawyers Association	16
2015 South Carolina Disproportionate Share Update	2/13/2015	South Carolina Hospital Association	5.5
2014 Governmental and Not-for-Profit Annual Update: Emerging Issues Affecting Not-for-Profit Entities	12/14/2014	AICPA	1.5
Frequent Frauds Found in Governments and Not-for-Profits: Interim Financial Reporting; Grant Expense Allocations	12/14/2014	AICPA	1

2014 Governmental and Not-for-Profit Annual Update: FASB Activities	12/7/2014	AICPA	2.5
2014 Governmental and Not-for-Profit Annual Update: AICPA Activities	11/30/2014	AICPA	2
2014 Governmental and Not-for-Profit Annual Update: GASB Activities	11/22/2014	AICPA	5
2014 Governmental and Not-for-Profit Annual Update: Federal Government Activities	11/15/2014	AICPA	2.5
Institute on Medicare and Medicaid Payment Issues FY2014	3/28/2014	AHLA	20
Quality Control Monitoring	11/6/2013	Myers and Stauffer LC	1
Audit/Attest Training	5/24/2013	Myers and Stauffer LC	13.5
Real-World Business Ethics For Auditors: How Will You React?	5/6/2013	AICPA	5
2013 Institute on Medicare And Medicaid Payment Issues	3/22/2013	AHLA	17
DSH Payment Examination Update	2/5/2013	Myers and Stauffer LC	7.5
Credits Per Year: 2013 - 44 credits, 2014- 34.5 credits, 2015 – 45.5 credits		**Total Credits**	**124**

DIANE KOVAR, CPA

Ms. Kovar has over 17 years of experience with Myers and Stauffer working on health care-related audits, fraud investigations, and litigation support services. In addition to being the project manager for West Virginia, she has managed DSH audits in Oregon, South Carolina and Connecticut. She has also worked on the DSH engagements in Rhode Island and New Hampshire. Outside of DSH, she has worked on health care engagements with the Maryland Department of Health and Mental Hygiene and CMS. Her relevant experience includes:

Diane Kovar, *CPA*

Senior Manager

EDUCATION

B.S., Accounting and Economics, Pennsylvania State University

EXPERIENCE

17 years professional experience

CORE COMPETENCIES

health care auditing with an emphasis on Medicare and Medicaid reimbursement

Medicaid DSH auditing

Medicaid DSH consulting

West Virginia Department of Health and Human Resources (2010-present)

- Project manager responsible for completion of DSH Audits for the State Fiscal Years 2005 through 2011.

Oregon Health Authority (2009-present)

- Project manager responsible for completion of DSH Audits for the State Fiscal Years 2005 through 2011
- Perform verifications of DSH claims data.

State of South Carolina - Department of Health and Human Services (2006-present)

- Perform verifications of DSH claims data submitted by hospitals to the state of South Carolina, Department of Health and Human Services in order to validate DSH payments made to the hospital providers.

State of Connecticut - Department of Social Services (2011-present)

- Perform verifications of DSH claims data submitted by hospitals to the state of Connecticut, Department of Social Services in order to validate DSH payments made to the hospital providers.

New Hampshire Department of Health and Human Services (2009-present)

- Perform verifications of DSH claims data.

Rhode Island Department of Human Resources (2010-present)

- Perform verifications of DSH claims data.

State of Maryland Department of Health and Mental Hygiene – Medicaid Program (2001-2006)

- Conducted desk reviews and field audits of federally qualified health centers, residential treatment centers, psychiatric hospitals, state facilities, and alcohol/drug treatment centers.

- Conducted Medicare focused reviews and desk reviews of hospitals, skilled nursing facilities, and rehabilitation facilities.

City of San Jose, California - Municipal Health Services Program (2001-2007)

- Performed audit of cost reports.

Centers for Medicare & Medicaid Services (CMS) (2000-present)

- Assisted in the planning, directing, and completing the CMS CFO audit (FY 2000-2004)
- Assisted in the planning, directing and completing the FY 2001 CMS accounts receivable engagement (AdminaStar Federal - Cincinnati, Ohio).
- Participated in a CMS SAS-70 of a Medicare contractor in FY 2003 - FY 2006.
- Participated in a CMS accounts receivable agreed-upon procedures of a Medicare contractor (FY 2003-2005).
- Participated in a CMS Medicare Advantage and/or Prescription Drug bid plan audit (FY 2005 - FY 2006).

U.S. Department of Justice (2001-present)

- Provides litigation support.

AFFILIATIONS

American Institute of Certified Public Accountants
Maryland Association of Certified Public Accountants

Diane Kovar CPE (Yellow Book) 2013-present			
Program	**Completion Date**	**Sponsor Name**	**Credits**
Governmental Accounting and Reporting: Foundations and Budgetary Accounting	12/2/2015	AICPA	1
HFS T8 and Filing Tips for 6/30/2015 FYE Filers - Providers	11/12/2015	Health Financial: Systems	1
HFS\Toyon HCRIS Database	11/4/2015	Health Financial: Systems	1
HFS Management Reports (Providers)	11/3/2015	Health Financial: Systems	1
Real-World Ethics: Pointer Electronics, Inc. - You are the Engagement Quality Review Partner	7/29/2015	AICPA	1.5
Real-World Business Ethics - Megatron Corp. - You are the Corporate Controller	7/28/2015	AICPA	1
Real-World Business Ethics: Superlative Software Corp. - You are the CFO	7/24/2015	AICPA	1.5
Excel Macros - Advanced	6/8/2015	The Business Learning Institute	8
Institute on Medicare and Medicaid Payment Issues 2015	3/27/2015	American Health Lawyers Association	20
2015 South Carolina Disproportionate Share Update	2/13/2015	South Carolina Hospital Association	5.5
fx Engagement Training	6/9/2014	Myers and Stauffer LC	4.5
Institute on Medicare and Medicaid Payment Issues FY2014	3/28/2014	AHLA	21
DSH Applications	1/15/2014	Myers and Stauffer LC	5.5
Ethics Principles and Applications	6/19/2013	LearnLive	4
Audit/Attest Training	5/24/2013	Myers and Stauffer LC	14
Institute on Medicare And Medicaid Payment Issues 2013	3/22/2013	AHLA	23.5
DSH Payment Examination Update	2/5/2013	Myers and Stauffer LC	7.5
Credits Per Year: 2013 - 49 credits, 2014- 31 credits, 2015 - 41.5 credits		**Total Credits**	**121.5**

BETH FRANEY, CFE

Ms. Franey has worked in the Medicare and Medicaid audit and investigation arena for over seven years. She has performed and reviewed disproportionate share program desk reviews for Massachusetts, South Carolina, Tennessee, West Virginia, Connecticut, Vermont and Rhode Island and Medicaid cost settlements for South Carolina. She managed Rhode Island's disproportionate share program audits for State Fiscal Years 2009 -2011 and continues to oversee the audits for SFY 2012. She has also performed health care litigation support and fraud investigation in Federal health care programs. Her relevant experience includes:

Rhode Island Office of Health and Human Services (2009-present)

- Managed completion of disproportionate share hospital audits for the State fiscal years 2009 and 2011.

Disproportionate share program audits and hospital cost settlements - States of Massachusetts, South Carolina, Tennessee, West Virginia, Connecticut, Vermont and Rode Island (2008-present)

- Performs and reviews disproportionate share hospital audits and Medicaid cost settlements

United States Department of Justice (2008-present)

- Provide litigation support for health care fraud investigations requiring in depth review and analysis of financial records

Program Safeguard Contractor for the Centers for Medicare & Medicaid Services (CMS) (2006-2008)

- Developed potential investigations of Medicare Parts A and B fraud by analyzing patterns in claims data
- Reviewed and applied Medicare billings, policies and Local Coverage Determinations (LCD) to apply complex regulatory information to billing practices supported outside law enforcement to aid in Federal health care fraud investigations

AFFILIATIONS

Association of Certified Fraud Examiners

Beth Franey, *CFE*

Manager

EDUCATION

B.S., Sociology, Towson University

EXPERIENCE

10 years professional experience

CORE COMPETENCIES

health care auditing and accounting of complex Medicaid programs

fraud research in Federal health care programs

health care fraud investigation and litigation support

Beth Franey CPE (Yellow Book) 2013-present			
Program	Completion Date	Sponsor Name	Credits
Financial Statement Analysis: How to Conduct an Analysis, Users of Financial Statements, Case Study, and Forecasting Bankruptcy	4/7/2015	AICPA	1
Financial Statement Analysis: Firm Valuation, Causal Ratios, and Forecasting Sustainable Growth	4/7/2015	AICPA	1.5
Financial Statement Analysis: Effect Ratios, Analysis of Profitability, Case Studies	4/7/2015	AICPA	1.5
SEC Reporting: The Annual Report - Form 10-K (Part 1 of 2)	4/7/2015	AICPA	2.5
Common Frauds and Internal Controls: Revenue Cycles	4/5/2015	AICPA	2
Right the First Time: Special & Fundraising Events, Allocation of Costs - Fundraising, Audit Issues - Statement of Functional Expenses, Naming Rights, Recent Issues	4/5/2015	AICPA	1.5
Right the First Time: Contributed Services, Split-Interest Agreements, Assessing Internal Control Deficiencies, Capital Campaigns and Contributions	4/5/2015	AICPA	1
Right the First Time: Financial Statements, Net Asset Classifications, Consideration of Fraud, Promises to Give, Distinguishing Contribution from Exchange Transactions	4/5/2015	AICPA	1.5
Ethics: Superlative Software Corp. - You are the CEO	4/3/2015	AICPA	1.5
Ethics: You are the Amended Return Preparer and You are the Outside Tax Advisor	4/3/2015	AICPA	2
You are the Outside Attorney for the Controller and the Tax Return Preparer	4/3/2015	AICPA	2.5
Forensic Accounting Investigative Practices: Searching for Hidden Assets, Forensic Accounting Reports, and Expert Witness Testimony	3/24/2015	AICPA	1
Forensic Accounting Investigative Practices: Evidence in the Investigative Process and Conducting Interviews	3/24/2015	AICPA	1
Forensic Accounting Investigative Practices: Tools Used in Forensic Investigations	3/24/2015	AICPA	1
Forensic Accounting Investigative Practices: Forensic Accounting	3/24/2015	AICPA	1
Documenting Fieldwork: Audit Tests, Workpaper Critique, Improving Workpaper Critique	3/23/2015	AICPA	1
2014 Governmental and Not-for-Profit Annual Update: AICPA Activities	3/23/2015	AICPA	1.5
Documenting Fieldwork: Preparation, Maintenance, Types of Workpapers	3/23/2015	AICPA	1.5

2014 Governmental and Not-for-Profit Annual Update: FASB Activities	3/23/2015	AICPA	2
Studies on Audit Deficiencies: Engagement Letters, Yellow Book CPE, The GAO and Independence, Single Audit or Program-Specific Audit	3/20/2015	AICPA	1.5
Studies on Audit Deficiencies: Management Representation Letters, Yellow Book andA-133 Reporting Issues	3/20/2015	AICPA	1
Internal Fraud: Analytical Techniques	3/20/2015	AICPA	1.5
Internal Fraud: Responses to Fraud, Interview Techniques, and Seeking Criminal Prosecution	3/20/2015	AICPA	1.5
A&A Issues Facing CPAs: Non-exchange Transactions in Government; NPO Accounting for Special Events	3/19/2015	AICPA	2
Government Auditing Standards: Standards for Financial Audits and Attestation Engagements	3/19/2015	AICPA	2
Government Auditing Standards: Fieldwork and Reporting Standards for Performance Audits	3/19/2015	AICPA	2
Identifying Fraudulent Financial Transactions: An Introduction to Financial Statement Fraud, The Profession's Focus on Financial Statement Fraud	3/19/2015	AICPA	2
Identifying Fraudulent Financial Transactions: Inadequate Disclosure Fraud, Fraud Prevention	3/19/2015	AICPA	2
Identity Theft: Finding Identifying Information on the Internet, Investigating Identity Theft, and Detecting and Preventing Identity Theft	3/19/2015	AICPA	2
Ethics: Megatron Corp. - You Are the Corporate Controller/AA&C LLP - You Are a Member of the Practice Development Committee	3/18/2015	AICPA	2
Frequent Frauds Found in Governments and Not-for-Profits: Personnel Fraud; Fictitious Employees; Overtime Fraud	3/18/2015	AICPA	1
Frequent Frauds Found in Governments and Not-for-Profits: Misuse of Assets	3/18/2015	AICPA	1
Frequent Frauds Found in Governments and Not-for-Profits: Management Override; Bribes and Kickbacks	3/18/2015	AICPA	1
Frequent Frauds Found in Governments and Not-for-Profits: Pledges and Contributions; Procurement Cards	3/18/2015	AICPA	1
Frequent Frauds Found in Governments and Not-for-Profits: Interim Financial Reporting; Grant Expense Allocations	3/18/2015	AICPA	1
Frequent Frauds Found in Governments and Not-for-Profits: Misappropriation of Benefits; Off-site and Out of Sight	3/18/2015	AICPA	1
Ethical Theory for Fraud Examiners (2014)	11/26/2014	ACFE	2
Institute on Medicare and Medicaid Payment Issues FY2014	3/28/2014	AHLA	21

Ethical Issues for Fraud Examiners	10/10/2013	ACFE	2
Five Fraud Magazine CPE Quizzes	10/4/2013	ACFE	10
Audit/Attest Training	5/24/2013	Myers and Stauffer LC	14
Institute on Medicare And Medicaid Payment Issues 2013	3/22/2013	AHLA	25.5
Credits Per Year: 2013 – 51.5 credits, 2014- 23 credits, 2015 - 57 credits		**Total Credits**	**131.5**

ROBERT HICKS, CPA

Mr. Hicks provides consulting and public accounting services to state Medicaid agencies addressing health care reimbursement issues. Mr. Hicks leads various Medicare/Medicaid accounting, auditing, rate setting, and consulting engagements.

Mr. Hicks is responsible for working with clients to set up various audit and consulting engagements. His duties include setting up the initial project requirements, communicating with the clients, ensuring adequate staffing, quality assurance, training, and supervisory reviews. His relevant experience includes:

Disproportionate Share Hospital Audits
Mr. Hicks serves as the lead for several of the firm's DSH audit contracts. He has been involved with the Medicaid DSH audits from the beginning of the first audits for 2005. He has established procedures and protocol for completing the DSH audits in accordance with federal regulations published in the December 19, 2008, Federal Register. Mr. Hicks has conducted Medicaid DSH audit training sessions for the Florida, Kansas, Louisiana, Missouri, New Jersey, North Dakota, and Kentucky Medicaid programs to educate hospital providers on the new federal DSH audit regulation.

Mr. Hicks has also worked with CMS on their audit of the state of Missouri's DSH audit report. He was actively involved in meeting with CMS officials to explain and assist in their review of the submitted DSH audit.

Mr. Hicks continues to regularly monitor and comment on all proposed DSH audit regulations and policy. He currently oversees the DSH audits for Missouri, Florida, New Jersey and Louisiana in addition to assisting on audits and quality reviews of various other states.

DSH Program Data Collection, Payment Calculation and Consulting Services
Mr. Hicks oversees the Kansas DSH calculations and the Louisiana non-rural community hospital DSH calculations. His duties on both projects include supervising staff in the collection of cost report data, claims data, and uninsured data for use in the calculation of DSH payments. He also reviews the actual calculations based on the state plan and produces final payment notifications to all eligible hospitals.

Beyond the actual DSH payment calculations, Mr. Hicks consults with states on their state plan amendments and assists in fiscal impact modeling as needed. Support also includes assisting in the interpretation of the DSH rules and meetings with the hospital associations as needed.

Robert Hicks, *CPA*
Member (Partner)

EDUCATION
B.S., Accounting, University of Missouri at Kansas City

EXPERIENCE
19 years professional experience

CORE COMPETENCIES
cost report auditing
Medicaid DSH auditing and consulting
nursing facility case mix rate setting
cost report development
expert witness
develops course curriculum and conducts training for department personnel, providers and Myers and Stauffer project teams

Currently Mr. Hicks is serving as an expert witness for two states in relation to hospital reimbursement rates and hospital DSH payment calculations.

Cost Report Audits and Settlements
Mr. Hicks has significant cost report auditing and reimbursement experience including 18 years performing audits and desk reviews of Medicare and Medicaid cost reports.

Mr. Hicks supervises nursing facility desk reviews, focused audits, and field audits for New Jersey Medicaid and hospital desk reviews and field audits for Florida Medicaid. His involvement includes supervising staff auditors, participating in on-site audits, and performing supervisor reviews of audits.

In 2011, Mr. Hicks supervised hospital desk reviews, focused audits, and field audits for North Carolina Medicaid. His involvement includes supervising staff auditors, participating in on-site audits, and performing supervisor reviews of audits.

Mr. Hicks has assisted Louisiana Medicaid in the design of their nursing facility, adult day health care, and intermediate care facility cost reports. In addition, Mr. Hicks served as a consultant to the Medicaid program on audit issues related to their nursing facilities and home and community based services.

PRESENTATIONS
"DSH Audits," Missouri, Kentucky, North Dakota, 2009-2013.

"DSH Audit Update," HFMA, 2014.

"DSH Update," Louisiana Hospitals, Baton Rouge, Louisiana, 2013.

"DSH Data Collection," Louisiana Rural Hospital Coalition, Baton Rouge, Louisiana, 2010.

"DSH Update," Missouri Hospitals, Webinar, 2013.

"DSH Audits," Missouri, Florida, Louisiana, New Jersey and Kentucky, 2014.

"2552-10 Medicare Cost Report," Myers and Stauffer Training Workshop, Baltimore, Maryland, 2011.

AFFILIATIONS
American Institute of Certified Public Accountants
Missouri Society of Certified Public Accountants

Robert Hicks CPE (Yellow Book) 2013-present			
Program	**Completion Date**	**Sponsor Name**	**Credits**
Managed Care Training for SFY 2014	10/29/2015	Myers and Stauffer LC	14.5
Professional Ethics: The AICPA's Comprehensive Course	8/31/2015	AICPA	8.5
Critical Issues Facing Accounting Professionals and Public Practitioners in 2015	5/12/2015	Western CPE	6
World's Liveliest Accounting Update 2015	5/11/2015	Western CPE	6
Minimizing Audit Supervision and Review Time	12/16/2014	Western CPE	3
New Jersey Law and Ethics Webinar	11/25/2014	NJCPA	4
Florida Medicaid Hospital Cost Reporting / Rate-Setting Training	7/10/2014	Myers and Stauffer LC	2
Florida Medicaid Hospital Cost Reporting / Rate-Setting Training (teaching credit)	7/10/2014	Myers and Stauffer LC	7.5
Nursing Facility Rate Setting	5/7/2014	Myers and Stauffer LC	11
Latest Developments in Government and Nonprofit Accounting and Auditing 2013	12/4/2013	Surgent McCoy	8
Social Security and Medicare (WCL5-KC)	12/3/2013	MSCPA	4
AUDIT/ATTEST TRAINING	5/24/2013	Myers and Stauffer LC	14
DSH Examination Update	2/5/2013	Myers and Stauffer LC	4
DSH Payment Examination Update	2/5/2013	Myers and Stauffer LC	7.5
Credits Per Year: 2013 – 37.5 credits, 2014- 27.5 credits, 2015 - 35 credits		**Total Credits**	**100**

Appendix C: Hospital Schedule

State of West Virginia
Schedule of Annual Reporting Requirements (table)
For the Year Ended June 30, 2013

Definition of Uncompensated Care: The definition of uncompensated care was based on guidance published by CMS in the 73 Fed. Reg. 77904 dated December 19, 2008 and the 79 Fed Reg. 71679 dated December 3, 2014. The calculated uncompensated care costs (UCC) represent the net uncompensated costs of providing inpatient and outpatient hospital services to Medicaid eligible individuals and individuals with no source of third party coverage for the inpatient and outpatient hospital services received. The UCC for these patient groups was calculated using Medicare cost reporting methods, and utilized the Medicare cost report, Medicaid Paid Claims Summaries, and Hospital-Provided Data. Total uncompensated care costs represents the net uncompensated care costs of providing inpatient and outpatient hospital services to patients that fall into one of the following Medicaid in-State and out-of-State payment categories: Fee-for-Service Medicaid primary, Fee-for-Service Crossovers, Managed Care Medicaid primary, Managed Care Medicaid Crossover, and Uninsured individuals with no source of third party coverage for the inpatient and outpatient hospital services received. The cost of services for each of these payment categories was calculated using the appropriate per diems or cost-to-charge ratios from each hospital's Medicare Cost Report. These costs were then reduced by the total payments received for the services provided, including any supplemental Medicaid payments and Section 1011 payments where applicable.

A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	L
Hospital Name	State Estimated Hospital-Specific DSH Limit	Medicaid I/P Utilization Rate	Low-Income Utilization Rate	State-Defined Eligibility Statistic	Regular IP/OP Medicaid FFS Rate Payments	IP/OP Medicaid MCO Payments	Supplemental / Enhanced IP/OP Medicaid Payments	Total Medicaid IP/OP Medicaid Payments (F+G+H)	Total Cost of Care - Medicaid IP/OP Services	Total Medicaid Uncompensated Care Costs (J-I)	Total IP/OP Indigent Care/Self-Pay Revenues	Total Applicable Section 1011 Payments	Total IP/OP Uninsured Cost of Care	Total Uninsured Uncompensated Care Costs (N-M-L)	Total Eligible Uncompensated Care Costs (K+O)	Total In-State DSH Payments Received	Total Out-of-State DSH Payments Received	Medicaid Provider Number	Medicare Provider Number	Total Hospital Cost
BECKLEY ARH	0.00%	0.00%			0	0	0	0	0	0	0	0	0	0	0	0	0			
BLUEFIELD REGIONAL MEDICAL CENTER	11.00%	0.00%			0	0	0	0	0	0	0	0	0	0	0	0	0			
BOONE MEMORIAL HOSPITAL	0.00%	0.00%			0	0	0	0	0	0	0	0	0	0	0	0	0			
BRAXTON COUNTY MEMORIAL HOSPITAL	0.00%	0.00%			0	0	0	0	0	0	0	0	0	0	0	0	0			
BROADDUS HOSPITAL	11.00%	0.00%			0	0	0	0	0	0	0	0	0	0	0	0	0			
CABELL-HUNTINGTON HOSPITAL	0.00%	0.00%			0	0	0	0	0	0	0	0	0	0	0	0	0			
CAMDEN-CLARK MEMORIAL HOSPITAL	0.00%	0.00%			0	0	0	0	0	0	0	0	0	0	0	0	0			
CHARLESTON AREA MEDICAL CENTER	11.00%	0.00%			0	0	0	0	0	0	0	0	0	0	0	0	0			
CAMC TEAYS VALLEY	11.00%	0.00%			0	0	0	0	0	0	0	0	0	0	0	0	0			
CITY HOSPITAL	0.00%	0.00%			0	0	0	0	0	0	0	0	0	0	0	0	0			
DAVIS MEMORIAL HOSPITAL	0.00%	0.00%			0	0	0	0	0	0	0	0	0	0	0	0	0			
EYE AND EAR CLINIC	11.00%	0.00%			0	0	0	0	0	0	0	0	0	0	0	0	0			
FAIRMONT GENERAL HOSPITAL	11.00%	0.00%			0	0	0	0	0	0	0	0	0	0	0	0	0			
GRAFTON CITY HOSPITAL	0.00%	0.00%			0	0	0	0	0	0	0	0	0	0	0	0	0			
GRANT MEMORIAL HOSPITAL	11.00%	0.00%			0	0	0	0	0	0	0	0	0	0	0	0	0			
GREENBRIER VALLEY MEDICAL CENTER	11.00%	0.00%			0	0	0	0	0	0	0	0	0	0	0	0	0			
HAMPSHIRE MEMORIAL HOSPITAL	0.00%	0.00%			0	0	0	0	0	0	0	0	0	0	0	0	0			
JACKSON GENERAL HOSPITAL	0.00%	0.00%			0	0	0	0	0	0	0	0	0	0	0	0	0			
JEFFERSON MEMORIAL HOSPITAL	11.00%	0.00%			0	0	0	0	0	0	0	0	0	0	0	0	0			
LOGAN REGIONAL MEDICAL CENTER	11.00%	0.00%			0	0	0	0	0	0	0	0	0	0	0	0	0			
MINNIE HAMILTON HEALTH CARE CENTER	0.00%	0.00%			0	0	0	0	0	0	0	0	0	0	0	0	0			
MONONGALIA GENERAL HOSPITAL	11.00%	0.00%			0	0	0	0	0	0	0	0	0	0	0	0	0			
MONTGOMERY GENERAL HOSPITAL	11.00%	0.00%			0	0	0	0	0	0	0	0	0	0	0	0	0			
MORGAN COUNTY WAR MEMORIAL HOSPITAL	0.00%	0.00%			0	0	0	0	0	0	0	0	0	0	0	0	0			
OHIO VALLEY GENERAL HOSPITAL	0.00%	0.00%			0	0	0	0	0	0	0	0	0	0	0	0	0			
PLATEAU MEDICAL CENTER	11.00%	0.00%			0	0	0	0	0	0	0	0	0	0	0	0	0			
PLEASANT VALLEY HOSPITAL	0.00%	0.00%			0	0	0	0	0	0	0	0	0	0	0	0	0			
POCAHONTAS MEMORIAL HOSPITAL	0.00%	0.00%			0	0	0	0	0	0	0	0	0	0	0	0	0			
POTOMAC VALLEY HOSPITAL OF WV	11.00%	0.00%			0	0	0	0	0	0	0	0	0	0	0	0	0			
PRESTON MEMORIAL HOSPITAL	11.00%	0.00%			0	0	0	0	0	0	0	0	0	0	0	0	0			
PRINCETON COMMUNITY HOSPITAL	0.00%	0.00%			0	0	0	0	0	0	0	0	0	0	0	0	0			
RALEIGH GENERAL HOSPITAL	0.00%	0.00%			0	0	0	0	0	0	0	0	0	0	0	0	0			
REYNOLDS MEMORIAL HOSPITAL	11.00%	0.00%			0	0	0	0	0	0	0	0	0	0	0	0	0			
ROANE GENERAL HOSPITAL	0.00%	0.00%			0	0	0	0	0	0	0	0	0	0	0	0	0			
SISTERSVILLE GENERAL HOSPITAL	0.00%	0.00%			0	0	0	0	0	0	0	0	0	0	0	0	0			
ST. FRANCIS HOSPITAL	11.00%	0.00%			0	0	0	0	0	0	0	0	0	0	0	0	0			
ST. JOSEPH'S HOSPITAL-BUCKHANNON	11.00%	0.00%			0	0	0	0	0	0	0	0	0	0	0	0	0			
ST. MARY'S MEDICAL CENTER, INC	0.00%	0.00%			0	0	0	0	0	0	0	0	0	0	0	0	0			
STONEWALL JACKSON MEMORIAL HOSPITAL	0.00%	0.00%			0	0	0	0	0	0	0	0	0	0	0	0	0			
SUMMERS COUNTY ARH	11.00%	0.00%			0	0	0	0	0	0	0	0	0	0	0	0	0			
SUMMERSVILLE REGIONAL MEMORIAL HOSPITAL	0.00%	0.00%			0	0	0	0	0	0	0	0	0	0	0	0	0			
THOMAS MEMORIAL HOSPITAL	0.00%	0.00%			0	0	0	0	0	0	0	0	0	0	0	0	0			
UNITED HOSPITAL CENTER, INC.	11.00%	0.00%			0	0	0	0	0	0	0	0	0	0	0	0	0			
WEBSTER COUNTY MEMORIAL HOSPITAL	11.00%	0.00%			0	0	0	0	0	0	0	0	0	0	0	0	0			
WEIRTON MEDICAL CENTER, INC.	0.00%	0.00%			0	0	0	0	0	0	0	0	0	0	0	0	0			
WELCH COMMUNITY HOSPITAL	0.00%	0.00%			0	0	0	0	0	0	0	0	0	0	0	0	0			
WEST VIRGINIA UNIVERSITY HOSPITALS	11.00%	0.00%			0	0	0	0	0	0	0	0	0	0	0	0	0			
WETZEL COUNTY HOSPITAL	0.00%	0.00%			0	0	0	0	0	0	0	0	0	0	0	0	0			
WHEELING HOSPITAL, INC.	0.00%	0.00%			0	0	0	0	0	0	0	0	0	0	0	0	0			
WILLIAMSON MEMORIAL HOSPITAL	0.00%	0.00%			0	0	0	0	0	0	0	0	0	0	0	0	0			
Institute for Mental Disease																				
HIGHLAND HOSPITAL	47.79%	46.02%			0	0	0	0	0	0	0	0	0	0	0	0	0			
MILDRED MITCHELL-BATEMAN HOSPITAL	11.41%	56.45%			0	0	0	0	0	0	0	0	0	0	0	0	0			
RIVER PARK HOSPITAL	21.76%	15.99%			0	0	0	0	0	0	0	0	0	0	0	0	0			
WILLIAM R. SHARPE JR. HOSPITAL	1.41%	70.03%			0	0	0	0	0	0	0	0	0	0	0	0	0			
Out-of-State DSH Hospitals																				
N/A																				

Appendix D: CMS Acceptance

COMMONWEALTH of VIRGINIA
Department of Medical Assistance Services

CYNTHIA B. JONES
DIRECTOR

600 EAST BROAD STREET
SUITE 1300
RICHMOND, VA 23219

November 30, 2015

Dear Sir/Madam:

I am writing on behalf of the Department of Medical Assistance Services (DMAS) to provide a professional confirmation regarding Myers and Stauffer LC's Disproportionate Share Hospital (DSH) audit work for the state of Virginia.

Myers and Stauffer (or its predecessor PHBV Partners/Clifton Gunderson) has served DMAS since 1993, performing DSH audit work since 2009. By my signature on this letter, I certify that the following DSH Audit Reports (prepared by Myers and Stauffer LC and/or its predecessor PHBV Partners/Clifton Gunderson) were accepted by the Centers for Medicare & Medicaid Services:

- SFY 2011
- SFY 2010
- SFY 2009

Please feel free to contact me if you have any questions at 804-225-4587 or by e-mail at mary.hairston@dmas.virginia.gov.

Sincerely,

Mary Hairston
Healthcare Reimbursement Manager
Provider Reimbursement Division
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, VA 23219

Fax: 804 371 8892

STATE OF NEW HAMPSHIRE
DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF MEDICAID BUSINESS AND POLICY

129 PLEASANT STREET, CONCORD, NH 03301-3857
603-271-9422 1-800-852-3345 Ext. 9422
Fax: 603-271-8431 TDD Access: 1-800-735-2964 www.dhhs.nh.gov

Nicholas A. Toumpas
Commissioner

Kathleen A. Dunn
Associate Commissioner

November 25, 2015

Dear Sir/Madam:

I am writing on behalf of the Department of Health and Human Services to provide a professional confirmation regarding Myers and Stauffer LC's Disproportionate Share Hospital (DSH) audit work for the state of New Hampshire.

Myers and Stauffer has served Department of Health and Human Services since September 9, 2009. By my signature on this letter, I certify that the following DSH Audit Reports (prepared by Myers and Stauffer LC and/or its predecessor PHBV Partners/Clifton Gunderson) were accepted by the Centers for Medicare & Medicaid Services:

• SFY 2011	• SFY 2007
• SFY 2010	• SFY 2006
• SFY 2009	• SFY 2005
• SFY 2008	

Please feel free to contact me if you have any questions at 603-271-9530 or Daniel.T.Rinden@DHHS.State.NH.US.

Sincerely,

Daniel Rinden
Administrator

The Department of Health and Human Services' Mission is to join communities and families in providing opportunities for citizens to achieve health and independence.

STATE OF CONNECTICUT
DEPARTMENT OF SOCIAL SERVICES

December 2, 2015

Dear Sir/Madam:

I am writing on behalf of the Department of Social Services to provide a professional confirmation regarding Myers and Stauffer LC's Disproportionate Share Hospital (DSH) audit work for the state of Connecticut.

Myers and Stauffer has served the Department of Social Services since 2011. By my signature on this letter, I certify that the following DSH Audit Reports (prepared by Myers and Stauffer LC and/or its predecessor PHBV Partners/Clifton Gunderson) were accepted by the Centers for Medicare & Medicaid Services:

- FFY 2011
- FFY 2010
- FFY 2009
- FFY 2008

Please feel free to contact me if you have any questions at Christopher.Lavigne@ct.gov or 860-424-5719.

Sincerely,

Christopher LaVigne
Director, Reimbursement and Certificate of Need Unit

55 FARMINGTON AVENUE • HARTFORD, CONNECTICUT 06105-3730
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Appendix E: DSH Survey Tool

State of West Virginia
Disproportionate Share Hospital (DSH) Examination Survey Part I
For State DSH Year 2013

DSH Version 5.12 1/7/2015

A. General DSH Year Information

	Begin	End
1. DSH Year:	07/01/2012	06/30/2013

2. Select Your Facility from the Drop-Down Menu Provided: SELECT HOSPITAL NAME

Identification of cost reports needed to cover the DSH Year:

	Cost Report Begin Date(s)	Cost Report End Date(s)
3. Cost Report Year 1		
4. Cost Report Year 2 (if applicable)		
5. Cost Report Year 3 (if applicable)		

	Data
6. Medicaid Provider Number:	M'Caid #
7. Medicaid Subprovider Number 1 (Psychiatric or Rehab):	M'caid Sub 1 #
8. Medicaid Subprovider Number 2 (Psychiatric or Rehab):	M'caid Sub 2 #
9. Medicare Provider Number:	M'care #

B. DSH OB Qualifying Information

Questions 1-3, below, should be answered in the accordance with Sec. 1923(d) of the Social Security Act.

During the DSH Year 07/01/2012 - 06/30/2013:

	Answer
1. Did the hospital have at least two obstetricians who had staff privileges at the hospital that agreed to provide obstetric services to Medicaid-eligible individuals during the DSH year? (In the case of a hospital located in a rural area, the term "obstetrician" includes any physician with staff privileges at the hospital to perform nonemergency obstetric procedures.)	
2. Was the hospital exempt from the requirement listed under #1 above because the hospital's inpatients are predominantly under 18 years of age?	
3. Was the hospital exempt from the requirement listed under #1 above because it did not offer non-emergency obstetric services to the general population when federal Medicaid DSH regulations were enacted on December 22, 1987?	

C. Disclosure of Other Medicaid Payments Received:

1. **Medicaid Supplemental Payments for DSH Year 07/01/2012 - 06/30/2013**
(Should include UPL and Non-Claim Specific payments paid based on the state fiscal year. However, DSH payments should NOT be included.)

State of West Virginia
Disproportionate Share Hospital (DSH) Examination Survey Part I
For State DSH Year 2013

Certification:

	Answer
1. **Was your hospital allowed to retain 100% of the DSH payment it received for this DSH year? Matching the federal share with an IGT/CPE is not a basis for answering this question "no". If your hospital was not allowed to retain 100% of its DSH payments, please explain what circumstances were present that prevented the hospital from retaining its payments.**	

Explanation for "No" answers: _____

The following certification is to be completed by the hospital's CEO or CFO:

I hereby certify that the information in Sections A, B, C, D, E, F, G, H, I, J, K and L of the DSH Survey files are true and accurate to the best of our ability, and supported by the financial and other records of the hospital. I understand that this information will be used to determine the Medicaid program's compliance with federal Disproportionate Share Hospital (DSH) eligibility and payments provisions. Detailed support exists for all amounts reported in the survey. These records will be retained for a period of not less than 5 years following the due date of the survey, and will be made available for inspection when requested.

Hospital CEO or CFO Signature _____ Title _____ Date _____

Hospital CEO or CFO Printed Name _____ Hospital CEO or CFO Telephone Number _____ Hospital CEO or CFO E-Mail _____

Contact information for individuals authorized to respond to inquiries related to this survey:

Hospital Contact:		**Outside Preparer:**	
Name		Name	
Title		Title	
Telephone Number		Firm Name	
E-Mail Address		Telephone Number	
Mailing Street Address		E-Mail Address	
Mailing City, State, Zip			

State of West Virginia
Disproportionate Share Hospital (DSH) Examination Survey Part I
For State DSH Year 2012

DSH Survey Submission Checklist

Please indicate with an "X" each item included or a "N/A" if not included. Consider a separate cover letter to explain any "N/A" answers to avoid additional documentation requests.

	1. Electronic copy of the DSH Survey Part I - DSH Year Data - 07/01/2012 - 06/30/2013
	2. Electronic copy of the DSH Survey Part II - Cost Report Data - Cost Report Year –
	3. N/A
	4. N/A
	5 (a). Electronic copy of Exhibit A - Uninsured Charges / Days - Must be in Excel (.xls or .xlsx) or CSV (.csv) using either a TAB or | (pipe symbol above the ENTER key)
	5 (b). Description of logic used to compile Exhibit A. Include a copy of all financial classes and payor plan codes utilized during the cost report period and a description of which codes were included or excluded if applicable.
	6 (a). Electronic copy of Exhibit B - Self-Pay Payments - Must be in Excel (.xls or .xlsx) or CSV (.csv) using either a TAB or | (pipe symbol above the ENTER key)
	6 (b). Description of logic used to compile Exhibit B. Include a copy of all transaction codes utilized to post payments during the cost reporting period and a description of which codes were included or excluded if applicable.
	7 (a). Electronic copy of Exhibit C for hospital-generated data (includes Medicaid eligibles, Medicare crossover, Medicaid MCO, or Out-Of-State Medicaid data that isn't supported by a state-provided or MCO-provided report) - Must be in Excel (.xls or .xlsx) or CSV (.csv) using either a TAB or | (pipe symbol above the ENTER key)
	7 (b). Description of logic used to compile each Exhibit C. Include a copy of all financial classes and payor plan codes utilized during the cost report period and a description of which codes were included or excluded if applicable.
	8. Copies of all out-of-state Medicaid fee-for-service PS&Rs (Remittance Advice Summary or Paid Claims Summary including crossovers)
	9. Copies of all out-of-state Medicaid managed care PS&Rs (Remittance Advice Summary or Paid Claims Summary including crossovers)
	10. Copies of in-state Medicaid managed care PS&Rs (Remittance Advice Summary or Paid Claims Summary including crossovers)
	11. Support for Section 1011 (Undocumented Alien) payments if not applied at patient level in Exhibit B
	12. Documentation supporting out-of-state DSH payments received. - Examples may include remittances, detailed general ledgers, or add-on rates
	13. Financial statements or other documentation to support total charity care charges and subsidies reported on Section F of DSH Survey Part II
	14. Revenue code cross-walk used to prepare cost report, or supporting grouping schedules
	15a. A detailed working trial balance used to prepare each cost report (including revenues)
	15b. A detailed revenue working trial balance by payor/contract. The schedule should show charges, contractual adjustments, and revenues by payor plan and contract (e.g., Medicare, each Medicaid agency payor, each Medicaid Managed care contract)
	16. Electronic copy of all cost reports used to prepare each DSH Survey Part II.
	17. Documentation supporting cost report payments calculated for Medicaid/Medicare cross-overs (dual eligible cost report payments)

This information contains protected health information (PHI), and as such, should be transferred via the Myers and Stauffer LC secure FTP site. If unable to transfer via the secure FTP site, send on an encrypted and password protected CD/DVD via U.S. mail to:

Myers and Stauffer LC
ATTN: WV DSH Examinations
400 Redland Court, Suite 300
Owings Mills, MD 21117
Fax: (410) 356-0188
Phone: (800) 505-1698
E-Mail: dkovar@mslc.com

Please Call Myers and Stauffer if you have any questions on completing the DSH survey.

5.12 Property of Myers and Stauffer LC Page 1

State of West Virginia
Disproportionate Share Hospital (DSH) Examination Survey Part II

Version 7.10

DSH Version 7.10 3/20/2015

D. General Cost Report Year Information

The following information is provided based on the information we received from the state. Please review this information for items 4 through 8 and select "Yes" or "No" to either agree or disagree with the accuracy of the information. If you disagree with one of these items, please provide the correct information along with supporting documentation when you submit your survey.

1. Select Your Facility from the Drop-Down Menu Provided.	SELECT HOSPITAL NAME			
2. Select Cost Report Year Covered by this Survey (enter "X"):	X			
3. Status of Cost Report Used for this Survey (Should be audited if available):				
3a. Date CMS processed the HCRIS file into the HCRIS database:				

	Data	Correct?	If Incorrect, Proper Information
4. Hospital Name:	SELECT HOSPITAL NAME		
5. Medicaid Provider Number:	M'Caid #		
6. Medicaid Subprovider Number 1 (Psychiatric or Rehab):	M'caid Sub 1 #		
7. Medicaid Subprovider Number 2 (Psychiatric or Rehab):	M'caid Sub 2 #		
8. Medicare Provider Number:	M'care #		

Out-of-State Medicaid Provider Number. List all states where you had a Medicaid provider agreement during the cost report year:

	State Name	Provider No.
9. State Name & Number		
10. State Name & Number		
11. State Name & Number		
12. State Name & Number		
13. State Name & Number		
14. State Name & Number		
15. State Name & Number		

(List additional states on a separate attachment)

E. Disclosure of Medicaid / Uninsured Payments Received: (-)

1. Section 1011 Payment Related to Hospital Services Included in Exhibits B & B-1 (See Note 1)			
2. Section 1011 Payment Related to Inpatient Hospital Services NOT Included in Exhibits B & B-1 (See Note 1)			
3. Section 1011 Payment Related to Outpatient Hospital Services NOT Included in Exhibits B & B-1 (See Note 1)			
4. **Total Section 1011 Payments Related to Hospital Services (See Note 1)**			$-
5. Section 1011 Payment Related to Non-Hospital Services Included in Exhibits B & B-1 (See Note 1)			
6. Section 1011 Payment Related to Non-Hospital Services NOT Included in Exhibits B & B-1 (See Note 1)			
7. **Total Section 1011 Payments Related to Non-Hospital Services (See Note 1)**			$-
8. **Out-of-State DSH Payments (See Note 2)**			

	Inpatient	Outpatient	Total
9. Total Cash Basis Patient Payments from Uninsured (On Exhibit B)			$-
10. Total Cash Basis Patient Payments from All Other Patients (On Exhibit B)			$-
11. Total Cash Basis Patient Payments Reported on Exhibit B (Agrees to Column (N) on Exhibit B)	$-	$-	$-
12. Uninsured Cash Basis Patient Payments as a Percentage of Total Cash Basis Patient Payments:	0.00%	0.00%	0.00%

Note 1: Subtitle B - Miscellaneous Provision, Section 1011 of the Medicare Prescription Drug Improvement and Modernization Act of 2003 provides federal reimbursement for emergency health services furnished to undocumented aliens. If your hospital received these funds during any cost report year covered by the survey, they must be reported here. If you can document that a portion of the payment received is related to non-hospital services (physician or ambulance services), report that amount in the section titled "Section 1011 Payments Related to Non-Hospital Services." Otherwise report 100 percent of the funds you received in the section related to hospital services.

Note 2: Report any DSH payments your hospital received from a state Medicaid program (other than your home state). In-state DSH payments will be reported directly from the Medicaid program and should not be included in this section of the survey.

State of West Virginia
Disproportionate Share Hospital (DSH) Examination Survey Part II

Version 7.10

F. MIUR / LIUR Qualifying Data from the Cost Report (-)

F-1. Total Hospital Days Used in Medicaid Inpatient Utilization Ratio (MIUR)

1. Total Hospital Days Per Cost Report Excluding Swing-Bed (C/R, W/S S-3, Pt. I, Col. 8, Sum of Lns. 14, 16, 17, 18.xx less lines 5 & 6) - (See Note in Section F-3, below)

F-2. Cash Subsidies for Patient Services Received from State or Local Governments and Charity Care Charges (Used in Low-Income Utilization Ratio (LIUR) Calculation):

2. Inpatient Hospital Subsidies
3. Outpatient Hospital Subsidies
4. Unspecified I/P and O/P Hospital Subsidies
5. Total Hospital Subsidies $ -

6. Inpatient Charity Care Charges
7. Outpatient Charity Care Charges
8. Total Charity Care Charges $ -

F-3. Calculation of Net Hospital Revenue from Patient Services (Used for LIUR) (W/S G-2 and G-3 of Cost Report)

NOTE: All data in this section must be verified by the hospital. If data is already present in this section, it was completed using CMS HCRIS cost report data. If the hospital has a more recent version of the cost report, the data should be updated to the hospital's version of the cost report. Formulas can be overwritten as needed with actual data.

	Total Patient Revenues (Charges)			Contractual Adjustments (formulas below can be overwritten if amounts are known)			
	Inpatient Hospital	Outpatient Hospital	Non-Hospital	Inpatient Hospital	Outpatient Hospital	Non-Hospital	Net Hospital Revenue
9. Hospital	$0.00			$ -	$ -	$ -	$ -
10. Subprovider I (Psych or Rehab)	$0.00			$ -	$ -	$ -	$ -
11. Subprovider II (Psych or Rehab)	$0.00			$ -	$ -	$ -	$ -
12. Swing Bed - SNF			$0.00			$ -	
13. Swing Bed - NF			$0.00			$ -	
14. Skilled Nursing Facility			$0.00			$ -	
15. Nursing Facility			$0.00			$ -	
16. Other Long-Term Care			$0.00			$ -	
17. Ancillary Services	$0.00	$0.00		$ -	$ -	$ -	$ -
18. Outpatient Services		$0.00			$ -	$ -	$ -
19. Home Health Agency			$0.00			$ -	
20. Ambulance			$0.00			$ -	
21. Outpatient Rehab Providers			$0.00	$ -	$ -	$ -	$ -
22. ASC	$0.00	$0.00		$ -	$ -	$ -	$ -
23. Hospice			$0.00			$ -	
24. Other	$0.00	$0.00	$0.00	$ -	$ -	$ -	$ -
25. Total	$ -	$ -	$ -	$ -	$ -	$ -	$ -
26. Total Hospital and Non Hospital		Total from Above	$ -		Total from Above	$ -	

27. Total Per Cost Report		Total Patient Revenues (G-3 Line 1)	-	Total Contractual Adj. (G-3 Line 2)	-
28. Increase worksheet G-3, Line 2 for Bad Debts NOT INCLUDED on worksheet G-3, Line 2 (impact is a decrease in net patient revenue)					+
29. Increase worksheet G-3, Line 2 for Charity Care Write-Offs NOT INCLUDED on worksheet G-3, Line 2 (impact is a decrease in net patient revenue)					+
30. Increase worksheet G-3, Line 2 to reverse offset of Medicaid DSH Revenue INCLUDED on worksheet G-3, Line 2 (impact is a decrease in net patient revenue)					+
31. Increase worksheet G-3, Line 2 to reverse offset of State and Local Patient Care Cash Subsidies INCLUDED on worksheet G-3, Line 2 (impact is a decrease in net patient revenue)					+
32. Decrease worksheet G-3, Line 2 to remove Medicaid Provider Taxes INCLUDED on worksheet G-3, Line 2 (impact is an increase in net patient revenue)					-
33. Blank Recon Line OR "Decrease worksheet G-3, Line 2 to remove Charity Care Charges related to insured patients INCLUDED on worksheet G-3, Line 2 (impact is an increase in net patient revenue)"					-
34. Adjusted Contractual Adjustments					-
35. Unreconciled Difference		Unreconciled Difference (Should be $0)	$ -	Unreconciled Difference (Should be $0)	$ -

G. Cost Report - Cost / Days / Charges

Cost Report Year (-) | SELECT HOSPITAL NAME

NOTE: All data in this section must be verified by the hospital. If data is already present in this section, it was completed using CMS HCRIS cost report data. If the hospital has a more recent version of the cost report, the data should be updated to the hospital's version of the cost report. Formulas can be overwritten as needed with actual data.

Line #	Cost Center Description	Total Allowable Cost	Intern & Resident Costs Removed on Cost Report *	RCE and Therapy Add-Back (If Applicable)		Provider Tax Assessment	Total Cost	I/P	O/P Charges	Total Charges	Medicaid Per Diem / Cost-to-Charge Ratios
		Cost Report Worksheet B, Part I, Col. 26	*Cost Report Worksheet B, Part I, Col. 25 (Intern & Resident Offset ONLY)**	*Cost Report Worksheet C, Part I, Col 2 and Col. 4*	*Swing-Bed Carve Out - Cost Report Worksheet D-1, Part I, Line 25*	*Allocation of Provider Tax from Section L of the Survey Based on Total Cost*	*Calculated*	*Days - Cost Report W/S D-1, Pt. I, Line 2 for Adults & Peds; W/S D-1, Pt. 2, Lines 42-47 for others*			*Calculated Per Diem*
	Routine Cost Centers (list below):										
1	03000 ADULTS & PEDIATRICS	$ -	$ -	$ -	$0.00	$ -	$ -	-			$ -
2	03100 INTENSIVE CARE UNIT	$ -	$ -	$ -		$ -	$ -	-			$ -
3	03200 CORONARY CARE UNIT	$ -	$ -	$ -		$ -	$ -	-			$ -
4	03300 BURN INTENSIVE CARE UNIT	$ -	$ -	$ -		$ -	$ -	-			$ -
5	03400 SURGICAL INTENSIVE CARE UNIT	$ -	$ -	$ -		$ -	$ -	-			$ -
6	03500 OTHER SPECIAL CARE UNIT	$ -	$ -	$ -		$ -	$ -	-			$ -
7	04000 SUBPROVIDER I	$ -	$ -	$ -		$ -	$ -	-			$ -
8	04100 SUBPROVIDER II	$ -	$ -	$ -		$ -	$ -	-			$ -
9	04200 OTHER SUBPROVIDER	$ -	$ -	$ -		$ -	$ -	-			$ -
10	04300 NURSERY	$ -	$ -	$ -		$ -	$ -	-			$ -
11		$ -	$ -	$ -		$ -	$ -	-			$ -
12		$ -	$ -	$ -		$ -	$ -	-			$ -
13		$ -	$ -	$ -		$ -	$ -	-			$ -
14		$ -	$ -	$ -		$ -	$ -	-			$ -
15		$ -	$ -	$ -		$ -	$ -	-			$ -
16		$ -	$ -	$ -		$ -	$ -	-			$ -
17		$ -	$ -	$ -		$ -	$ -	-			$ -
18	Total Routine	$ -	$ -	$ -	$ -	$ -	$ -	-			
19	Weighted Average										$ -

		Hospital Observation Days - Cost Report W/S S-3, Pt. I, Line 28, Col. 8	*Subprovider I Observation Days - Cost Report W/S S-3, Pt. I, Line 28.01, Col. 8*	*Subprovider II Observation Days - Cost Report W/S S-3, Pt. I, Line 28.02, Col. 8*		*Calculated (Per Diems Above Multiplied by Days)*	*Inpatient Charges - Cost Report Worksheet C, Pt. I, Col. 6*	*Outpatient Charges - Cost Report Worksheet C, Pt. I, Col. 7*	*Total Charges - Cost Report Worksheet C, Pt. I, Col. 8*	*Medicaid Calculated Cost-to-Charge Ratio*
	Observation Data (Non-Distinct)									
20	092xx Observation (Non-Distinct)	-	-	-		$ -	$0.00	$0.00	$ -	-

State of West Virginia
Disproportionate Share Hospital (DSH) Examination Survey Part II

Version 7.10

G. Cost Report - Cost / Days / Charges

Cost Report Year (-) | SELECT HOSPITAL NAME

Line #	Cost Center Description	Total Allowable Cost	Intern & Resident Costs Removed on Cost Report *	RCE and Therapy Add-Back (If Applicable)		Provider Tax Assessment	Total Cost	I/P	O/P Charges	Total Charges	Medicaid Per Diem / Cost-to-Charge Ratios
		Cost Report Worksheet B, Part I, Col. 26	*Cost Report Worksheet B, Part I, Col. 25 (Intern & Resident Offset ONLY)**	*Cost Report Worksheet C, Part I, Col.2 and Col. 4*		*Allocation of Provider Tax from Section L of the Survey Based on Total Cost*	*Calculated*	*Inpatient Charges - Cost Report Worksheet C, Pt. I, Col. 6*	*Outpatient Charges - Cost Report Worksheet C, Pt. I, Col. 7*	*Total Charges - Cost Report Worksheet C, Pt. I, Col. 8*	*Medicaid Calculated Cost-to-Charge Ratio*
	Ancillary Cost Centers (from W/S C excluding Observation) (list below):										
21		$0.00	$ -	$0.00		$ -	$ -	$0.00	$0.00	$ -	-
22		$0.00	$ -	$0.00		$ -	$ -	$0.00	$0.00	$ -	-
23		$0.00	$ -	$0.00		$ -	$ -	$0.00	$0.00	$ -	-
24		$0.00	$ -	$0.00		$ -	$ -	$0.00	$0.00	$ -	-
25		$0.00	$ -	$0.00		$ -	$ -	$0.00	$0.00	$ -	-
26		$0.00	$ -	$0.00		$ -	$ -	$0.00	$0.00	$ -	-
27		$0.00	$ -	$0.00		$ -	$ -	$0.00	$0.00	$ -	-
28		$0.00	$ -	$0.00		$ -	$ -	$0.00	$0.00	$ -	-
29		$0.00	$ -	$0.00		$ -	$ -	$0.00	$0.00	$ -	-
30		$0.00	$ -	$0.00		$ -	$ -	$0.00	$0.00	$ -	-
31		$0.00	$ -	$0.00		$ -	$ -	$0.00	$0.00	$ -	-
32		$0.00	$ -	$0.00		$ -	$ -	$0.00	$0.00	$ -	-
33		$0.00	$ -	$0.00		$ -	$ -	$0.00	$0.00	$ -	-
34		$0.00	$ -	$0.00		$ -	$ -	$0.00	$0.00	$ -	-
35		$0.00	$ -	$0.00		$ -	$ -	$0.00	$0.00	$ -	-
36		$0.00	$ -	$0.00		$ -	$ -	$0.00	$0.00	$ -	-
37		$0.00	$ -	$0.00		$ -	$ -	$0.00	$0.00	$ -	-
38		$0.00	$ -	$0.00		$ -	$ -	$0.00	$0.00	$ -	-
39		$0.00	$ -	$0.00		$ -	$ -	$0.00	$0.00	$ -	-
40		$0.00	$ -	$0.00		$ -	$ -	$0.00	$0.00	$ -	-
41		$0.00	$ -	$0.00		$ -	$ -	$0.00	$0.00	$ -	-
42		$0.00	$ -	$0.00		$ -	$ -	$0.00	$0.00	$ -	-
43		$0.00	$ -	$0.00		$ -	$ -	$0.00	$0.00	$ -	-
44		$0.00	$ -	$0.00		$ -	$ -	$0.00	$0.00	$ -	-
45		$0.00	$ -	$0.00		$ -	$ -	$0.00	$0.00	$ -	-
46		$0.00	$ -	$0.00		$ -	$ -	$0.00	$0.00	$ -	-
47		$0.00	$ -	$0.00		$ -	$ -	$0.00	$0.00	$ -	-
48		$0.00	$ -	$0.00		$ -	$ -	$0.00	$0.00	$ -	-
49		$0.00	$ -	$0.00		$ -	$ -	$0.00	$0.00	$ -	-
50		$0.00	$ -	$0.00		$ -	$ -	$0.00	$0.00	$ -	-
51		$0.00	$ -	$0.00		$ -	$ -	$0.00	$0.00	$ -	-
52		$0.00	$ -	$0.00		$ -	$ -	$0.00	$0.00	$ -	-
53		$0.00	$ -	$0.00		$ -	$ -	$0.00	$0.00	$ -	-
54		$0.00	$ -	$0.00		$ -	$ -	$0.00	$0.00	$ -	-
55		$0.00	$ -	$0.00		$ -	$ -	$0.00	$0.00	$ -	-
56		$0.00	$ -	$0.00		$ -	$ -	$0.00	$0.00	$ -	-
57		$0.00	$ -	$0.00		$ -	$ -	$0.00	$0.00	$ -	-
58		$0.00	$ -	$0.00		$ -	$ -	$0.00	$0.00	$ -	-
59		$0.00	$ -	$0.00		$ -	$ -	$0.00	$0.00	$ -	-
60		$0.00	$ -	$0.00		$ -	$ -	$0.00	$0.00	$ -	-
61		$0.00	$ -	$0.00		$ -	$ -	$0.00	$0.00	$ -	-
62		$0.00	$ -	$0.00		$ -	$ -	$0.00	$0.00	$ -	-
63		$0.00	$ -	$0.00		$ -	$ -	$0.00	$0.00	$ -	-
64		$0.00	$ -	$0.00		$ -	$ -	$0.00	$0.00	$ -	-
65		$0.00	$ -	$0.00		$ -	$ -	$0.00	$0.00	$ -	-
66		$0.00	$ -	$0.00		$ -	$ -	$0.00	$0.00	$ -	-
67		$0.00	$ -	$0.00		$ -	$ -	$0.00	$0.00	$ -	-
68		$0.00	$ -	$0.00		$ -	$ -	$0.00	$0.00	$ -	-
69		$0.00	$ -	$0.00		$ -	$ -	$0.00	$0.00	$ -	-
70		$0.00	$ -	$0.00		$ -	$ -	$0.00	$0.00	$ -	-
71		$0.00	$ -	$0.00		$ -	$ -	$0.00	$0.00	$ -	-
72		$0.00	$ -	$0.00		$ -	$ -	$0.00	$0.00	$ -	-
73		$0.00	$ -	$0.00		$ -	$ -	$0.00	$0.00	$ -	-
74		$0.00	$ -	$0.00		$ -	$ -	$0.00	$0.00	$ -	-
75		$0.00	$ -	$0.00		$ -	$ -	$0.00	$0.00	$ -	-

G. Cost Report - Cost / Days / Charges

Cost Report Year (-) SELECT HOSPITAL NAME

	Line #	Cost Center Description	Total Allowable Cost	Intern & Resident Costs Removed on Cost Report *	RCE and Therapy Add-Back (If Applicable)		Provider Tax Assessment	Total Cost	I/P	O/P Charges	Total Charges	Medicaid Per Diem / Cost-to-Charge Ratios
76			$0.00	$ -	$0.00		$ -	$ -	$0.00	$0.00	$ -	-
77			$0.00	$ -	$0.00		$ -	$ -	$0.00	$0.00	$ -	-
78			$0.00	$ -	$0.00		$ -	$ -	$0.00	$0.00	$ -	-
79			$0.00	$ -	$0.00		$ -	$ -	$0.00	$0.00	$ -	-
80			$0.00	$ -	$0.00		$ -	$ -	$0.00	$0.00	$ -	-
81			$0.00	$ -	$0.00		$ -	$ -	$0.00	$0.00	$ -	-
82			$0.00	$ -	$0.00		$ -	$ -	$0.00	$0.00	$ -	-
83			$0.00	$ -	$0.00		$ -	$ -	$0.00	$0.00	$ -	-
84			$0.00	$ -	$0.00		$ -	$ -	$0.00	$0.00	$ -	-
85			$0.00	$ -	$0.00		$ -	$ -	$0.00	$0.00	$ -	-
86			$0.00	$ -	$0.00		$ -	$ -	$0.00	$0.00	$ -	-
87			$0.00	$ -	$0.00		$ -	$ -	$0.00	$0.00	$ -	-
88			$0.00	$ -	$0.00		$ -	$ -	$0.00	$0.00	$ -	-
89			$0.00	$ -	$0.00		$ -	$ -	$0.00	$0.00	$ -	-
90			$0.00	$ -	$0.00		$ -	$ -	$0.00	$0.00	$ -	-
91			$0.00	$ -	$0.00		$ -	$ -	$0.00	$0.00	$ -	-
92			$0.00	$ -	$0.00		$ -	$ -	$0.00	$0.00	$ -	-
93			$0.00	$ -	$0.00		$ -	$ -	$0.00	$0.00	$ -	-
94			$0.00	$ -	$0.00		$ -	$ -	$0.00	$0.00	$ -	-
95			$0.00	$ -	$0.00		$ -	$ -	$0.00	$0.00	$ -	-
96			$0.00	$ -	$0.00		$ -	$ -	$0.00	$0.00	$ -	-
97			$0.00	$ -	$0.00		$ -	$ -	$0.00	$0.00	$ -	-
98			$0.00	$ -	$0.00		$ -	$ -	$0.00	$0.00	$ -	-
99			$0.00	$ -	$0.00		$ -	$ -	$0.00	$0.00	$ -	-
100			$0.00	$ -	$0.00		$ -	$ -	$0.00	$0.00	$ -	-
101			$0.00	$ -	$0.00		$ -	$ -	$0.00	$0.00	$ -	-
102			$0.00	$ -	$0.00		$ -	$ -	$0.00	$0.00	$ -	-
103			$0.00	$ -	$0.00		$ -	$ -	$0.00	$0.00	$ -	-
104			$0.00	$ -	$0.00		$ -	$ -	$0.00	$0.00	$ -	-
105			$0.00	$ -	$0.00		$ -	$ -	$0.00	$0.00	$ -	-
106			$0.00	$ -	$0.00		$ -	$ -	$0.00	$0.00	$ -	-
107			$0.00	$ -	$0.00		$ -	$ -	$0.00	$0.00	$ -	-
108			$0.00	$ -	$0.00		$ -	$ -	$0.00	$0.00	$ -	-
109			$0.00	$ -	$0.00		$ -	$ -	$0.00	$0.00	$ -	-
110			$0.00	$ -	$0.00		$ -	$ -	$0.00	$0.00	$ -	-
111			$0.00	$ -	$0.00		$ -	$ -	$0.00	$0.00	$ -	-
112			$0.00	$ -	$0.00		$ -	$ -	$0.00	$0.00	$ -	-
113			$0.00	$ -	$0.00		$ -	$ -	$0.00	$0.00	$ -	-
114			$0.00	$ -	$0.00		$ -	$ -	$0.00	$0.00	$ -	-
115			$0.00	$ -	$0.00		$ -	$ -	$0.00	$0.00	$ -	-
116			$0.00	$ -	$0.00		$ -	$ -	$0.00	$0.00	$ -	-
117			$0.00	$ -	$0.00		$ -	$ -	$0.00	$0.00	$ -	-
118			$0.00	$ -	$0.00		$ -	$ -	$0.00	$0.00	$ -	-
119			$0.00	$ -	$0.00		$ -	$ -	$0.00	$0.00	$ -	-
120			$0.00	$ -	$0.00		$ -	$ -	$0.00	$0.00	$ -	-
121			$0.00	$ -	$0.00		$ -	$ -	$0.00	$0.00	$ -	-
122			$0.00	$ -	$0.00		$ -	$ -	$0.00	$0.00	$ -	-
123			$0.00	$ -	$0.00		$ -	$ -	$0.00	$0.00	$ -	-
124			$0.00	$ -	$0.00		$ -	$ -	$0.00	$0.00	$ -	-
125			$0.00	$ -	$0.00		$ -	$ -	$0.00	$0.00	$ -	-

G. Cost Report - Cost / Days / Charges

Cost Report Year (-) SELECT HOSPITAL NAME

Line #	Cost Center Description	Total Allowable Cost	Intern & Resident Costs Removed on Cost Report *	RCE and Therapy Add-Back (If Applicable)	Provider Tax Assessment	Total Cost	I/P	O/P Charges	Total Charges	Medicaid Per Diem / Cost-to-Charge Ratios
126	**Total Ancillary**	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
127	**Weighted Average**									-
128	**Sub Totals**	$ -	$ -	$ -		$ -	$ -			
129	NF, SNF, and Swing Bed Cost for Medicaid *(Sum of applicable Cost Report Worksheet D-3, Title 19, Column 3, Line 200 and Worksheet D, Part V, Title 19, Column 5-7, Line 200)*					$0.00				
130	NF, SNF, and Swing Bed Cost for Medicare *(Sum of applicable Cost Report Worksheet D-3, Title 18, Column 3, Line 200 and Worksheet D, Part V, Title 18, Column 5-7, Line 200)*					$0.00				
131	NF, SNF, and Swing Bed Cost for Other Payors *(Hospital must calculate. Submit support for calculation of cost.)*									
132	**Grand Totals**					$ -				
133	Total Intern/Resident Cost as a Percent of Other Allowable Cost					0.00%				

* Note A - Final cost-to-charge ratios should include teaching cost. Only enter Intern & Resident costs if it was removed in Column 25 of Worksheet B, Pt. I of the cost report you are using.

State of West Virginia
Disproportionate Share Hospital (DSH) Examination Survey Part II

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

Cost Report Year (-) SELECT HOSPITAL NAME

Line #		Cost Center Description	Medicaid Per Diem Cost for Routine Cost Centers	Medicaid Cost to Charge Ratio for Ancillary Cost Centers	In-State Medicaid FFS Primary		In-State Medicaid Managed Care Primary		In-State Medicare FFS Cross-Overs (with Medicaid Secondary)		In-State Other Medicaid Eligibles (Not Included Elsewhere)		Uninsured		Total In-State Medicaid	
					Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient (See Exhibit A)	Outpatient (See Exhibit A)	Inpatient	Outpatient
			From Section G	From Section G	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From Hospital's Own Internal Analysis	From Hospital's Own Internal Analysis		
	Routine Cost Centers (from Section G):				**Days**		**Days**		**Days**		**Days**		**Days**		**Days**	
1	03000	ADULTS & PEDIATRICS	$ -												-	
2	03100	INTENSIVE CARE UNIT	$ -												-	
3	03200	CORONARY CARE UNIT	$ -												-	
4	03300	BURN INTENSIVE CARE UNIT	$ -												-	
5	03400	SURGICAL INTENSIVE CARE UNIT	$ -												-	
6	03500	OTHER SPECIAL CARE UNIT	$ -												-	
7	04000	SUBPROVIDER I	$ -												-	
8	04100	SUBPROVIDER II	$ -												-	
9	04200	OTHER SUBPROVIDER	$ -												-	
10	04300	NURSERY	$ -												-	
11			$ -												-	
12			$ -												-	
13			$ -												-	
14			$ -												-	
15			$ -												-	
16			$ -												-	
17			$ -												-	
18				**Total Days**	-		-		-		-		-		-	
19	Total Days per PS&R or Other Paid Claims Summary															
20		Unreconciled Days (Explain Variance)			-		-		-		-					
					Routine Charges		**Routine Charges**		**Routine Charges**		**Routine Charges**		**Routine Charges**		**Routine Charges**	
21		Routine Charges													$ -	
21.01		Calculated Routine Charge Per Diem			$ -		$ -		$ -		$ -		$ -		$ -	
	Ancillary Cost Centers (from W/S C) (from Section G):				**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**
22	092xx	Observation (Non-Distinct)		-											$ -	$ -
23				-											$ -	$ -
24				-											$ -	$ -
25				-											$ -	$ -
26				-											$ -	$ -
27				-											$ -	$ -
28				-											$ -	$ -
29				-											$ -	$ -
30				-											$ -	$ -
31				-											$ -	$ -
32				-											$ -	$ -
33				-											$ -	$ -
34				-											$ -	$ -
35				-											$ -	$ -
36				-											$ -	$ -
37				-											$ -	$ -
38				-											$ -	$ -
39				-											$ -	$ -
40				-											$ -	$ -
41				-											$ -	$ -
42				-											$ -	$ -
43				-											$ -	$ -
44				-											$ -	$ -
45				-											$ -	$ -
46				-											$ -	$ -
47				-											$ -	$ -
48				-											$ -	$ -
49				-											$ -	$ -
50				-											$ -	$ -
51				-											$ -	$ -
52				-											$ -	$ -
53				-											$ -	$ -
54				-											$ -	$ -
55				-											$ -	$ -
56				-											$ -	$ -
57				-											$ -	$ -
58				-											$ -	$ -
59				-											$ -	$ -
60				-											$ -	$ -
61				-											$ -	$ -
62				-											$ -	$ -
63				-											$ -	$ -
64				-											$ -	$ -
65				-											$ -	$ -
66				-											$ -	$ -
67				-											$ -	$ -
68				-											$ -	$ -
69				-											$ -	$ -
70				-											$ -	$ -
71				-											$ -	$ -
72				-											$ -	$ -
73				-											$ -	$ -
74				-											$ -	$ -
75				-											$ -	$ -
76				-											$ -	$ -
77				-											$ -	$ -
78				-											$ -	$ -
79				-											$ -	$ -
80				-											$ -	$ -
81				-											$ -	$ -
82				-											$ -	$ -
83				-											$ -	$ -
84				-											$ -	$ -
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120				-											$ -	$ -
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122				-											$ -	$ -
123				-											$ -	$ -
124				-											$ -	$ -

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Property of Myers and Stauffer LC

State of West Virginia
Disproportionate Share Hospital (DSH) Examination Survey Part II

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

Cost Report Year (-) SELECT HOSPITAL NAME

		In-State Medicaid FFS Primary		In-State Medicaid Managed Care Primary		In-State Medicare FFS Cross-Overs (with Medicaid Secondary)		In-State Other Medicaid Eligibles (Not Included Elsewhere)		Uninsured		Total In-State Medicaid	
125												$ -	$ -
126												$ -	$ -
127												$ -	$ -
	Totals / Payments												
128	**Total Charges** *(includes organ acquisition from Section J)*	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ - (Agrees to Exhibit A)	$ - (Agrees to Exhibit A)	$ -	$ -
129	Total Charges per PS&R or Other Paid Claims Summary												
130	Unreconciled Charges (Explain Variance)	-	-	-	-	-	-	-	-				
131	**Total Calculated Cost (includes organ acquisition from Section J)**	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)											$ -	$ -
133	Other Total Third Party Liability (including Co-Pay and Spend-Down but excluding Medicare on crossovers)											$ -	$ -
134	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)	$ -	$ -	$ -	$ -								
135	Medicaid Cost Settlement Payments (See Note B)											$ -	$ -
136	Other Medicaid Payments Reported on Cost Report Year (See Note C)											$ -	$ -
137	Medicare Paid Amount (excludes coinsurance/deductibles)											$ -	$ -
138	Medicare Cross-Over Bad Debt Payments									(Agrees to Exhibit B and B-1)	(Agrees to Exhibit B and B-1)	$ -	$ -
139	Other Medicare Cross-Over Payments (See Note D)											$ -	$ -
140	Payment from Hospital Uninsured During Cost Report Year (Cash Basis									-	-		
141	Section 1011 Payment Related to Inpatient Hospital Services NOT Included in Exhibits B & B-1 (from Section E)									$ -	$ -		
142	**Calculated Payment Shortfall / (Longfall)**	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
143	**Calculated Payments as a Percentage of Cost**	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%

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

State of West Virginia
Disproportionate Share Hospital (DSH) Examination Survey Part II

Version 7.10

I. Out-of-State Medicaid Data:

Cost Report Year (-) | SELECT HOSPITAL NAME

Line #	Cost Center Description	Medicaid Per Diem Cost for Routine Cost Centers	Medicaid Cost to Charge Ratio for Ancillary Cost Centers	Out-of-State Medicaid FFS Primary		Out-of-State Medicaid Managed Care Primary		Out-of-State Medicare FFS Cross-Overs (with Medicaid Secondary)		Out-of-State Other Medicaid Eligibles (Not Included Elsewhere)		Total Out-Of-State Medicaid	
				Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient
		From Section G	From Section G	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)		
	Routine Cost Centers (list below):			Days		Days		Days		Days		Days	
1	03000 ADULTS & PEDIATRICS	$ -										-	
2	03100 INTENSIVE CARE UNIT	$ -										-	
3	03200 CORONARY CARE UNIT	$ -										-	
4	03300 BURN INTENSIVE CARE UNIT	$ -										-	
5	03400 SURGICAL INTENSIVE CARE UNIT	$ -										-	
6	03500 OTHER SPECIAL CARE UNIT	$ -										-	
7	04000 SUBPROVIDER I	$ -										-	
8	04100 SUBPROVIDER II	$ -										-	
9	04200 OTHER SUBPROVIDER	$ -										-	
10	04300 NURSERY	$ -										-	
11		$ -										-	
12		$ -										-	
13		$ -										-	
14		$ -										-	
15		$ -										-	
16		$ -										-	
17		$ -										-	
18			Total Days	-		-		-		-		-	
19	Total Days per PS&R or Other Paid Claims Summary												
20	Unreconciled Days (Explain Variance)			-		-		-		-			
				Routine Charges		Routine Charges		Routine Charges		Routine Charges		Routine Charges	
21	Routine Charges											$ -	
21.01	Calculated Routine Charge Per Diem			$ -		$ -		$ -		$ -		$ -	
	Ancillary Cost Centers (from W/S C) (list below):			Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges
22	092xx Observation (Non-Distinct)		-									$ -	$ -
23			-									$ -	$ -
24			-									$ -	$ -
25			-									$ -	$ -
26			-									$ -	$ -
27			-									$ -	$ -
28			-									$ -	$ -
29			-									$ -	$ -
30			-									$ -	$ -
31			-									$ -	$ -
32			-									$ -	$ -
33			-									$ -	$ -
34			-									$ -	$ -
35			-									$ -	$ -
36			-									$ -	$ -
37			-									$ -	$ -
38			-									$ -	$ -
39			-									$ -	$ -
40			-									$ -	$ -
41			-									$ -	$ -
42			-									$ -	$ -
43			-									$ -	$ -
44			-									$ -	$ -
45			-									$ -	$ -
46			-									$ -	$ -
47			-									$ -	$ -
48			-									$ -	$ -
49			-									$ -	$ -
50			-									$ -	$ -
51			-									$ -	$ -
52			-									$ -	$ -
53			-									$ -	$ -
54			-									$ -	$ -
55			-									$ -	$ -
56			-									$ -	$ -
57			-									$ -	$ -
58			-									$ -	$ -
59			-									$ -	$ -
60			-									$ -	$ -
61			-									$ -	$ -
62			-									$ -	$ -
63			-									$ -	$ -
64			-									$ -	$ -

State of West Virginia
Disproportionate Share Hospital (DSH) Examination Survey Part II

Version 7.10

I. Out-of-State Medicaid Data:

Cost Report Year (-) | SELECT HOSPITAL NAME

				Out-of-State Medicaid FFS Primary		Out-of-State Medicaid Managed Care Primary		Out-of-State Medicare FFS Cross-Overs (with Medicaid Secondary)		Out-of-State Other Medicaid Eligibles (Not Included Elsewhere)		Total Out-Of-State Medicaid	
65			-									$ -	$ -
66			-									$ -	$ -
67			-									$ -	$ -
68			-									$ -	$ -
69			-									$ -	$ -
70			-									$ -	$ -
71			-									$ -	$ -
72			-									$ -	$ -
73			-									$ -	$ -
74			-									$ -	$ -
75			-									$ -	$ -
76			-									$ -	$ -
77			-									$ -	$ -
78			-									$ -	$ -
79			-									$ -	$ -
80			-									$ -	$ -
81			-									$ -	$ -
82			-									$ -	$ -
83			-									$ -	$ -
84			-									$ -	$ -
85			-									$ -	$ -
86			-									$ -	$ -
87			-									$ -	$ -
88			-									$ -	$ -
89			-									$ -	$ -
90			-									$ -	$ -
91			-									$ -	$ -
92			-									$ -	$ -
93			-									$ -	$ -
94			-									$ -	$ -
95			-									$ -	$ -
96			-									$ -	$ -
97			-									$ -	$ -
98			-									$ -	$ -
99			-									$ -	$ -
100			-									$ -	$ -
101			-									$ -	$ -
102			-									$ -	$ -
103			-									$ -	$ -
104			-									$ -	$ -
105			-									$ -	$ -
106			-									$ -	$ -
107			-									$ -	$ -
108			-									$ -	$ -
109			-									$ -	$ -
110			-									$ -	$ -
111			-									$ -	$ -
112			-									$ -	$ -
113			-									$ -	$ -
114			-									$ -	$ -
115			-									$ -	$ -
116			-									$ -	$ -
117			-									$ -	$ -
118			-									$ -	$ -
119			-									$ -	$ -
120			-									$ -	$ -
121			-									$ -	$ -
122			-									$ -	$ -
123			-									$ -	$ -
124			-									$ -	$ -
125			-									$ -	$ -
126			-									$ -	$ -
127			-									$ -	$ -

State of West Virginia
Disproportionate Share Hospital (DSH) Examination Survey Part II

Version 7.10

I. Out-of-State Medicaid Data:

Cost Report Year (-) SELECT HOSPITAL NAME

	Totals / Payments	Out-of-State Medicaid FFS Primary		Out-of-State Medicaid Managed Care Primary		Out-of-State Medicare FFS Cross-Overs (with Medicaid Secondary)		Out-of-State Other Medicaid Eligibles (Not included Elsewhere)		Total Out-Of-State Medicaid	
128	**Total Charges (includes organ acquisition from Section K)**	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
129	Total Charges per PS&R or Other Paid Claims Summary										
130	Unreconciled Charges (Explain Variance)	-	-	-	-	-	-	-	-		
131	**Total Calculated Cost (includes organ acquisition from Section K)**	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)									$ -	$ -
133	Other Total Third Party Liability (including Co-Pay and Spend-Down but excluding Medicare on crossovers)									$ -	$ -
134	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)	$ -	$ -	$ -	$ -						
135	Medicaid Cost Settlement Payments (See Note B)									$ -	$ -
136	Other Medicaid Payments Reported on Cost Report Year (See Note C)									$ -	$ -
137	Medicare Paid Amount (excludes coinsurance/deductibles)									$ -	$ -
138	Medicare Cross-Over Bad Debt Payments									$ -	$ -
139	Other Medicare Cross-Over Payments (See Note D)									$ -	$ -
140	**Calculated Payment Shortfall / (Longfall)**	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
141	**Calculated Payments as a Percentage of Cost**	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
142											

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

J. Transplant Facilities Only: Organ Acquisition Cost In-State Medicaid and Uninsured

Cost Report Year (-) | SELECT HOSPITAL NAME

		Total Organ Acquisition Cost	Additional Add-In Intern/Resident Cost	Total Adjusted Organ Acquisition Cost	Revenue for Medicaid/ Cross-Over / Uninsured Organs Sold	Total Useable Organs (Count)	In-State Medicaid FFS Primary		In-State Medicaid Managed Care Primary		In-State Medicare FFS Cross-Overs (with Medicaid Secondary)		In-State Other Medicaid Eligibles (Not included Elsewhere)		Uninsured	
							Charges	Useable Organs (Count)	Charges	Useable Organs (Count)	Charges	Useable Organs (Count)	Charges	Useable Organs (Count)	Charges	Useable Organs (Count)
		Cost Report Worksheet D-4, Pt. III, Col. 1, Ln 61	*Add-On Cost Factor on Section G, Line 104 x Total Cost Report Organ Acquisition Cost*	*Sum of Cost Report Organ Acquisition Cost and the Add-On Cost*	*Similar to Instructions from Cost Report W/S D-4 Pt. III, Col. 1, Ln 66 (substitute Medicare with Medicaid/ Cross-Over & uninsured). See Note C below.*	*Cost Report Worksheet D-4, Pt. III, Line 62*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Hospital's Own Internal Analysis*	*From Hospital's Own Internal Analysis*
	Organ Acquisition Cost Centers (list below):															
1	Lung Acquisition	$0.00	$ -	$ -		0										
2	Kidney Acquisition	$0.00	$ -	$ -		0										
3	Liver Acquisition	$0.00	$ -	$ -		0										
4	Heart Acquisition	$0.00	$ -	$ -		0										
5	Pancreas Acquisition	$0.00	$ -	$ -		0										
6	Intestinal Acquisition	$0.00	$ -	$ -		0										
7	Islet Acquisition	$0.00	$ -	$ -		0										
8			$ -	$ -												
9	**Totals**	$ -	$ -	$ -	$ -	-	$ -	-	$ -	-	$ -	-	$ -	-	$ -	-
10	**Total Cost**							-		-		-		-		-

Note A - These amounts must agree to your inpatient and outpatient Medicaid paid claims summary, if available (If not, use hospital's logs and submit with survey).
Note B: Enter Organ Acquisition Payments in Section H as part of your In-State Medicaid total payments.
Note C: Enter the total revenue applicable to organs furnished to other providers, to organ procurement organizations and others, and for organs transplanted into non-Medicaid / non-Uninsured patients (but where organs were included in the Medicaid and Uninsured organ counts above). Such revenues must be determined under the accrual method of accounting. If organs are transplanted into non-Medicaid/non-Uninsured patients who are not liable for payment on a charge basis, and as such there is no revenue applicable to the related organ acquisitions, the amount entered must also include an amount representing the acquisition cost of the organs transplanted into such patients.

K. Transplant Facilities Only: Organ Acquisition Cost Out-of-State Medicaid

Cost Report Year (-) | SELECT HOSPITAL NAME

		Total Organ Acquisition Cost	Additional Add-In Intern/Resident Cost	Total Adjusted Organ Acquisition Cost	Revenue for Medicaid/ Cross-Over / Uninsured Organs Sold	Total Useable Organs (Count)	Out-of-State Medicaid FFS Primary		Out-of-State Medicaid Managed Care Primar		Out-of-State Medicare FFS Cross-Overs (with Medicaid Secondary)		Out-of-State Other Medicaid Eligibles (Not Included Elsewhere)	
							Charges	Useable Organs (Count)	Charges	Useable Organs (Count)	Charges	Useable Organs (Count)	Charges	Useable Organs (Count)
		Cost Report Worksheet D-4, Pt. III, Col. 1, Ln 61	*Add-On Cost Factor on Section G, Line 104 x Total Cost Report Organ Acquisition Cost*	*Sum of Cost Report Organ Acquisition Cost and the Add-On Cost*	*Similar to Instructions from Cost Report W/S D-4 Pt. III, Col. 1, Ln 66 (substitute Medicare with Medicaid/ Cross-Over & uninsured). See Note C below.*	*Cost Report Worksheet D-4, Pt. III, Line 62*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*
	Organ Acquisition Cost Centers (list below):													
11	Lung Acquisition	$ -	$ -	$ -	$ -	0								
12	Kidney Acquisition	$ -	$ -	$ -	$ -	0								
13	Liver Acquisition	$ -	$ -	$ -	$ -	0								
14	Heart Acquisition	$ -	$ -	$ -	$ -	0								
15	Pancreas Acquisition	$ -	$ -	$ -	$ -	0								
16	Intestinal Acquisition	$ -	$ -	$ -	$ -	0								
17	Islet Acquisition	$ -	$ -	$ -	$ -	0								
18		$ -	$ -	$ -	$ -	0								
19	**Totals**	$ -	$ -	$ -	$ -	-	$ -	-	$ -	-	$ -	-	$ -	-
20	**Total Cost**							-		-		-		-

Note A - These amounts must agree to your inpatient and outpatient Medicaid paid claims summary, if available (If not, use hospital's logs and submit with survey
Note B: Enter Organ Acquisition Payments in Section I as part of your Out-of-State Medicaid total payments.

L. Provider Tax Assessment Reconciliation / Adjustment

An adjustment is necessary to properly reflect the Medicaid and uninsured share of the provider tax assessment for some hospitals. The Medicaid and uninsured share of the provider tax assessment collected is an allowable cost in determining hospital-specific DSH limits and, therefore, can be included in the DSH audit survey. However, depending on how your hospital reports it on the Medicare cost report, an adjustment may be necessary to ensure the cost is properly reflected in determining your hospital-specific DSH limit. For instance, if your hospital removed part or all of the provider tax assessment on the Medicare cost report, the full amount of the provider tax assessment would not have been apportioned to the various payers through the step down allocation process, resulting in the Medicaid and uninsured share being understated in determining the hospital-specific DSH limit. If your hospital needs to make an adjustment for the Medicaid and uninsured share of the provider tax assessment, please fill out the reconciliation below, and submit the supporting general ledger entries and other supporting documentation to Myers and Stauffer, LC along with your hospital's DSH examination surveys.

Cost Report Year (-) SELECT HOSPITAL NAME

Worksheet A Provider Tax Assessment Reconciliation:

			Dollar Amount	W/S A Cost Center Line	
1	Hospital Gross Provider Tax Assessment (from general ledger)*				
1a.	*Working Trial Balance Account Type and Account # that includes Gross Provider Tax Assessment*				*(WTB Account #)*
2	Hospital Gross Provider Tax Assessment Included in Expense on the Cost Report (W/S A, Col. 2)				*(Where is the cost included on w/s A?)*
3	Difference (Explain Here ---------->)		$ -		
	Provider Tax Assessment Reclassifications (from w/s A-6 of the Medicare cost report)				
4	*Reclassification Code*				*(Reclassified to / (from))*
5	*Reclassification Code*				*(Reclassified to / (from))*
6	*Reclassification Code*				*(Reclassified to / (from))*
7	*Reclassification Code*				*(Reclassified to / (from))*
	DSH UCC ALLOWABLE - Provider Tax Assessment Adjustments (from w/s A-8 of the Medicare cost report)				
8	*Reason for adjustment*				*(Adjusted to / (from))*
9	*Reason for adjustment*				*(Adjusted to / (from))*
10	*Reason for adjustment*				*(Adjusted to / (from))*
11	*Reason for adjustment*				*(Adjusted to / (from))*
	DSH UCC NON-ALLOWABLE Provider Tax Assessment Adjustments (from w/s A-8 of the Medicare cost report)				
12	*Reason for adjustment*				
13	*Reason for adjustment*				
14	*Reason for adjustment*				
15	*Reason for adjustment*				
16	Total Net Provider Tax Assessment Expense Included in the Cost Report		$ -		

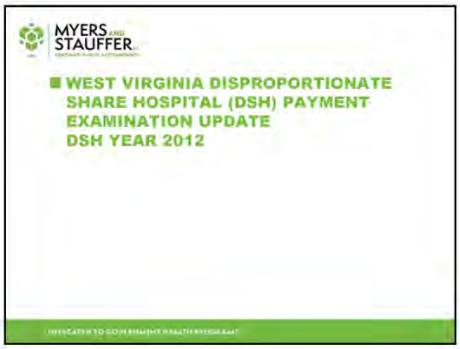
DSH UCC Provider Tax Assessment Adjustment:

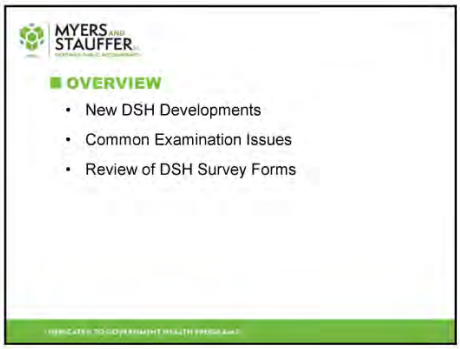
17	Gross Allowable Assessment Not Included in the Cost Report	$ -

** Assessment must exclude any non-hospital assessment including Nursing Facility*

Appendix F: Sample Training Materials 1

12/2/2015





1

12/2/2015

MYERS AND STAUFFER

NEW

NEW DSH DEVELOPMENTS

- *December 3, 2014 Final Rule Expanded Definition of Uninsured implemented in FR Vol. 79, No. 232, Wednesday, Dec. 03, 2014, Final Rule*
  - Definitions of uninsured as laid out in the January 2012 proposed rule have been finalized.
  - Myers and Stauffer has been utilizing the definitions of uninsured as stated in the January 2012 proposed rule since the 2009 DSH examinations.
  - Now that the proposed rule has been finalized, Myers and Stauffer will continue to utilize those definitions as they have been since the 2009 DSH examinations.

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NEW DSH DEVELOPMENTS

- Under the final rule, the DSH examination will now look at whether a patient is uninsured using a "service-specific" approach as opposed to the creditable coverage approach previously employed.

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NEW DSH DEVELOPMENTS

- Under the final rule, the following may be considered uninsured:
  - Individuals with exhausted insurance benefits at the time of service
  - Individuals who have reached lifetime insurance limits for certain services
  - Individuals whose benefit package does not cover the hospital service received (must be a covered service under the Medicaid state plan)

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NEW DSH DEVELOPMENTS

- Individuals must exhaust benefits prior to obtaining services to be considered uninsured (i.e., if individual exhausts coverage during the course of services, they cannot be consider uninsured).
- Individuals with high deductible or catastrophic plans are considered insured even in instances where policy requires individual to satisfy a deductible or share in the cost services.

2

12/2/2015

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NEW DSH DEVELOPMENTS

- Specific Exclusions Listed in the Proposed Rule:
  - Bad Debts for individuals with third party coverage
  - Unpaid coinsurance/deductibles for individuals with third party coverage
  - Prisoners (individuals who are inmates in a public institution or are otherwise involuntarily in secure custody as a result of criminal charges)

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NEW DSH DEVELOPMENTS

- CMS audits of the DSH audits continue
  - CMS goal is to audit every state over the next few years.
  - CMS audits the state and independent auditor's procedures and documentation for sufficiency.
  - A few providers in each state are also selected for further scrutiny (these providers in effect get audited twice).
  - No formal results have yet been issued

MYERS AND STAUFFER

NEW DSH DEVELOPMENTS

- CMS audits of the DSH audits continue
  - CMS intends to issue formal results to provide more guidance to states, auditors and providers.
  - CMS has not announced when West Virginia will be audited

MYERS AND STAUFFER

COMMON 2011 EXAMINATION ISSUES

- Hospitals over DSH limits: 14 out of 54 (26%).
- Compliance with the documentation requests was generally good.
- The number of findings, and the number of hospitals for each finding decreased significantly from 2010 to 2011.
- Seven hospitals could not support charges, days and payments related to dual eligible patients. State data had to be used as alternate data, which is not necessarily complete.
- Six hospitals could not provide usable crosswalks showing how program charges by revenue code were mapped to the CMS 2552. Charges had to be allocated based on submitted total or Medicaid charges.

3

12/2/2015

COMMON 2011 EXAMINATION ISSUES

- Five hospitals did not submit revenue code detail for Medicaid eligible and/or uninsured data. Days and charges were allocated based on the Medicare cost report totals or the hospital's submitted DSH Survey information.
- Four hospitals submitted self pay payments on the accrual basis (payments related to uninsured services provided during the cost reporting period) instead of the cash basis (all uninsured payments received during the cost reporting period regardless of the year of service).
- Two hospitals did not submit a signed certification attesting to the accuracy of the submitted DSH data.

PAID CLAIMS DATA UPDATE FOR 2012

- Medicaid fee-for-service paid claims data
  - Will be obtained from the state and will be mapped by MSLC using the hospital submitted crosswalk and entered into Survey Part II Section H.
  - Reported based on cost report year (using discharge date).
  - At revenue code level.
  - Summary or detailed data is available upon request once available.

PAID CLAIMS DATA UPDATE FOR 2012

- Medicare/Medicaid cross-over paid claims data
  - The hospital should send in a detailed listing in Exhibit C format (consistent with prior year).
  - Must EXCLUDE CHIP and other non-Title 19 services.
  - Should be reported based on cost report year (using discharge date).

PAID CLAIMS DATA UPDATE FOR 2012

- Medicaid managed care paid claims data
  - If the hospital cannot obtain a paid claims listing from the MCO, the hospital should send in a detailed listing in Exhibit C format (consistent with prior year).
  - Must EXCLUDE CHIP and other non-Title 19 services.
  - Should be reported based on cost report year (using discharge date).

4

12/2/2015

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PAID CLAIMS DATA UPDATE FOR 2012

- Out-of-State Medicaid paid claims data
  - If the hospital cannot obtain a paid claims listing from the state, the hospital should send in a detailed listing in Exhibit C format (consistent with prior year).
  - Must EXCLUDE CHIP and other non-Title 19 services.
  - Should be reported based on cost report year (using discharge date).

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PAID CLAIMS DATA UPDATE FOR 2012

- "Other" Medicaid Eligibles
  - Medicaid-eligible patient services where Medicaid did not receive the claim or have any cost-sharing may not be included in the state's data. The hospital must submit these eligible services on Exhibit C for them to be eligible for inclusion in the DSH uncompensated care cost (UCC).
  - This would include Medicare MCO primary/Medicaid secondary claims, **private insurance primary/Medicaid secondary claims**, and any other Medicaid eligible claims not included elsewhere.
  - Must EXCLUDE CHIP and other non-Title 19 services.
  - Should be reported based on cost report year (using discharge date).

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PAID CLAIMS DATA UPDATE FOR 2012

- "Other" Medicaid Eligibles (cont.)
  - 2008 DSH Rule and January, 2010 CMS FAQ #33 requires that ***all*** Medicaid eligibles are reported on the DSH survey and included in the UCC calculation.
  - Exhibit C should be submitted for this population. If no "Other" Medicaid Eligibles are submitted, we will contact you to request that they be submitted. If we still do not receive the requested Exhibit C, we may have to list the hospital as non-compliant in the 2012 DSH examination report.
  - Ensure that you ***separately report*** Medicaid, Medicare, third party liability (TPL), and self-pay payments in Exhibit C.

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PAID CLAIMS DATA UPDATE FOR 2012

- Uninsured Services
  - As in years past, uninsured charges/days will be reported on Exhibit A and patient payments will be reported on Exhibit B.
  - Exhibit A should be reported based on cost report year (using discharge date).
  - Exhibit B patient payments will be reported based on cash basis (received during the cost report year).

5

12/2/2015

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DEDICATED TO GOVERNMENT HEALTH PROGRAMS

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DSH EXAMINATION SURVEYS

General Instruction – Survey Files

- The survey is split into 2 separate Excel files:
  - DSH Survey Part I – DSH Year Data.
    - DSH year-specific information.
    - Always complete one copy.
  - DSH Survey Part II – Cost Report Year Data.
    - Cost report year-specific information.
    - Complete a separate copy for each cost report year needed to cover the DSH year.
    - Hospitals with year end changes or that are new to DSH may have to complete 2 or 3 year ends.

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

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DSH EXAMINATION SURVEYS

General Instruction – Survey Files

- Don't complete a DSH Part II survey for a cost report year already submitted in a previous DSH exam year.
  - Example: Hospital A provided a survey for their year ending 12/31/11 with the DSH audit of SFY 2011 in the prior year. In the DSH year 2012 exam, Hospital A would only need to submit a survey for their year ending 12/31/12.
- Both surveys have an Instructions tab that has been updated. Please refer to those tabs if you are unsure of what to enter in a section. If it still isn't clear, please contact Myers and Stauffer.

MYERS AND STAUFFER

DSH EXAMINATION SURVEYS

General Instruction – HCRIS Data

- Myers and Stauffer will pre-load certain sections of Part II of the survey using the Healthcare Cost Report Information System (HCRIS) data from CMS. However, the hospital is responsible for reviewing the data to ensure it is correct and reflects the best available cost report (audited if available).
- Hospitals that do not have a Medicare cost report on file with CMS will not see any data pre-loaded and will need to complete all lines as instructed.

6

12/2/2015

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DSH SURVEY PART I – DSH YEAR DATA

Section A

- DSH Year should already be filled in.
- Hospital name may already be selected (if not, select from the drop-down box).
- Verify the cost report year end dates (should only include those that weren't previously submitted).
  - If these are incorrect, please call Myers and Stauffer and request a new copy.

Section B

- Answer all OB questions using drop-down boxes.

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DSH SURVEY PART I – DSH YEAR DATA

Section C

- Report any Medicaid supplemental payments, including UPL and Non-Claim Specific payments, for the state fiscal year. Do NOT include DSH payments.

Certification

- Answer the "Retain DSH" question but please note that IGTs and CPEs are not a basis for answering the question "No".
- Enter contact information.
- Have CEO or CFO sign this section after completion of Part II of the survey.

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7

12/2/2015

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DSH YEAR SURVEY PART II SECTION D – GENERAL INFORMATION

Submit one copy of the part II survey for each cost report year not previously submitted.

- **Question #2 – An "X" should be shown in the column of the cost report year survey you are preparing.**
  - If you have multiple years listed, you will need to prepare multiple surveys).
  - If there is an error in the year ends, contact Myers and Stauffer to send out a new copy.
- **Question #3 – This question may be already answered based on pre-loaded HCRIS data. If your hospital is going to update the cost report data to a more recent version of the cost report, select the status of the cost report you are using with this drop-down box.**

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DSH YEAR SURVEY PART II SECTION E, MISC. PAYMENT INFO.

- 1011 Payments - You must report your Section 1011 payments included in payments on Exhibit B (posted at the patient level), and payments received but not included in Exhibit B (not posted at the patient level), and separate the 1011 payments between hospital services and non-hospital services (non-hospital services include physician services).
- If your facility received DSH payments from another state (other than your home state) these payments must be reported on this section of the survey (calculate amount for the cost report period).
- Enter in total cash basis patient payment totals from Exhibit B as instructed. These are check totals to compare to the supporting Exhibit B.

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8

12/2/2015

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DSH YEAR SURVEY PART II
SECTION F MIUR/LIUR

- The state must report your actual MIUR and LIUR for the DSH year - data is needed to calculate the MIUR/LIUR.
- Section F-1: Total hospital days from cost report. Myers and Stauffer will pre-load CMS HCRIS cost report data into this section. If it is incorrect or doesn't agree to a more recently audited version of the cost report, please correct as needed and update question #3 in Section D.
- Section F-2: If cash subsidies are specified for I/P or O/P services, record them as such, otherwise record entire amount as unspecified.
- Section F-2: Report charity care charges based on your own hospital financials or the definition used for your state DSH payment (support must be submitted).

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

MYERS AND STAUFFER

DSH YEAR SURVEY PART II
SECTION F, MIUR/LIUR

Section F-3: Report hospital revenues and contractual adjustments.

- Myers and Stauffer will pre-load CMS HCRIS cost report data into this section. If it is incorrect or doesn't agree to a more recently audited version of the cost report, please correct as needed and update question #3 in Section D.
- Totals should agree with the cost report worksheets G-2 and G-3. If not, provide an explanation with the survey.
- Contractuals by service center are set-up to calculate based on total revenues and the total contractuals from G-3. If you have contractuals by service center or the calculation does not reasonably state the contractual split between hospital and non-hospital, overwrite the formulas as needed and submit the necessary support.

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MYERS AND STAUFFER

NEW

DSH YEAR SURVEY PART II
SECTION F, MIUR/LIUR

Section F-3: Reconciling Items Necessary for Proper Calculation of LIUR

- Bad debt and charity care write-offs not included on G-3, line 2 should be entered on lines 28 and 29 so they can be properly excluded in calculating net patient service revenue utilized in the LIUR.
- Medicaid DSH payments and state and local patient care cash subsidies included on G-3, line 2 should be entered on line 30 and 31 so they can be properly excluded in calculating net patient service revenue also.
- Medicaid Provider Tax included on G-3, line 2 should be entered on line 32 so it can be properly excluded in calculating net patient service revenue.

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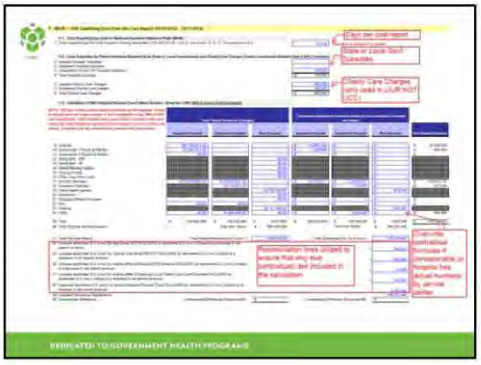

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9

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MYERS AND STAUFFER LC

DSH YEAR SURVEY PART II SECTION G, COST REPORT DATA

- Calculation of Routine Cost Per Diems
  - Days
  - Cost
- Calculation of Ancillary Cost-to-Charge Ratios
  - Charges
  - Cost

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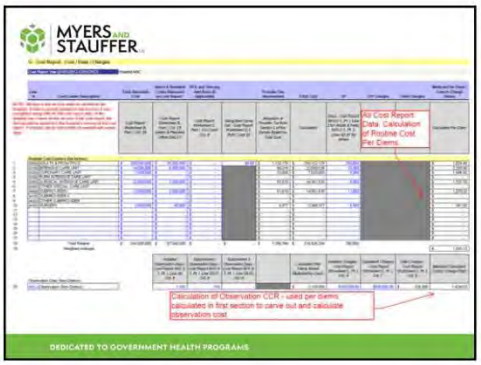

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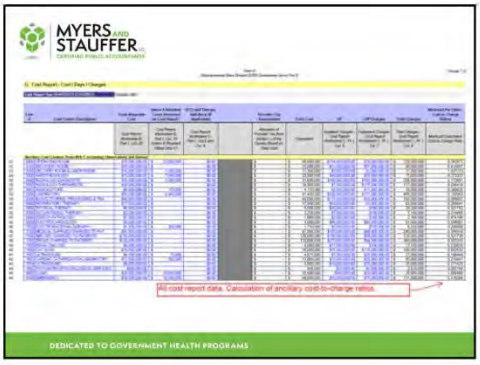

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DSH SURVEY PART II SECTION H, IN-STATE MEDICAID

- Enter inpatient (routine) days, I/P and O/P charges, and payments. The form will calculate cost and shortfall / long-fall for:
  - In-State FFS Medicaid Primary *(Traditional Medicaid).*
  - In-State Medicaid Managed Care Primary *(Medicaid MCO).*
  - In-State Medicare FFS Cross-Overs *(Traditional Medicare with Traditional Medicaid Secondary).*
  - In-State Other Medicaid Eligibles *(would include Medicare MCO/Medicaid secondary, private insurance/Medicaid secondary and other Medicaid not included elsewhere).*

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10

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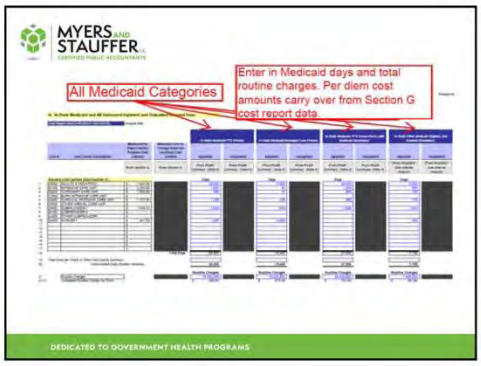
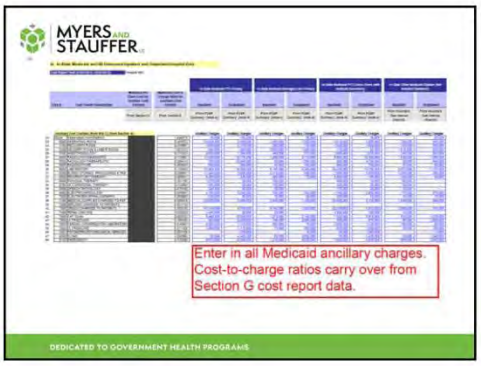
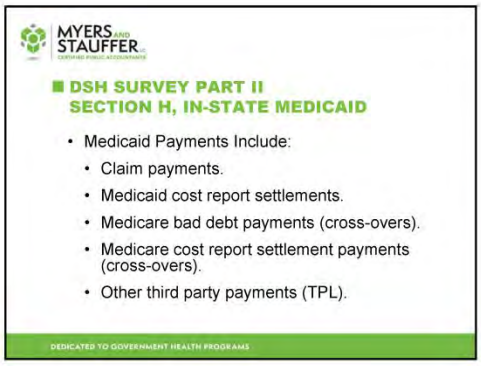
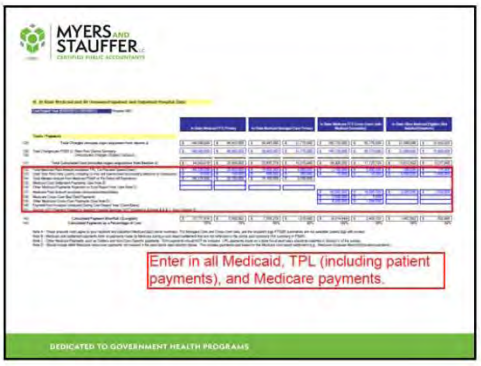

MYERS AND STAUFFER LC
All Medicaid Categories
Enter in Medicaid days and total routine charges. Per diem cost amounts carry over from Section G cost report data.
DEDICATED TO GOVERNMENT HEALTH PROGRAMS


MYERS AND STAUFFER LC
Enter in all Medicaid ancillary charges. Cost-to-charge ratios carry over from Section G cost report data.
DEDICATED TO GOVERNMENT HEALTH PROGRAMS


MYERS AND STAUFFER LC
DSH SURVEY PART II
SECTION H, IN-STATE MEDICAID
Medicaid Payments Include:
Claim payments.
Medicaid cost report settlements.
Medicare bad debt payments (cross-overs).
Medicare cost report settlement payments (cross-overs).
Other third party payments (TPL).
DEDICATED TO GOVERNMENT HEALTH PROGRAMS


MYERS AND STAUFFER LC
Enter in all Medicaid, TPL (including patient payments), and Medicare payments.
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11

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MYERS AND STAUFFER

DSH SURVEY PART II SECTION H, UNINSURED

- Report uninsured services, patient days (by routine cost center) and ancillary charges by cost center.
- Survey form Exhibit A shows the data elements that need to be collected and provided to Myers and Stauffer.
- For uninsured payments, enter the uninsured hospital patient payment totals from your Survey form Exhibit B. Do NOT pick up the non-hospital or insured patient payments in Section H even though they are reported in Exhibit B.

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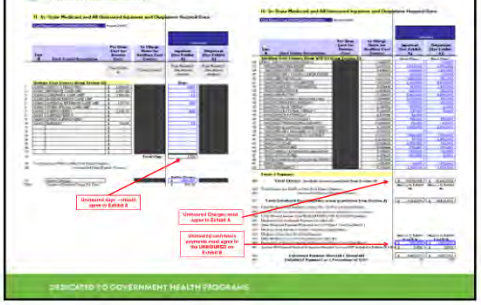

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MYERS AND STAUFFER

DSH SURVEY PART II – SECTION H, IN-STATE MEDICAID AND UNINSURED

- Additional Edits
  - In the far right column, you will see an edit message if your total charges or days by cost center exceed those reported from the cost report in Section G of the survey. Please clear these edits prior to filing the survey.
  - Calculated payments as a percentage of cost by payor (at bottom).
    - Review percentage for reasonableness.

MYERS AND STAUFFER

DSH SURVEY PART II SECTION I, OUT OF STATE MEDICAID

- Report Out-of-State Medicaid days, ancillary charges and payments.
- Report in the same format as Section H. Days, charges and payments received must agree to the other state's PS&R (or similar) claim payment summary. If no summary is available, submit Exhibit C (hospital data) as support.
- If your hospital provided services to several other states, please consolidate your data and provide support for your survey responses.

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12

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DSH SURVEY PART II – SECTIONS J & K, ORGAN ACQUISITION

- Total organ acquisition cost and total useable organs will be pre-loaded from HCRIS data. If it is incorrect or doesn't agree to a more recently audited version of the cost report, please correct as needed and update question #3 in Section D.
- These schedules should be used to calculate organ acquisition cost for Medicaid (in-state and out-of-state) and uninsured.
- Summary claims data (PS&R) or similar documents and provider records (organ counts) must be provided to support the charges and useable organ counts reported on the survey. The data for uninsured organ acquisitions should be reported separately from the Exhibit A.

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DSH SURVEY PART II - SECTIONS J & K, ORGAN ACQUISITION

- All organ acquisition charges should be reported in Sections J & K of the survey and should be EXCLUDED from Section H & I of the survey. (days should also be excluded from H & I)
- Medicaid and uninsured charges/days included in the cost report D-4 series as part of the total organ acquisition charges/days, must be excluded from Sections H & I of the survey.

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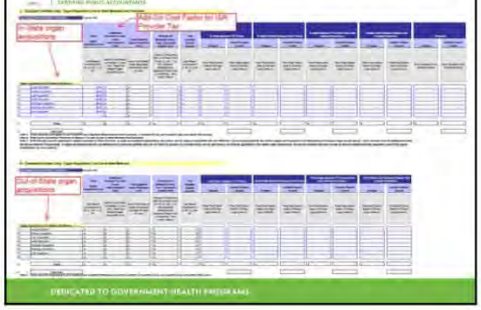

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DSH SURVEY PART II SECTION L, PROVIDER TAXES

- **Federal Register / Vol. 75, No. 157 dated Monday, August 16, 2010 (CMS-1498-F)**
  - Discussion on costs of provider taxes as allowable costs for CAHs. (page 50362)
  - CMS is concerned that, even if a particular tax may be an allowable cost that is related to the care of Medicare beneficiaries, providers may not, in fact, "incur" the entire amount of these assessed taxes. (page 50363)

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13

12/2/2015

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DSH SURVEY PART II SECTION L, PROVIDER TAXES

"This clarification will not have an effect of disallowing any particular tax but rather make clear that our **Medicare contractors** will continue to **make a determination** of whether a provider tax is allowable, on a **case-by-case basis**, using our current and longstanding reasonable cost principles. In addition, the **Medicare contractors** will continue to determine if an adjustment to the amount of allowable provider taxes is warranted to account for payments a provider receives that are associated with the assessed tax." (emphasis added)

MYERS AND STAUFFER

DSH SURVEY PART II SECTION L, PROVIDER TAXES

- Due to Medicare cost report tax adjustments, an adjustment to cost may be necessary to properly reflect the Medicaid and uninsured share of the provider tax assessment for some hospitals.
- Medicaid and uninsured share of the provider tax assessment is an allowable cost for Medicaid DSH even if Medicare offsets some of the tax.

MYERS AND STAUFFER

DSH SURVEY PART II SECTION L, PROVIDER TAXES

- The Medicaid DSH audit rule clearly indicates that the portion of permissible provider taxes applicable to Medicaid and uninsured is an allowable cost for the Medicaid DSH UCC. (FR Vol. 73, No. 245, Friday, Dec. 19, 2008, page 77923)
- By "permissible", they are referring to a "valid" tax in accordance with 42 CFR §433.68(b).

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DSH SURVEY PART II SECTION L, PROVIDER TAXES

- *Ober Kaler 2005 and 2006 Illinois Tax Groups v. Blue Cross Blue Shield Association/National Government Services, ¶82,616, (Mar. 30, 2010)* supports allowing the provider taxes to be treated differently for Medicare than for Medicaid.
- *Abraham Lincoln Memorial Hospital v. Sebelius*, No. 11-2809 (7th Cir. October 16, 2012) also states that because the two programs are independent of one another, CMS's decisions with respect to a State's Medicaid program are not controlling on how CMS interprets the application of Medicare provisions.

14

12/2/2015

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DSH SURVEY PART II SECTION L, PROVIDER TAXES

- Section L is used to report allowable Medicaid Provider Tax.
- Added to assist in reconciling total provider tax expense reported in the cost report and the amount actually incurred by a hospital (paid to the state).
- Complete the section using cost report data and hospital's own general ledger.

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MYERS AND STAUFFER LC

DSH SURVEY PART II SECTION L, PROVIDER TAXES

- All permissible provider tax not included in allowable cost on the cost report will be added back and allocated to the Medicaid and uninsured UCC on a reasonable basis (e.g., charges).

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DSH SURVEY PART II SECTION L, PROVIDER TAXES

- At a minimum the following should still be excluded from the final tax expense:
  - Additional payments paid into the association "pool" should NOT be included in the tax expense.
  - Association fees.
  - Non-hospital taxes (e.g., nursing home and pharmacy taxes).

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15

12/2/2015

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EXHIBIT A – UNINSURED CHARGES/DAYS BY REVENUE CODE

- Survey form Exhibit A has been designed to assist hospitals in collecting and reporting all uninsured charges and routine days needed to cost out the uninsured services.
  - Total hospital charges / routine days from Exhibit A must agree to the total entered in Section H of the survey.
  - Must be for dates of service (discharge date basis) in the cost report fiscal year.
  - Line item data must be at patient date of service level with multiple lines showing revenue code level charges.

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EXHIBIT A - UNINSURED

- Exhibit A:
  - Include Primary Payor Plan, Secondary Payor Plan, Provider #, Account # (unique by visit), Birth Date, SSN, and Gender , Name, Admit, Discharge, Service Indicator, Revenue Code, Total Charges (by revenue code), Days (by revenue code), Patient Payments, TPL, Claim Status fields, and Medical Record #.
  - A complete list (key) of payor plans is required to be submitted separately with the survey.

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EXHIBIT A - UNINSURED

- Claim Status (Column R) is the same as the prior year – need to indicate if Exhausted / Non-Covered Insurance claims are being included under the December 3, 2014 final DSH rule.
  - If exhausted / non-covered insurance services are included on Exhibit A, then they must also be included on Exhibit B for patient payments.
- Submit Exhibit A in the format shown either in Excel or a CSV file using the tab or | (pipe symbol above the enter key).

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16

12/2/2015

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EXHIBIT B – ALL PATIENT PAYMENTS (SELF-PAY) ON A CASH BASIS

- Survey form Exhibit B has been designed to assist hospitals in collecting and reporting all patient payments received on a cash basis.
  - Exhibit B should include all patient payments regardless of their insurance status.
  - Total patient payments from this exhibit are entered in Section E of the survey.
  - Insurance status should be noted on each patient payment so you can sub-total the uninsured hospital patient payments and enter them in Section H of the survey.

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

MYERS AND STAUFFER

EXHIBIT B – ALL PATIENT PAYMENTS (SELF-PAY) ON A CASH BASIS

- Patient payments received for uninsured services need to be reported on a cash basis.
  - For example, a cash payment received during the 2012 cost report year that relates to a service provided in the 2005 cost report year, must be used to reduce uninsured cost for the 2012 cost report year.

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EXHIBIT B – ALL PATIENT PAYMENTS (SELF-PAY) ON A CASH BASIS

- Exhibit B
  - Include *Primary Payor Plan, Secondary Payor Plan, Payment Transaction Code, Provider #, Account # (unique by visit), Birth Date, SSN,* and *Gender, Admit, Discharge, Date of Collection, Amount of Collection, 1011 Indicator, Service Indicator, Hospital Charges, Physician Charges, Non-Hospital Charges, Insurance Status, Claim Status, Calculated Collection, and Medical Record #* fields.
    - A separate "key" for all payment transaction codes should be submitted with the survey.
- Submit Exhibit B in the format shown using Excel or a CSV file using the tab or | (pipe symbol above the enter key).

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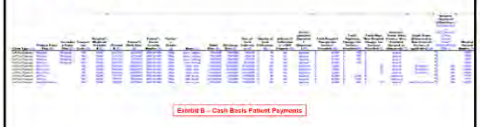

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17

12/2/2015

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EXHIBIT C – HOSPITAL-PROVIDED MEDICAID DATA

- Medicaid data reported on the survey must be supported by a third-party paid claims summary such as a PS&R, Managed Care Plan provided report, or state-run paid claims report.
  - If not available, the hospital must submit the detail behind the reported survey data in the Exhibit C format. Otherwise, the data may not be allowed in the final UCC.

MYERS AND STAUFFER

EXHIBIT C – HOSPITAL-PROVIDED MEDICAID DATA

- Types of data that may require an Exhibit C are as follows:
  - Self-reported Medicaid MCO data (Section H).
  - Self-reported Medicaid/Medicare cross-over data (Section H).
  - Self-reported "Other" Medicaid eligibles (Section H). This includes Medicare MCO/Medicaid, private insurance/Medicaid, and any other Medicaid eligible population not included elsewhere.
  - All self-reported Out-of-State Medicaid categories (Section I).

MYERS AND STAUFFER

EXHIBIT C – HOSPITAL-PROVIDED MEDICAID DATA

- Exhibit C
  - Include *Primary Payor Plan, Secondary Payor Plan, Hospital MCD #, Account # (unique by visit), Patient's MCD Recipient #, DOB, Social, Gender, Name, Admit, Discharge, Service Indicator, Rev Code, Total Charges, Days, Medicare Payments, Medicaid Payments, TPL Payments, Self-Pay Payments, Sum All Payments, and Medical Record #* fields.
    - A complete list (key) of payor plans is required to be submitted separately with the survey.
  - Submit Exhibit C in the format shown using Excel or a CSV file using the tab or | (pipe symbol above the enter key).

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Exhibit C – MEDICAID ELIGIBLE POPULATIONS (Example Medicaid Managed Care)

18

12/2/2015

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DSH SURVEY PART I – DSH YEAR DATA

Checklist

- Separate tab in Part I of the survey.
- Should be completed after Part I and Part II surveys are prepared.
- Includes list of all supporting documentation that needs to be submitted with the survey for audit.
- Includes Myers and Stauffer address and phone numbers.

MYERS AND STAUFFER

DSH SURVEY PART I – DSH YEAR DATA

Submission Checklist

1. Electronic copy of the DSH Survey Part I – DSH Year Data.
2. Electronic copy of the DSH Survey Part II – Cost Report Year Data.
3. Electronic Copy of Exhibit A – Uninsured Charges/Days.
   - *Must be in Excel (.xls or .xlsx) or CSV (.csv) using either a TAB or | (pipe symbol above the ENTER key).*
4. Description of logic used to compile Exhibit A. Include a copy of all financial classes and payor plan codes utilized during the cost report period and a description of which codes were included or excluded if applicable.

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DSH SURVEY PART I – DSH YEAR DATA

Submission Checklist (cont.)

5. Electronic Copy of Exhibit B – Self-Pay Payments.
   - *Must be in Excel (.xls or .xlsx) or CSV (.csv) using either a TAB or | (pipe symbol above the ENTER key).*
6. Description of logic used to compile Exhibit B. Include a copy of all transaction codes utilized to post payments during the cost reporting period and a description of which codes were included or excluded if applicable.

MYERS AND STAUFFER

DSH SURVEY PART I – DSH YEAR DATA

Submission Checklist (cont.)

7. Electronic copy of Exhibit C for hospital-generated data (includes Medicaid eligibles, Medicare cross-over, Medicaid MCO, Other Medicaid eligible, or Out-Of-State Medicaid data that isn't supported by a state-provided or MCO-provided report).
   - *Must be in Excel (.xls or .xlsx) or CSV (.csv) using either a TAB or | (pipe symbol above the ENTER key).*
8. Description of logic used to compile each Exhibit C. Include a copy of all financial classes and payor plan codes utilized during the cost report period and a description of which codes were included or excluded if applicable.

19

12/2/2015

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DSH SURVEY PART I – DSH YEAR DATA

Submission Checklist (cont.)

9. Copies of all out-of-state Medicaid fee-for-service PS&Rs (Remittance Advice Summary or Paid Claims Summary including cross-overs) if applicable.
10. Copies of all out-of-state Medicaid managed care PS&Rs (Remittance Advice Summary or Paid Claims Summary including cross-overs) if applicable.
11. Copies of in-state Medicaid managed care PS&Rs (Remittance Advice Summary or Paid Claims Summary including cross-overs) if applicable.

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DSH SURVEY PART I – DSH YEAR DATA

Submission Checklist (cont.)

12. Support for Section 1011 (Undocumented Alien) payments if not applied at patient level in Exhibit B.
13. Documentation supporting out-of-state DSH payments received. Examples may include remittances, detailed general ledgers, or add-on rates.
14. Financial statements to support total charity care charges and state / local govt. cash subsidies reported.
15. Revenue code cross-walk used to prepare cost report.

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DSH SURVEY PART I – DSH YEAR DATA

Submission Checklist (cont.)

16. A detailed working trial balance used to prepare each cost report (including revenues).
17. A detailed revenue working trial balance by payor/contract. The schedule should show charges, contractual adjustments, and revenues by payor plan and contract (e.g., Medicare, each Medicaid agency payor, each Medicaid Managed care contract).
18. Electronic copy of all cost reports used to prepare each DSH Survey Part II.
19. Documentation supporting cost report payments calculated for Medicaid/Medicare cross-overs (dual eligibles).

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20

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FAQ

1. **What is the definition of uninsured for Medicaid DSH purposes?**

   Uninsured patients are individuals with no source of third party health care coverage (insurance) for the specific inpatient or outpatient hospital service provided. Prisoners must be excluded.

   - On December 3, 2014, CMS finalized the proposed rule published on January 18, 2012 Federal Register to clarify the definition of uninsured and prisoners.
   - Under this final DSH rule, the DSH examination looks at whether a patient is uninsured using a "service-specific" approach.
   - Based on the 2014 final DSH rule, the survey allows for hospitals to report "fully exhausted" and "insurance non-covered" services as uninsured.

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

MYERS AND STAUFFER LC

FAQ

1. **What is the definition of uninsured for Medicaid DSH purposes? (Continued from previous slide)**

   Excluded prisoners were defined in the 2014 final DSH rule as:

   - Individuals who are inmates in a public institution or are otherwise involuntarily held in secure custody as a result of criminal charges. These individuals are considered to have a source of third party coverage.
     - Prisoner Exception
       - If a person has been released from secure custody and is referred to the hospital by law enforcement or correction authorities, they can be included.
       - The individual must be admitted as a patient rather than an inmate to the hospital.
       - The individual cannot be in restraints or seclusion.

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MYERS AND STAUFFER LC

FAQ

2. **What is meant by "Exhausted" and "Non-Covered" in the uninsured Exhibits A and B?**

   Under the December 3, 2014 final DSH rule, hospitals can report services if insurance is "fully exhausted" or if the service provided was "not covered" by insurance. The service must still be a hospital service that would normally be covered by Medicaid.

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MYERS AND STAUFFER LC

FAQ

3. **What categories of services can be included in uninsured on the DSH survey?**

   Services that are defined under the Medicaid state plan as a Medicaid inpatient or outpatient hospital service may be included in uninsured. *(Auditing & Reporting pg. 77907 & Reporting pg. 77913)*

   - There has been some confusion with this issue. CMS attempts to clarify this in #24 of their FAQ titled "*Additional Information on the DSH Reporting and Audit Requirements*". It basically says if a service is a hospital service it can be included even if Medicaid only covered a specific group of individuals for that service.
     - EXAMPLE: A state Medicaid program covers speech therapy for beneficiaries under 18 at a hospital. However, a hospital provides speech therapy to an uninsured individual over the age of 18. Can they include it in uninsured? The answer is "Yes" since speech therapy is a Medicaid hospital service even though they wouldn't cover beneficiaries over 18.

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21

12/2/2015

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FAQ

4. **Can a service be included as uninsured, if insurance didn't pay due to improper billing, late billing, or lack of medical necessity?**

   No. Improper billing by a provider does not change the status of the individual as insured or otherwise covered. In no instance should costs associated with claims denied by a health insurance carrier for such a reason be included in the calculation of hospital-specific uncompensated care (would include denials due to medical necessity). *(Reporting pages 77911 & 77913)*

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

MYERS AND STAUFFER LC

FAQ

5. **Can unpaid co-pays or deductibles be considered uninsured?**

   No. The presence of a co-pay or deductible indicates the patient has insurance and none of the co-pay or deductible is allowable even under the 2014 final DSH rule. *(Reporting pg. 77911)*

6. **Can a hospital report their charity charges as uninsured?**

   Typically a hospital's charity care will meet the definition of uninsured but since charity care policies vary there may be exceptions. If charity includes unpaid co-pays or deductibles, those cannot be included. Each hospital will have to review their charity care policy and compare it to the DSH rules for uninsured.

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

MYERS AND STAUFFER LC

FAQ

7. **Can bad debts be considered uninsured?**

   Bad debts cannot be considered uninsured if the patient has third party coverage. The exception would be if they qualify as uninsured under the 2014 final DSH rule as an exhausted or insurance non-covered service (but those must be separately identified).

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

MYERS AND STAUFFER LC

FAQ

8. **How do IMDs (Institutes for Mental Disease) report patients between 22-64 that are not Medicaid-eligible due to their admission to the IMD?**

   - Many states remove individuals between the ages of 22 and 64 from Medicaid eligibility rolls; if so these costs should be reported as uncompensated care for the uninsured. If these individuals are reported on the Medicaid eligibility rolls, they should be reported as uncompensated care for the Medicaid population. *(Reporting pg. 77929 and CMS Feb. 2010 FAQ #28 – Additional Information on the DSH Reporting and Audit Requirements)*
   - Per CMS FAQ, if the state removes a patient from the Medicaid rolls and they have Medicare, they cannot be included in the DSH UCC.
     - Under the 2014 final DSH rule, these patients may be included in the DSH UCC if Medicare is exhausted.

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22

12/2/2015

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FAQ

9. Can a hospital report services covered under automobile polices as uninsured?

Not if the automobile policy pays for the service. We interpret the phrase "who have health insurance (or other third party coverage)" to broadly refer to individuals who have creditable coverage consistent with the definitions under 45 CFR Parts 144 and 146, as well as individuals who have coverage based upon a legally liable third party payer. The phrase would not include individuals who have insurance that provides only excepted benefits, such as those described in 42 CFR 146.145, unless that insurance actually provides coverage for the hospital services at issue (such as when an automobile liability insurance policy pays for a hospital stay). *(Reporting pages 77911 & 77916)*

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

MYERS AND STAUFFER

FAQ

10. How are patient payments to be reported on Exhibit B?

Cash-basis! Exhibit B should include patient payments collected during the cost report period (cash-basis). Under the DSH rules, uninsured cost must be offset by uninsured cash-basis payments.

11. Does Exhibit B include only uninsured patient payments or ALL patient payments?

ALL patient payments. Exhibit B includes all cash-basis patient payments so that testing can be done to ensure no payments were left off of the uninsured. The total patient payments on Exhibit B should reconcile to your total self-pay payments collected during the cost report year.

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

MYERS AND STAUFFER

FAQ

12. Should we include state and local government payments for indigent in uninsured on Exhibit B?

Uninsured payments do not include payments made by State-only or local only government programs for services provided to indigent patients (no Federal share or match). *(Reporting pg. 77914)*

13. Can physician services be included in the DSH survey?

Physician costs that are billed as physician professional services and reimbursed as such should not be considered in calculating the hospital-specific DSH limit. *(Reporting pg. 77924)*

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MYERS AND STAUFFER

FAQ

14. Do dual eligibles (Medicare/Medicaid) have to be included in the Medicaid UCC?

Yes. CMS believes the costs attributable to dual eligible patients should be included in the calculation of the uncompensated care costs, but in calculating the uncompensated care costs, it is necessary to take into account both the Medicare and Medicaid payments made. In calculating the Medicare payment, the hospital should include all Medicare adjustments (DSH, IME, GME, etc.). *(Reporting pg. 77913)*

15. Does Medicaid MCO and Out-of-State Medicaid have to be included?

Yes. Under the statutory hospital-specific DSH limit, it is necessary to calculate the cost of furnishing services to the Medicaid populations, including those served by Managed Care Organizations (MCO), and offset those costs with payments received by the hospital for those services. *(Reporting pages 77930 & 77926)*

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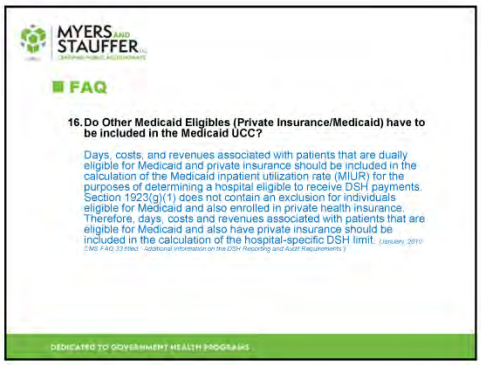
23

12/2/2015


MYERS AND STAUFFER
FAQ
16. Do Other Medicaid Eligibles (Private Insurance/Medicaid) have to be included in the Medicaid UCC?
Days, costs, and revenues associated with patients that are dually eligible for Medicaid and private insurance should be included in the calculation of the Medicaid inpatient utilization rate (MIUR) for the purposes of determining a hospital eligible to receive DSH payments. Section 1923(g)(1) does not contain an exclusion for individuals eligible for Medicaid and also enrolled in private health insurance. Therefore, days, costs and revenues associated with patients that are eligible for Medicaid and also have private insurance should be included in the calculation of the hospital-specific DSH limit. (January 2010 CMS FAQ 33 titled "Additional Information on the DSH Reporting and Audit Requirements")
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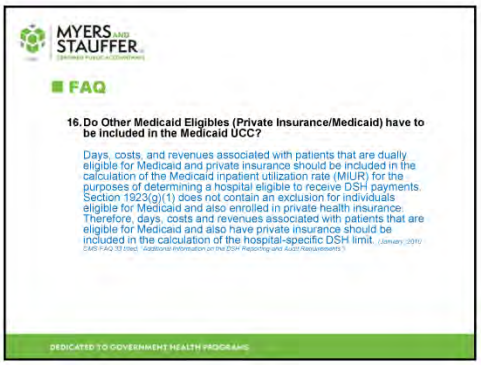
MYERS AND STAUFFER
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24

Appendix G: Sample Training Materials 2

12/2/2015

MYERS AND STAUFFER LC

DISPROPORTIONATE SHARE HOSPITAL (DSH) PAYMENT EXAMINATION

Oregon Fiscal Year 2012

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

MYERS AND STAUFFER LC

TRAINING OVERVIEW

- DSH Examination Overview
- Review SFY 2012 Medicaid DSH Examination Survey
- FAQ's – DSH Reporting
- Conclusion

DEDICATED TO GOVERNMENT HEALTH PROGRAMS 2

MYERS AND STAUFFER LC

DSH PAYMENTS

DSH implemented under Section 1923 of the Social Security Act (42 U.S. Code, Section 1396r-4)

Medicaid DSH payments are intended to cover no more that the uncompensated care costs for Medicaid and uninsured (for hospitals that qualify)

DEDICATED TO GOVERNMENT HEALTH PROGRAMS 3

MYERS AND STAUFFER LC

DSH AUDIT FEDERAL REGULATION

- FR Vol. 73, No. 245, Friday, Dec. 19, 2008
  - Independent Certified Audit of State DSH Payment Adjustments
- FR Vol. 79, No. 232, Wednesday, Dec. 03, 2015
  - Final Rule Expanded Definition of Uninsured
- 42 CFR 447.299 (c)
  - Medicaid Reporting Requirements
- 42 CFR 455.300 Purpose
- 42 CFR 455.301 Definitions
- 42 CFR 455.304 Conditions for FFP

DEDICATED TO GOVERNMENT HEALTH PROGRAMS 4

1

12/2/2015

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FEDERAL REGULATION

Medicaid DSH Reporting Requirements

For DSH year 2005 and after state must annually report:

1. Hospital Name
2. Estimate of hospital-specific DSH limit
3. Medicaid I/P utilization rate
4. Low income utilization rate
5. State defined DSH qualification criteria
6. IP/OP Medicaid FFS basic rate payments
7. IP/OP Medicaid managed care payments
8. Supplemental/enhanced Medicaid IP/OP payments
9. Total Medicaid IP/OP payments

5

MYERS AND STAUFFER

FEDERAL REGULATION

Medicaid Reporting Requirements:

For DSH year 2005 and after state must annually report:

10. Total cost of care for Medicaid IP/OP Services
11. Total Medicaid uncompensated care
12. Uninsured IP/OP revenue
13. Total applicable Section 1011 payments
14. Total cost of IP/OP care for the uninsured
15. Total uninsured IP/OP uncompensated care costs
16. Total annual uncompensated care costs
17. DSH payments

6

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FEDERAL REGULATION

Medicaid Reporting Requirements:

New Reporting Elements starting 2011:

18. Medicaid Provider Number
19. Medicare Provider Number
20. Total Hospital Cost
21. Out of State Hospitals must report items 1-6, 8, 9, 17, 18 and 19.

7

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FEDERAL REGULATION

Definitions: (42 CFR 455.301)

Independent certified audit

- Auditor operates independently from Medicaid agency and subject hospitals
- Express an opinion for each verification
- Identify data issues or other caveats (e.g., missing or alternate data used)

Medicaid state plan rate year

- 12 month period defined by state's approved Medicaid state plan that estimates eligible uncompensated care costs and determines corresponding DSH payments as well as other Medicaid payment rates (Oregon's DSH Plan Year is 6/30).

8

2

12/2/2015

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FEDERAL REGULATION

Conditions for Federal Financial Participation (42 CFR 455.304)

- **General**
  - The state must submit an independent audit to CMS for each completed Medicaid state plan rate year
  - FFP is not available for expenditures for DSH payments that are found in the independent certified audit to exceed the hospital-specific eligible uncompensated care cost limit
- **Timing**
  - Audits must be completed by the last day of the federal fiscal year ending three years from the end of the Medicaid state plan rate year under audit
  - 2012 audits are due to the state by September 30, 2015

9

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FEDERAL REGULATION

Conditions for Federal Financial Participation (42 CFR 455.304)

- **Documentation**
- State must use the following data sources to complete the independent certified audit:
  - Approved Medicaid state plan
  - Payments and utilization information from State's MMIS
  - Medicare 2552-96/2552-10 (Teaching Hospitals use version that includes direct medical education in allowable costs)
  - Audited hospital financial statement and accounting records

10

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FEDERAL REGULATION

Conditions for Federal Financial Participation (FFP) (42 CFR 455.304)

Specific Requirements

- Verification No. 1: Each hospital in the state that qualifies for a DSH payment is allowed to retain that payment to offset its uncompensated costs.
- Verification No. 2: DSH payments made to each qualifying hospital comply with the hospital-specific DSH payment limit. The DSH payments made in the audited Medicaid state plan year must be measured against the actual uncompensated care cost in that same plan year.
- Verification No. 3: Only uncompensated care costs of furnishing inpatient and outpatient hospital services to Medicaid and uninsured individuals are eligible for inclusion of the hospital-specific DSH limit.

11

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FEDERAL REGULATION

Conditions for Federal Financial Participation (FFP) (42 CFR 455.304)

Specific Requirements

- Verification No. 4: For purposes of the hospital-specific DSH limit, Medicaid payments which are in excess of Medicaid costs must be applied against the uncompensated care costs.
- Verification No. 5: Any information and records of all of a hospital's Medicaid inpatient and outpatient and uninsured service costs have been separately documented and retained by the state.
- Verification No. 6: The information in Verification No. 5 includes a description of the methodology for calculating each hospital's payment limit under Section 1923(g)(1).

12

3

12/2/2015

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FEDERAL REGULATION

Conditions for Federal Financial Participation (FFP) (42 CFR 455.304)

Transition Provision

- Findings of state reports and audits for Medicaid state plan years 2005-2010 will not be given weight except to the extent that the findings draw into question the reasonableness of the state's uncompensated care cost estimates used for calculating prospective DSH payments for Medicaid state plan year **2011** and thereafter.
- SPY **2011** was the first year with the potential for pay back of FFP for DSH payments exceeding limit. SPY **2012** under review is subject to pay back of FFP for DSH payments exceeding limit.

13

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SELECT CMS RESPONSES TO COMMENTS

Medicaid Services

- A state cannot include in calculating the hospital-specific DSH limit cost of services that are not defined under its Medicaid state plan as a Medicaid inpatient or outpatient hospital service *(Auditing & Reporting pg. 77907 & Reporting pg. 77913)*
  - There has been some confusion with this issue. CMS attempts to clarify this in **#24** of their FAQ titled "*Additional Information on the DSH Reporting and Audit Requirements*". It basically says if a service is a hospital service it can be included even if Medicaid only covered a specific group of individuals for that service.
    - EXAMPLE : A state Medicaid program covers speech therapy for beneficiaries under 18 at a hospital. However, a hospital provides speech therapy to an uninsured individual over the age of 18. Can they include it in uninsured? The answer is "Yes" since speech therapy is a Medicaid hospital service even though they wouldn't cover beneficiaries over 18.

14

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SELECT CMS RESPONSES TO COMMENTS

Medicaid Services (continued)

- CMS believes the costs attributable to dual eligible patients should be included in the calculation of the uncompensated care costs, but in calculating the uncompensated care costs, it is necessary to take into account both the Medicare and Medicaid payments made. In calculating the Medicare payment, the hospital should include all Medicare adjustments (DSH, IME, GME, etc.) *(Reporting pg. 77912)*
- Under the statutory hospital-specific DSH limit, it is necessary to calculate the cost of furnishing services to the Medicaid populations, including those served by Managed Care Organizations (MCO), and offset those costs with payments received by the hospital for those services. *(Reporting pages 77920 & 77926)*

15

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SELECT CMS RESPONSES TO COMMENTS

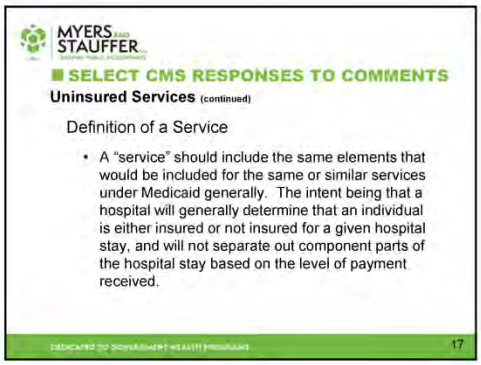
Uninsured Services

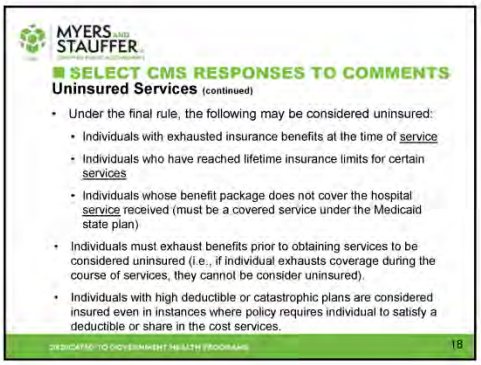
- Originally (per FR Vol. 73, No. 245, Friday, Dec. 19, 2008) uninsured patients were defined as individuals with no source of third party health care coverage (insurance). If the patient had health insurance, even if the third party insurer did not pay, those services were insured and could not be reported as uninsured on the survey.
- The uninsured definition was expanded per FR Vol. 79, No. 232, Wednesday, Dec. 03, 2015.
  - Under the expanded uninsured definition final rule, the DSH examination now looks at whether a patient is uninsured using a "service-specific" approach as opposed to the creditable coverage approach previously employed.

16

4

12/2/2015


MYERS AND STAUFFER
SELECT CMS RESPONSES TO COMMENTS
Uninsured Services (continued)
Definition of a Service
• A "service" should include the same elements that would be included for the same or similar services under Medicaid generally. The intent being that a hospital will generally determine that an individual is either insured or not insured for a given hospital stay, and will not separate out component parts of the hospital stay based on the level of payment received.
17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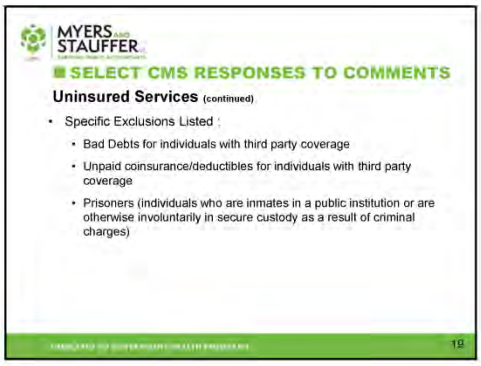
SELECT CMS RESPONSES TO COMMENTS
Uninsured Services (continued)
• Under the final rule, the following may be considered uninsured:
• Individuals with exhausted insurance benefits at the time of service
• Individuals who have reached lifetime insurance limits for certain services
• Individuals whose benefit package does not cover the hospital service received (must be a covered service under the Medicaid state plan)
• Individuals must exhaust benefits prior to obtaining services to be considered uninsured (i.e., if individual exhausts coverage during the course of services, they cannot be consider uninsured).
• Individuals with high deductible or catastrophic plans are considered insured even in instances where policy requires individual to satisfy a deductible or share in the cost services.
18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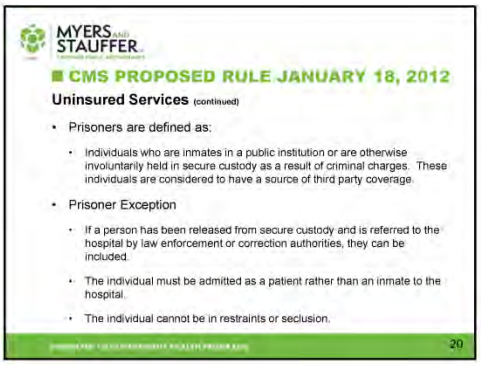
SELECT CMS RESPONSES TO COMMENTS
Uninsured Services (continued)
• Specific Exclusions Listed :
• Bad Debts for individuals with third party coverage
• Unpaid coinsurance/deductibles for individuals with third party coverage
• Prisoners (individuals who are inmates in a public institution or are otherwise involuntarily in secure custody as a result of criminal charges)
19


MYERS AND STAUFFER
CMS PROPOSED RULE JANUARY 18, 2012
Uninsured Services (continued)
• Prisoners are defined as:
• Individuals who are inmates in a public institution or are otherwise involuntarily held in secure custody as a result of criminal charges. These individuals are considered to have a source of third party coverage.
• Prisoner Exception
• If a person has been released from secure custody and is referred to the hospital by law enforcement or correction authorities, they can be included.
• The individual must be admitted as a patient rather than an inmate to the hospital.
• The individual cannot be in restraints or seclusion.
20

5

12/2/2015

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SELECT CMS RESPONSES TO COMMENTS

Uninsured Services (continued)

Improper billing by a provider does not change the status of the individual as insured or otherwise covered. In no instance should costs associated with claims denied by a health insurance carrier for such a reason be included in the calculation of hospital-specific uncompensated care (would include denials due to medical necessity). *(Reporting pages 77911 & 77913)*

A state cannot include in calculating the hospital-specific DSH limit cost of services that are not defined under its Medicaid state plan as a Medicaid inpatient or outpatient hospital service. *(Auditing & Reporting pg. 77907 & Reporting pg. 77913)*

21

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SELECT CMS RESPONSES TO COMMENTS

Uninsured Payments

- Uncompensated inpatient and outpatient hospital care costs for uninsured services is offset by payments actually made by or on behalf of those patients in the Medicaid state plan rate year under audit. *(Reporting pg. 77913)*
- Revenues (cash receipts) required to be offset against a hospital's DSH limit include any amounts received by the hospital by or on behalf of either self-pay or uninsured individuals during the Medicaid state plan rate year under audit. *(Reporting pg. 77913)*
- Uninsured payments do not include payments made by State-only or local only government programs for services provided to indigent patients (no Federal share or match). *(Reporting pg. 77914)*

22

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SELECT CMS RESPONSES TO COMMENTS

Uninsured Payments (continued)

- Due to the inability to control these revenue streams and to foster administrative ease, audits should take into account these self-pay revenues (including liens and collections) during the year in which they are received, irrespective of whether such revenues are applicable to a prior period. *(Reporting pg. 77927)*
- Section 1011 payments are made to a hospital for costs incurred for the provision of specific services to specific aliens to the extent that the provider was not otherwise reimbursed for such services. Because a portion of the Section 1011 payments are made for uncompensated care costs that are also eligible under the hospital-specific DSH limit a defined portion of the section 1011 payments must be recognized as an amount paid on behalf of those uninsured. *(Reporting pg. 77916)*

23

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SELECT CMS RESPONSES TO COMMENTS

Other Reporting Issues

CMS confirms that intergovernmental transfers (IGT) cannot be included as a cost for purposes of calculating the hospital-specific DSH limit. An IGT is not a cost of providing health care services. *(Reporting pg. 77920)*

Medicaid hospital payments include the total computable federal and non-federal share payment amount. Certified Public Expenditure (CPE) and IGT are non-federal share payments to the extent that governmentally operated hospitals are the source. *(Reporting pg. 77922)*

Physician costs that are billed as physician professional services and reimbursed as such should not be considered in calculating the hospital-specific DSH limit. *(Reporting pg. 77924)*

24

6

12/2/2015

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SELECT CMS RESPONSES TO COMMENTS

Reporting (Institution for Mental Disease)

- The reporting requirement should include whether the DSH facility is an IMD. Identification of whether a DSH facility is an IMD will assist CMS in assessing the appropriateness of the DSH payment. *(Reporting pg. 77929)*
- Many states remove individuals between the ages of 22 and 64 from Medicaid eligibility rolls; if so these costs should be reported as uncompensated care for the uninsured. If these individuals are reported on the Medicaid eligibility rolls, they should be reported as uncompensated care for the Medicaid population. *(Reporting pg. 77929 and CMS Feb. 2010 FAQ #28 – Additional Information on the DSH Reporting and Audit Requirements)*

25

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SELECT CMS RESPONSES TO COMMENTS

Auditing (General)

- If audited Medicare cost reports are not available, the DSH report and audit may need to be based on Medicare cost reports as filed. *(Auditing pg. 77929 and CMS Feb. 2010 FAQ #1 – Additional Information on the DSH Reporting and Audit Requirements)*
- The methodology will need to exclude costs from services furnished to individuals with third party coverage, prisoners, duplicate accounts, individuals included in calculating the Medicaid shortfall, charges associated with elective procedures, and any professional charges. *(Auditing pg. 77930)*
- In instances where the hospital financial and cost reporting periods differ from the Medicaid state plan rate year, states and auditors may need to review multiple audited hospital financial reports and cost reports to fully cover the Medicaid state plan rate year under audit. At most, two financial and/or cost reports should provide the appropriate data. The data may need to be allocated based on the months covered by the financial or cost reporting period that are included in the Medicaid state plan period under audit. *(Auditing pg. 77930)*

26

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SELECT CMS RESPONSES TO COMMENTS

Auditing (Time Period Subject to Audit)

To the extent that a significant adjustment to Medicaid payments occurs and States claim Federal matching dollars (or return Federal matching dollars) as a prior period adjustment, States should correct the audit and report by indicating post-audit adjustments to Medicaid and DSH payments (or uncompensated care costs if Medicaid payment adjustments affect the Medicaid shortfall). When post-audit retroactive adjustments to Medicaid payments are not significant, the payments should be measured during the audit of the Medicaid State plan rate year in which the revenues are received. *CMS Feb. 2010 FAQ #17-Additonal Information on the DSH Reporting and Audit Requirements.*

27

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DSH DEVELOPMENTS

MEDICAID DSH Additional Information of the DSH Reporting and Audit Requirements – Part 2 -CMS Website April 7, 2014

- *#12 in the CMS document – Specifies payments made by a managed-care organization related to state-only/local-only indigent care patients must be offset against costs because the statutory exception to exclude the state-only/local government only payments is limited to payments received directly from the state or unit of government.*

7

12/2/2015

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DSH DEVELOPMENTS

- **#35-Hospitals opened after December 22, 1987 do not automatically meet the exemption to the obstetric services requirement.**
  - Indicates that hospitals claiming the exemption to having two physicians providing obstetric services because they did not offer non-emergency obstetrical services to the general population as of December 22, 1987 cannot claim that exemption if the hospital opened after December 22, 1987.

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DSH DEVELOPMENTS

- CMS audits of the DSH audits continue
  - CMS goal is to audit every state over the next few years.
  - CMS audits the state and independent auditor's procedures and documentation for sufficiency.
  - A few providers in each state are also selected for further scrutiny (these providers in effect get audited twice).
  - No formal results have yet been issued

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DSH DEVELOPMENTS

- CMS audits of the DSH audits continue
  - CMS intends to issue formal results to provide more guidance to states, auditors and providers.
  - CMS has not announced when Oregon will be audited

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QUESTIONS/COMMENTS?

32

8

12/2/2015

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PAID CLAIMS DATA FOR 2012

- Medicaid fee-for-service paid claims data
  - Will be obtained from the state and will be sent to hospitals to be mapped and entered into Survey Part II Section H.
  - Reported based on cost report year (using admit date).
  - At revenue code level.
  - Summary or detailed data is available upon request once available.

MYERS AND STAUFFER

PAID CLAIMS DATA FOR 2012

- Medicare/Medicaid cross-over paid claims data
  - The hospital should send in a detailed listing in Exhibit C format.
  - Must EXCLUDE CHIP and other non-Title 19 services.
  - Should be reported based on cost report year (using admit date).

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PAID CLAIMS DATA FOR 2012

- Medicaid managed care paid claims data
  - If the hospital cannot obtain a paid claims listing from the MCO, the hospital should send in a detailed listing in Exhibit C format.
  - Must EXCLUDE CHIP and other non-Title 19 services.
  - Should be reported based on cost report year (using admit date).

MYERS AND STAUFFER

PAID CLAIMS DATA FOR 2012

- Out-of-State Medicaid paid claims data
  - If the hospital cannot obtain a paid claims listing from the state, the hospital should send in a detailed listing in Exhibit C format.
  - Must EXCLUDE CHIP and other non-Title 19 services.
  - Should be reported based on cost report year (using admit date).

9

12/2/2015

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PAID CLAIMS DATA FOR 2012

- "Other" Medicaid Eligibles
  - Medicaid-eligible patient services where Medicaid did not receive the claim or have any cost-sharing may not be included in the state's data. The hospital must submit these eligible services on Exhibit C for them to be eligible for inclusion in the DSH uncompensated care cost (UCC).
  - This would include Medicare MCO primary/Medicaid secondary claims, **private insurance primary/Medicaid secondary claims**, and any other Medicaid eligible claims not included elsewhere.
  - Must EXCLUDE CHIP and other non-Title 19 services.
  - Should be reported based on cost report year (using admit date).

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PAID CLAIMS DATA FOR 2012

- "Other" Medicaid Eligibles (cont.)
  - 2008 DSH Rule and January, 2010 CMS FAQ #33 requires that ***all*** Medicaid eligibles are reported on the DSH survey and included in the UCC calculation.
  - Exhibit C should be submitted for this population. If no "Other" Medicaid Eligibles are submitted, we will contact you to request that they be submitted. If we still do not receive the requested Exhibit C, we may have to list the hospital as non-compliant in the 2012 DSH examination report.
  - Ensure that you ***separately report*** Medicaid, Medicare, third party liability (TPL), and self-pay payments in Exhibit C.

MYERS AND STAUFFER

PAID CLAIMS DATA FOR 2012

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

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10

12/2/2015

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DSH EXAMINATION SURVEYS

General Instruction – Survey Files

- The survey is split into 2 separate Excel files:
  - DSH Survey Part I – DSH Year Data.
    - DSH year-specific information.
    - Always complete one copy.
  - DSH Survey Part II – Cost Report Year Data.
    - Cost report year-specific information.
    - Complete a separate copy for each cost report year needed to cover the DSH year.
    - Hospitals with year end changes or that are new to DSH may have to complete 2 or 3 year ends.

MYERS AND STAUFFER

DSH EXAMINATION SURVEYS

General Instruction – Survey Files

- Don't complete a DSH Part II survey for a cost report year already submitted in a previous DSH exam year.
  - Example: Hospital A provided a survey for their year ending 12/31/11 with the DSH audit of SFY 2011 in the prior year. In the DSH year 2012 exam, Hospital A would only need to submit a survey for their year ending 12/31/12.
- Both surveys have an Instructions tab that has been updated. Please refer to those tabs if you are unsure of what to enter in a section. If it still isn't clear, please contact Myers and Stauffer.

MYERS AND STAUFFER

DSH EXAMINATION SURVEYS

General Instruction – HCRIS Data

- Myers and Stauffer will pre-load certain sections of Part II of the survey using the Healthcare Cost Report Information System (HCRIS) data from CMS. However, the hospital is responsible for reviewing the data to ensure it is correct and reflects the best available cost report (audited if available).
- Hospitals that do not have a Medicare cost report on file with CMS will not see any data pre-loaded and will need to complete all lines as instructed.

MYERS AND STAUFFER

DSH SURVEY PART I – DSH YEAR DATA

Section A

- DSH Year should already be filled in.
- Hospital name may already be selected (if not, select from the drop-down box).
- Verify the cost report year end dates (should only include those that weren't previously submitted).
  - If these are incorrect, please call Myers and Stauffer and request a new copy.

Section B

- Answer all OB questions using drop-down boxes.

11

12/2/2015

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DSH SURVEY PART I – DSH YEAR DATA

Section C

- Report any Medicaid supplemental payments, including UPL and Non-Claim Specific payments, for the state fiscal year. Do NOT include DSH payments.

Certification

- Answer the "Retain DSH" question but please note that IGTs and CPEs are not a basis for answering the question "No".
- Enter contact information.
- Have CEO or CFO sign this section after completion of Part II of the survey.

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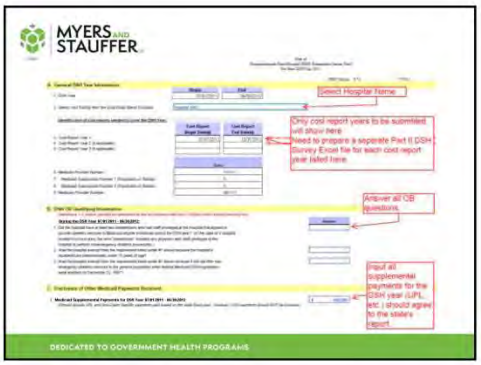

EXHIBIT A – UNINSURED CHARGES/DAYS BY REVENUE CODE

- Survey form Exhibit A has been designed to assist hospitals in collecting and reporting all uninsured charges and routine days needed to cost out the uninsured services.
  - Total hospital charges / routine days from Exhibit A must agree to the total entered in Section H of the survey.
  - Must be for dates of service (admit date basis) in the cost report fiscal year.
  - Line item data must be at patient date of service level with multiple lines showing revenue code level charges.

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12

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EXHIBIT A - UNINSURED

- Exhibit A:
  - Include Primary Payor Plan, Secondary Payor Plan, Provider #, Account # (unique by visit), Birth Date, SSN, and Gender , Name, Admit, Discharge, Service Indicator, Revenue Code, Total Charges (by revenue code), Days (by revenue code), Patient Payments, TPL, Claim Status fields, and Medical Record #.
  - A complete list (key) of payor plans is required to be submitted separately with the survey.

MYERS AND STAUFFER

EXHIBIT A - UNINSURED

- Claim Status (Column R) is the same as the prior year – need to indicate if Exhausted / Non-Covered Insurance claims are being included under the December 3, 2014 final DSH rule.
  - If exhausted / non-covered insurance services are included on Exhibit A, then they must also be included on Exhibit B for patient payments.
- Submit Exhibit A in the format shown either in Excel or a CSV file using the tab or | (pipe symbol above the enter key).

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EXHIBIT B – ALL PATIENT PAYMENTS (SELF-PAY) ON A CASH BASIS

- Survey form Exhibit B has been designed to assist hospitals in collecting and reporting all patient payments received on a cash basis.
  - Exhibit B should include all patient payments regardless of their insurance status.
  - Total patient payments from this exhibit are entered in Section E of the survey.
  - Insurance status should be noted on each patient payment so you can sub-total the uninsured hospital patient payments and enter them in Section H of the survey.

13

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EXHIBIT B – ALL PATIENT PAYMENTS (SELF-PAY) ON A CASH BASIS

- Patient payments received for uninsured services need to be reported on a cash basis.
  - For example, a cash payment received during the 2012 cost report year that relates to a service provided in the 2005 cost report year, must be used to reduce uninsured cost for the 2012 cost report year.

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EXHIBIT B – ALL PATIENT PAYMENTS (SELF-PAY) ON A CASH BASIS

- Exhibit B
  - Include *Primary Payor Plan, Secondary Payor Plan, Payment Transaction Code, Provider #, Account # (unique by visit), Birth Date, SSN,* and *Gender, Admit, Discharge, Date of Collection, Amount of Collection, 1011 Indicator, Service Indicator, Hospital Charges, Physician Charges, Non-Hospital Charges, Insurance Status, Claim Status, Calculated Collection, and Medical Record #* fields.
    - A separate "key" for all payment transaction codes should be submitted with the survey.
- Submit Exhibit B in the format shown using Excel or a CSV file using the tab or | (pipe symbol above the enter key).

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EXHIBIT C – HOSPITAL-PROVIDED MEDICAID DATA

- Medicaid data reported on the survey must be supported by a third-party paid claims summary such as a PS&R, Managed Care Plan provided report, or state-run paid claims report.
  - If not available, the hospital must submit the detail behind the reported survey data in the Exhibit C format. Otherwise, the data may not be allowed in the final UCC.

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14

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EXHIBIT C – HOSPITAL-PROVIDED MEDICAID DATA

- Types of data that may require an Exhibit C are as follows:
  - Self-reported Medicaid MCO data (Section H).
  - Self-reported Medicaid/Medicare cross-over data (Section H).
  - Self-reported "Other" Medicaid eligibles (Section H). This includes Medicare MCO/Medicaid, private insurance/Medicaid, and any other Medicaid eligible population not included elsewhere.
  - All self-reported Out-of-State Medicaid categories (Section I).

MYERS AND STAUFFER

EXHIBIT C – HOSPITAL-PROVIDED MEDICAID DATA

- Exhibit C
  - Include *Primary Payor Plan, Secondary Payor Plan, Hospital MCD #, Account # (unique by visit), Patient's MCD Recipient #, DOB, Social, Gender, Name, Admit, Discharge, Service Indicator, Rev Code, Total Charges, Days, Medicare Payments, Medicaid Payments, TPL Payments, Self-Pay Payments, Sum All Payments, and Medical Record #* fields.
    - A complete list (key) of payor plans is required to be submitted separately with the survey.
  - Submit Exhibit C in the format shown using Excel or a CSV file using the tab or | (pipe symbol above the enter key).

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15

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DSH YEAR SURVEY PART II SECTION D – GENERAL INFORMATION

Submit one copy of the part II survey for each cost report year not previously submitted.

- **Question #2 – An "X" should be shown in the column of the cost report year survey you are preparing.**
  - If you have multiple years listed, you will need to prepare multiple surveys).
  - If there is an error in the year ends, contact Myers and Stauffer to send out a new copy.
- **Question #3 – This question may be already answered based on pre-loaded HCRIS data. If your hospital is going to update the cost report data to a more recent version of the cost report, select the status of the cost report you are using with this drop-down box.**

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DSH YEAR SURVEY PART II SECTION E, MISC. PAYMENT INFO.

- 1011 Payments - You must report your Section 1011 payments included in payments on Exhibit B (posted at the patient level), and payments received but not included in Exhibit B (not posted at the patient level), and separate the 1011 payments between hospital services and non-hospital services (non-hospital services include physician services).
- If your facility received DSH payments from another state (other than your home state) these payments must be reported on this section of the survey (calculate amount for the cost report period).
- Enter in total cash basis patient payment totals from Exhibit B as instructed. These are check totals to compare to the supporting Exhibit B.

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16

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DSH YEAR SURVEY PART II
SECTION F MIUR/LIUR

- The state must report your actual MIUR and LIUR for the DSH year - data is needed to calculate the MIUR/LIUR.
- Section F-1: Total hospital days from cost report. Myers and Stauffer will pre-load CMS HCRIS cost report data into this section. If it is incorrect or doesn't agree to a more recently audited version of the cost report, please correct as needed and update question #3 in Section D.
- Section F-2: If cash subsidies are specified for I/P or O/P services, record them as such, otherwise record entire amount as unspecified.
- Section F-2: Report charity care charges based on your own hospital financials or the definition used for your state DSH payment (support must be submitted).

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MYERS AND STAUFFER

DSH YEAR SURVEY PART II
SECTION F, MIUR/LIUR

Section F-3: Report hospital revenues and contractual adjustments.

- Myers and Stauffer will pre-load CMS HCRIS cost report data into this section. If it is incorrect or doesn't agree to a more recently audited version of the cost report, please correct as needed and update question #3 in Section D.
- Totals should agree with the cost report worksheets G-2 and G-3. If not, provide an explanation with the survey.
- Contractuals by service center are set-up to calculate based on total revenues and the total contractuals from G-3. If you have contractuals by service center or the calculation does not reasonably state the contractual split between hospital and non-hospital, overwrite the formulas as needed and submit the necessary support.

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MYERS AND STAUFFER

NEW

DSH YEAR SURVEY PART II
SECTION F, MIUR/LIUR

Section F-3: Reconciling Items Necessary for Proper Calculation of LIUR

- Bad debt and charity care write-offs not included on G-3, line 2 should be entered on lines 28 and 29 so they can be properly excluded in calculating net patient service revenue utilized in the LIUR.
- Medicaid DSH payments and state and local patient care cash subsidies included on G-3, line 2 should be entered on line 30 and 31 so they can be properly excluded in calculating net patient service revenue also.
- Medicaid Provider Tax included on G-3, line 2 should be entered on line 32 so it can be properly excluded in calculating net patient service revenue.

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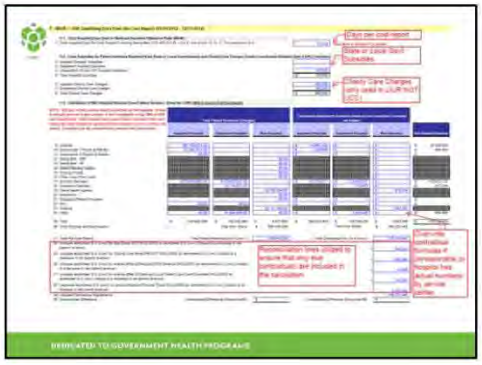

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17

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MYERS AND STAUFFER LC

DSH YEAR SURVEY PART II SECTION G, COST REPORT DATA

- Calculation of Routine Cost Per Diems
  - Days
  - Cost
- Calculation of Ancillary Cost-to-Charge Ratios
  - Charges
  - Cost

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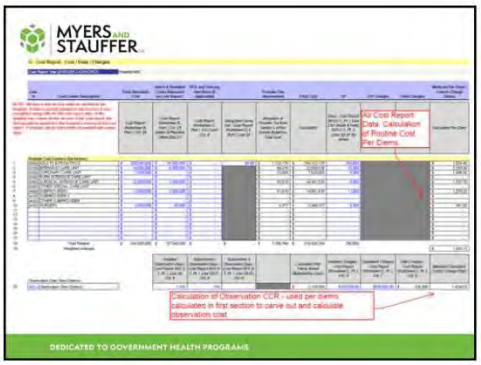

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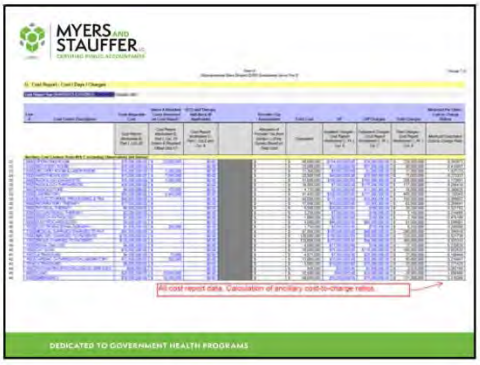

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MYERS AND STAUFFER LC

DSH SURVEY PART II SECTION H, IN-STATE MEDICAID

- Enter inpatient (routine) days, I/P and O/P charges, and payments. The form will calculate cost and shortfall / long-fall for:
  - In-State FFS Medicaid Primary *(Traditional Medicaid).*
  - In-State Medicaid Managed Care Primary *(Medicaid MCO).*
  - In-State Medicare FFS Cross-Overs *(Traditional Medicare with Traditional Medicaid Secondary).*
  - In-State Other Medicaid Eligibles *(would include Medicare MCO/Medicaid secondary, private insurance/Medicaid secondary and other Medicaid not included elsewhere).*

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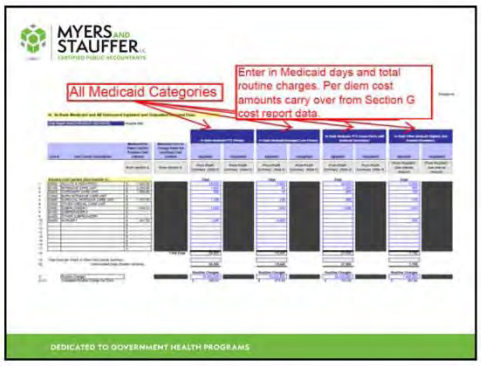
18

12/2/2015


MYERS AND STAUFFER LC
All Medicaid Categories
Enter in Medicaid days and total routine charges. Per diem cost amounts carry over from Section G cost report data.
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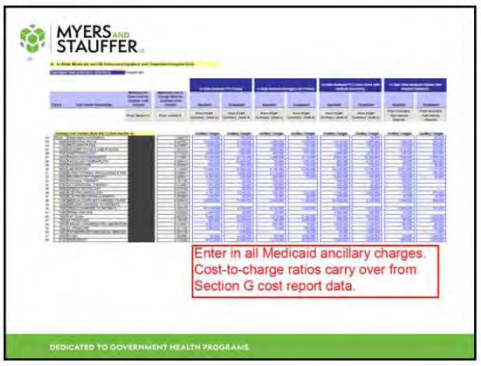
MYERS AND STAUFFER LC
Enter in all Medicaid ancillary charges. Cost-to-charge ratios carry over from Section G cost report data.
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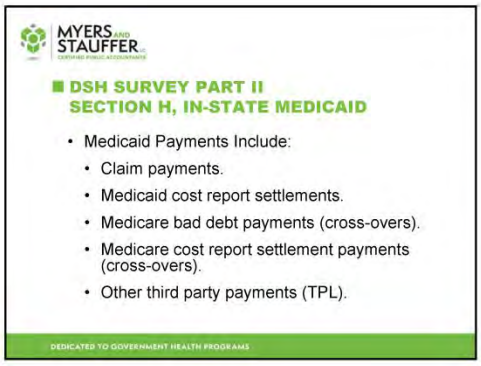
MYERS AND STAUFFER LC
DSH SURVEY PART II
SECTION H, IN-STATE MEDICAID
Medicaid Payments Include:
Claim payments.
Medicaid cost report settlements.
Medicare bad debt payments (cross-overs).
Medicare cost report settlement payments (cross-overs).
Other third party payments (TPL).
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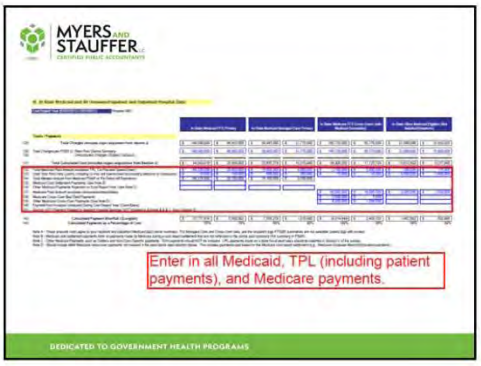
MYERS AND STAUFFER LC
Enter in all Medicaid, TPL (including patient payments), and Medicare payments.
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19

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DSH SURVEY PART II SECTION H, UNINSURED

- Report uninsured services, patient days (by routine cost center) and ancillary charges by cost center.
- Survey form Exhibit A shows the data elements that need to be collected and provided to Myers and Stauffer.
- For uninsured payments, enter the uninsured hospital patient payment totals from your Survey form Exhibit B. Do NOT pick up the non-hospital or insured patient payments in Section H even though they are reported in Exhibit B.

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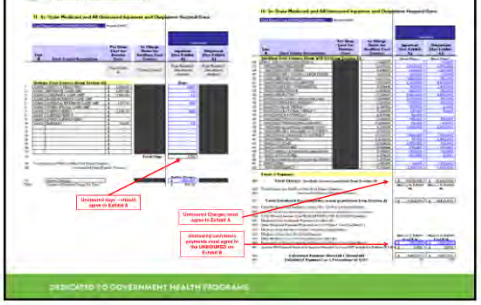

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DSH SURVEY PART II – SECTION H, IN-STATE MEDICAID AND UNINSURED

- Additional Edits
  - In the far right column, you will see an edit message if your total charges or days by cost center exceed those reported from the cost report in Section G of the survey. Please clear these edits prior to filing the survey.
  - Calculated payments as a percentage of cost by payor (at bottom).
    - Review percentage for reasonableness.

MYERS AND STAUFFER

DSH SURVEY PART II SECTION I, OUT OF STATE MEDICAID

- Report Out-of-State Medicaid days, ancillary charges and payments.
- Report in the same format as Section H. Days, charges and payments received must agree to the other state's PS&R (or similar) claim payment summary. If no summary is available, submit Exhibit C (hospital data) as support.
- If your hospital provided services to several other states, please consolidate your data and provide support for your survey responses.

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20

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DSH SURVEY PART II – SECTIONS J & K, ORGAN ACQUISITION

- Total organ acquisition cost and total useable organs will be pre-loaded from HCRIS data. If it is incorrect or doesn't agree to a more recently audited version of the cost report, please correct as needed and update question #3 in Section D.
- These schedules should be used to calculate organ acquisition cost for Medicaid (in-state and out-of-state) and uninsured.
- Summary claims data (PS&R) or similar documents and provider records (organ counts) must be provided to support the charges and useable organ counts reported on the survey. The data for uninsured organ acquisitions should be reported separately from the Exhibit A.

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DSH SURVEY PART II - SECTIONS J & K, ORGAN ACQUISITION

- All organ acquisition charges should be reported in Sections J & K of the survey and should be EXCLUDED from Section H & I of the survey. (days should also be excluded from H & I)
- Medicaid and uninsured charges/days included in the cost report D-4 series as part of the total organ acquisition charges/days, must be excluded from Sections H & I of the survey.

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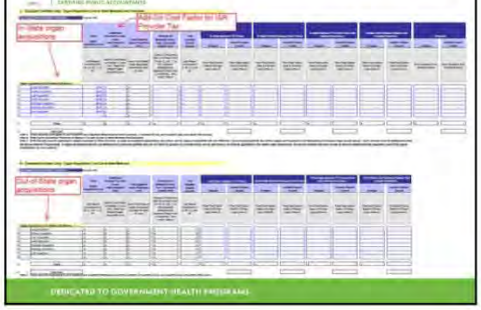

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DSH SURVEY PART II SECTION L, PROVIDER TAXES

- **Federal Register / Vol. 75, No. 157 dated Monday, August 16, 2010 (CMS-1498-F)**
  - Discussion on costs of provider taxes as allowable costs for CAHs. (page 50362)
  - CMS is concerned that, even if a particular tax may be an allowable cost that is related to the care of Medicare beneficiaries, providers may not, in fact, ''incur'' the entire amount of these assessed taxes. (page 50363)

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21

12/2/2015

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DSH SURVEY PART II SECTION L, PROVIDER TAXES

"This clarification will not have an effect of disallowing any particular tax but rather make clear that our **Medicare contractors** will continue to **make a determination** of whether a provider tax is allowable, on a **case-by-case basis**, using our current and longstanding reasonable cost principles. In addition, the **Medicare contractors** will continue to determine if an adjustment to the amount of allowable provider taxes is warranted to account for payments a provider receives that are associated with the assessed tax." (emphasis added)

MYERS AND STAUFFER

DSH SURVEY PART II SECTION L, PROVIDER TAXES

- Due to Medicare cost report tax adjustments, an adjustment to cost may be necessary to properly reflect the Medicaid and uninsured share of the provider tax assessment for some hospitals.
- Medicaid and uninsured share of the provider tax assessment is an allowable cost for Medicaid DSH even if Medicare offsets some of the tax.

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DSH SURVEY PART II SECTION L, PROVIDER TAXES

- The Medicaid DSH audit rule clearly indicates that the portion of permissible provider taxes applicable to Medicaid and uninsured is an allowable cost for the Medicaid DSH UCC. (FR Vol. 73, No. 245, Friday, Dec. 19, 2008, page 77923)
- By "permissible", they are referring to a "valid" tax in accordance with 42 CFR §433.68(b).

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DSH SURVEY PART II SECTION L, PROVIDER TAXES

- *Ober Kaler 2005 and 2006 Illinois Tax Groups v. Blue Cross Blue Shield Association/National Government Services, ¶82,616, (Mar. 30, 2010)* supports allowing the provider taxes to be treated differently for Medicare than for Medicaid.
- *Abraham Lincoln Memorial Hospital v. Sebelius*, No. 11-2809 (7th Cir. October 16, 2012) also states that because the two programs are independent of one another, CMS's decisions with respect to a State's Medicaid program are not controlling on how CMS interprets the application of Medicare provisions.

22

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DSH SURVEY PART II SECTION L, PROVIDER TAXES

- Section L is used to report allowable Medicaid Provider Tax.
- Added to assist in reconciling total provider tax expense reported in the cost report and the amount actually incurred by a hospital (paid to the state).
- Complete the section using cost report data and hospital's own general ledger.

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MYERS AND STAUFFER LC

DSH SURVEY PART II SECTION L, PROVIDER TAXES

- All permissible provider tax not included in allowable cost on the cost report will be added back and allocated to the Medicaid and uninsured UCC on a reasonable basis (e.g., charges).

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MYERS AND STAUFFER LC

DSH SURVEY PART II SECTION L, PROVIDER TAXES

- At a minimum the following should still be excluded from the final tax expense:
  - Additional payments paid into the association "pool" should NOT be included in the tax expense.
  - Association fees.
  - Non-hospital taxes (e.g., nursing home and pharmacy taxes).

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23

12/2/2015

DSH SURVEY PART I – DSH YEAR DATA

Checklist

- Separate tab in Part I of the survey.
- Should be completed after Part I and Part II surveys are prepared and Exhibits A-C completed.
- Includes list of all supporting documentation that needs to be submitted with the survey for audit.
- Includes Myers and Stauffer address and phone numbers.

DSH SURVEY PART I - DSH YEAR DATA

Submission Checklist

1. Electronic copy of the DSH Survey Part I – DSH Year Data.
2. Electronic copy of the DSH Survey Part II – Cost Report Year Data.
3. Electronic Copy of Exhibit A – Uninsured Charges/Days.
   - *Must be in Excel (.xls or .xlsx) or CSV (.csv) using either a TAB or | (pipe symbol above the ENTER key).*
4. Description of logic used to compile Exhibit A. Include a copy of all financial classes and payor plan codes utilized during the cost report period and a description of which codes were included or excluded if applicable.

DSH SURVEY PART I - DSH YEAR DATA

Submission Checklist (cont.)

5. Electronic Copy of Exhibit B – Self-Pay Payments.
   - *Must be in Excel (.xls or .xlsx) or CSV (.csv) using either a TAB or | (pipe symbol above the ENTER key).*
6. Description of logic used to compile Exhibit B. Include a copy of all transaction codes utilized to post payments during the cost reporting period and a description of which codes were included or excluded if applicable.

24

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DSH SURVEY PART I – DSH YEAR DATA

Submission Checklist (cont.)

7. Electronic copy of Exhibit C for hospital-generated data (includes Medicaid eligibles, Medicare cross-over, Medicaid MCO, Other Medicaid eligible, or Out-Of-State Medicaid data that isn't supported by a state-provided or MCO-provided report).
   - *Must be in Excel (.xls or .xlsx) or CSV (.csv) using either a TAB or | (pipe symbol above the ENTER key).*
8. Description of logic used to compile each Exhibit C. Include a copy of all financial classes and payor plan codes utilized during the cost report period and a description of which codes were included or excluded if applicable.

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DSH SURVEY PART I – DSH YEAR DATA

Submission Checklist (cont.)

9. Copies of all out-of-state Medicaid fee-for-service PS&Rs (Remittance Advice Summary or Paid Claims Summary including cross-overs) if applicable.
10. Copies of all out-of-state Medicaid managed care PS&Rs (Remittance Advice Summary or Paid Claims Summary including cross-overs) if applicable.
11. Copies of in-state Medicaid managed care PS&Rs (Remittance Advice Summary or Paid Claims Summary including cross-overs) if applicable.

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DSH SURVEY PART I – DSH YEAR DATA

Submission Checklist (cont.)

12. Support for Section 1011 (Undocumented Alien) payments if not applied at patient level in Exhibit B.
13. Documentation supporting out-of-state DSH payments received. Examples may include remittances, detailed general ledgers, or add-on rates.
14. Financial statements to support total charity care charges and state / local govt. cash subsidies reported.
15. Revenue code cross-walk used to prepare cost report.

MYERS AND STAUFFER

DSH SURVEY PART I – DSH YEAR DATA

Submission Checklist (cont.)

16. A detailed working trial balance used to prepare each cost report (including revenues).
17. A detailed revenue working trial balance by payor/contract. The schedule should show charges, contractual adjustments, and revenues by payor plan and contract (e.g., Medicare, each Medicaid agency payor, each Medicaid Managed care contract).
18. Electronic copy of all cost reports used to prepare each DSH Survey Part II.
19. Documentation supporting cost report payments calculated for Medicaid/Medicare cross-overs (dual eligibles).

25

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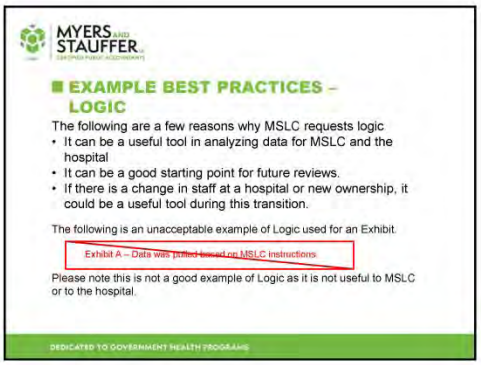
MYERS AND STAUFFER
EXAMPLE BEST PRACTICES – LOGIC
The following are a few reasons why MSLC requests logic
• It can be a useful tool in analyzing data for MSLC and the hospital
• It can be a good starting point for future reviews.
• If there is a change in staff at a hospital or new ownership, it could be a useful tool during this transition.
The following is an unacceptable example of Logic used for an Exhibit.
Exhibit A – Data was pulled based on MSLC instructions
Please note this is not a good example of Logic as it is not useful to MSLC or to the hospital.
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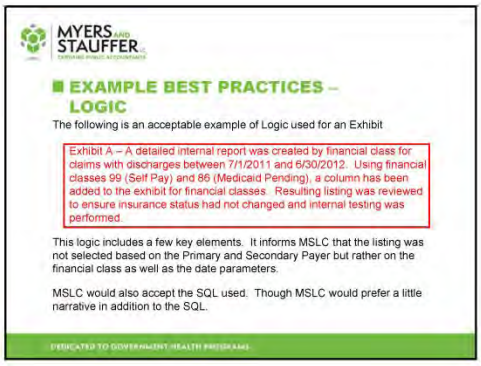
MYERS AND STAUFFER
EXAMPLE BEST PRACTICES – LOGIC
The following is an acceptable example of Logic used for an Exhibit
Exhibit A – A detailed internal report was created by financial class for claims with discharges between 7/1/2011 and 6/30/2012. Using financial classes 99 (Self Pay) and 86 (Medicaid Pending), a column has been added to the exhibit for financial classes. Resulting listing was reviewed to ensure insurance status had not changed and internal testing was performed.
This logic includes a few key elements. It informs MSLC that the listing was not selected based on the Primary and Secondary Payer but rather on the financial class as well as the date parameters.
MSLC would also accept the SQL used. Though MSLC would prefer a little narrative in addition to the SQL.
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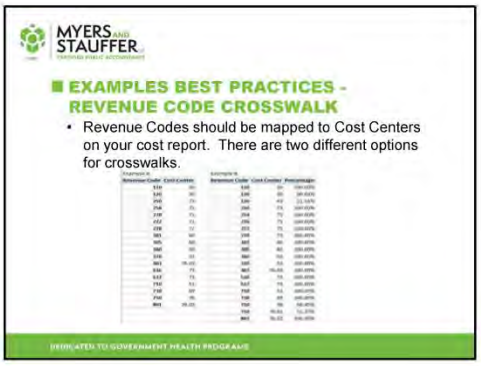
MYERS AND STAUFFER
EXAMPLES BEST PRACTICES - REVENUE CODE CROSSWALK
• Revenue Codes should be mapped to Cost Centers on your cost report. There are two different options for crosswalks.
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26

12/2/2015

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REVENUE CODE CROSSWALK EXAMPLE B

Easy steps to building a crosswalk based on Exhibit

Note additional data has been added in columns to the right of the standard format.

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MYERS AND STAUFFER

REVENUE CODE CROSSWALK EXAMPLE B

- Select all of the data in the Exhibit and insert a pivot table based on the data.

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REVENUE CODE CROSSWALK EXAMPLE B

- Select Row Labels
  - Revenue Code
  - Cost Center
- ∑ Values
  - Total Charges for Services Provided by Revenue Code

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REVENUE CODE CROSSWALK EXAMPLE B

- ∑ Values
  - Total Charges for Services Provided by Revenue Code

Needs to be formatted

Left click on Field and Select Value Field Settings

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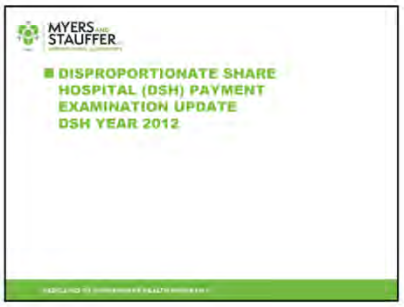
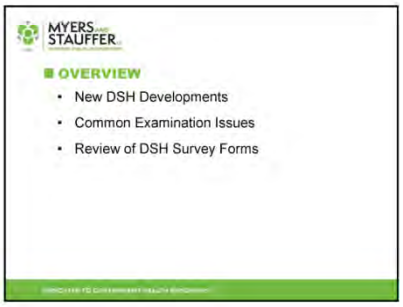
27

Appendix H: Sample Training Materials 3

12/2/2015

South Carolina DSH Training





1

12/2/2015

NEW DSH DEVELOPMENTS

- *December 3, 2014 Final Rule Expanded Definition of Uninsured implemented in FR Vol. 79, No. 232, Wednesday, Dec. 03, 2014, Final Rule*
  - Definitions of uninsured as laid out in the January 2012 proposed rule have been finalized.
  - Myers and Stauffer has been utilizing the definitions of uninsured as stated in the January 2012 proposed rule since the 2009 DSH examinations.
  - Now that the proposed rule has been finalized, Myers and Stauffer will continue to utilize those definitions as they have been since the 2009 DSH examinations.

NEW DSH DEVELOPMENTS

- Under the final rule, the DSH examination will now look at whether a patient is uninsured using a "service-specific" approach as opposed to the creditable coverage approach previously employed.

NEW DSH DEVELOPMENTS

- Under the final rule, the following may be considered uninsured:
  - Individuals with exhausted insurance benefits at the time of service
  - Individuals who have reached lifetime insurance limits for certain services
  - Individuals whose benefit package does not cover the hospital service received (must be a covered service under the Medicaid state plan)

NEW DSH DEVELOPMENTS

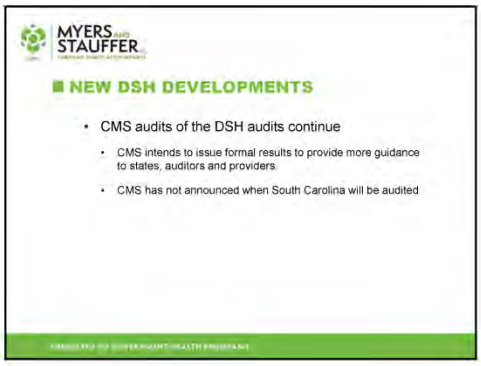
- Individuals must exhaust benefits prior to obtaining services to be considered uninsured (i.e., if individual exhausts coverage during the course of services, they cannot be consider uninsured).
- Individuals with high deductible or catastrophic plans are considered insured even in instances where policy requires individual to satisfy a deductible or share in the cost services.

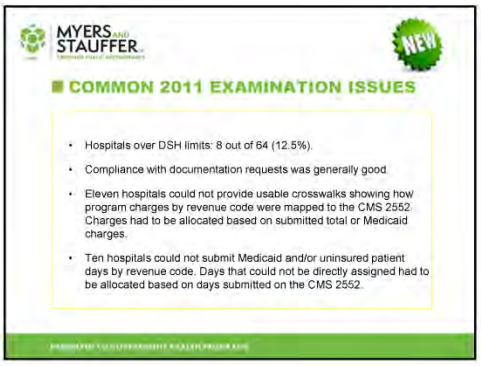
2

12/2/2015


MYERS AND STAUFFER
NEW DSH DEVELOPMENTS
Specific Exclusions Listed in the Proposed Rule:
Bad Debts for individuals with third party coverage
Unpaid coinsurance/deductibles for individuals with third party coverage
Prisoners (individuals who are inmates in a public institution or are otherwise involuntarily in secure custody as a result of criminal charges)


MYERS AND STAUFFER
NEW DSH DEVELOPMENTS
CMS audits of the DSH audits continue
CMS goal is to audit every state over the next few years.
CMS audits the state and independent auditor's procedures and documentation for sufficiency.
A few providers in each state are also selected for further scrutiny (these providers in effect get audited twice).
No formal results have yet been issued


MYERS AND STAUFFER
NEW DSH DEVELOPMENTS
CMS audits of the DSH audits continue
CMS intends to issue formal results to provide more guidance to states, auditors and providers.
CMS has not announced when South Carolina will be audited


MYERS AND STAUFFER
NEW
COMMON 2011 EXAMINATION ISSUES
Hospitals over DSH limits: 8 out of 64 (12.5%).
Compliance with documentation requests was generally good.
Eleven hospitals could not provide usable crosswalks showing how program charges by revenue code were mapped to the CMS 2552. Charges had to be allocated based on submitted total or Medicaid charges.
Ten hospitals could not submit Medicaid and/or uninsured patient days by revenue code. Days that could not be directly assigned had to be allocated based on days submitted on the CMS 2552.

3

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COMMON 2011 EXAMINATION ISSUES

- Four hospitals submitted insufficient information to calculate the Low Income Utilization Rate (LIUR). LIUR shown as 0% on Annual Reporting Requirements Schedule.
- Two hospitals could not supply adequate support for Medicaid crossover charges and patient days. State data had to be used as alternate data, which is not necessarily complete.
- Three hospitals did not sign survey certification statement.

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PAID CLAIMS DATA UPDATE FOR 2012

- Medicaid fee-for-service paid claims data
  - Will be obtained from the state and will be mapped by MSLC using the hospital submitted crosswalk and entered into Survey Part II Section H.
  - Reported based on cost report year (using discharge date).
  - At revenue code level.
  - Summary or detailed data is available upon request once available.

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MYERS AND STAUFFER

PAID CLAIMS DATA UPDATE FOR 2012

- Medicare/Medicaid cross-over paid claims data
  - The hospital should send in a detailed listing in Exhibit C format (consistent with prior year).
  - Must EXCLUDE CHIP and other non-Title 19 services.
  - Should be reported based on cost report year (using discharge date).

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PAID CLAIMS DATA UPDATE FOR 2012

- Medicaid managed care paid claims data
  - If the hospital cannot obtain a paid claims listing from the MCO, the hospital should send in a detailed listing in Exhibit C format (consistent with prior year).
  - Must EXCLUDE CHIP and other non-Title 19 services.
  - Should be reported based on cost report year (using discharge date).

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4

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PAID CLAIMS DATA UPDATE FOR 2012

- Out-of-State Medicaid paid claims data
  - If the hospital cannot obtain a paid claims listing from the state, the hospital should send in a detailed listing in Exhibit C format (consistent with prior year).
  - Must EXCLUDE CHIP and other non-Title 19 services.
  - Should be reported based on cost report year (using discharge date).

MYERS AND STAUFFER

PAID CLAIMS DATA UPDATE FOR 2012

- "Other" Medicaid Eligibles
  - Medicaid-eligible patient services where Medicaid did not receive the claim or have any cost-sharing may not be included in the state's data. The hospital must submit these eligible services on Exhibit C for them to be eligible for inclusion in the DSH uncompensated care cost (UCC).
  - This would include Medicare MCO primary/Medicaid secondary claims, private insurance primary/Medicaid secondary claims, and any other Medicaid eligible claims not included elsewhere.
  - Must EXCLUDE CHIP and other non-Title 19 services.
  - Should be reported based on cost report year (using discharge date).

MYERS AND STAUFFER

PAID CLAIMS DATA UPDATE FOR 2012

- "Other" Medicaid Eligibles (cont.)
  - 2008 DSH Rule and January, 2010 CMS FAQ #33 requires that ***all*** Medicaid eligibles are reported on the DSH survey and included in the UCC calculation.
  - Exhibit C should be submitted for this population. If no "Other" Medicaid Eligibles are submitted, we will contact you to request that they be submitted. If we still do not receive the requested Exhibit C, we may have to list the hospital as non-compliant in the 2012 DSH examination report.
  - Ensure that you ***separately report*** Medicaid, Medicare, third party liability (TPL), and self-pay payments in Exhibit C.

MYERS AND STAUFFER

PAID CLAIMS DATA UPDATE FOR 2012

- Uninsured Services
  - As in years past, uninsured charges/days will be reported on Exhibit A and patient payments will be reported on Exhibit B.
  - Should be reported based on cost report year (using discharge date).
  - Exhibit B patient payments will be reported based on cash basis (received during the cost report year).

5

12/2/2015

MYERS AND STAUFFER

DSH EXAMINATION SURVEYS

General Instruction – Survey Files

- The survey is split into 2 separate Excel files:
  - DSH Survey Part I – DSH Year Data.
    - DSH year-specific information.
    - Always complete one copy.
  - DSH Survey Part II – Cost Report Year Data.
    - Cost report year-specific information.
    - Complete a separate copy for each cost report year needed to cover the DSH year.
    - Hospitals with year end changes or that are new to DSH may have to complete 2 or 3 year ends.

MYERS AND STAUFFER

DSH EXAMINATION SURVEYS

General Instruction – Survey Files

- Don't complete a DSH Part II survey for a cost report year already submitted in a previous DSH exam year.
  - Example: Hospital A provided a survey for their year ending 12/31/11 with the DSH audit of SFY 2011 in the prior year. In the DSH year 2012 exam, Hospital A would only need to submit a survey for their year ending 12/31/12.
- Both surveys have an Instructions tab that has been updated. Please refer to those tabs if you are unsure of what to enter in a section. If it still isn't clear, please contact Myers and Stauffer.

MYERS AND STAUFFER

DSH EXAMINATION SURVEYS

General Instruction – HCRIS Data

- Myers and Stauffer will pre-load certain sections of Part II of the survey using the Healthcare Cost Report Information System (HCRIS) data from CMS. However, the hospital is responsible for reviewing the data to ensure it is correct and reflects the best available cost report (audited if available).
- Hospitals that do not have a Medicare cost report on file with CMS will not see any data pre-loaded and will need to complete all lines as instructed.

6

12/2/2015

MYERS AND STAUFFER LC

DSH SURVEY PART I – DSH YEAR DATA

Section A

- DSH Year should already be filled in.
- Hospital name may already be selected (if not, select from the drop-down box).
- Verify the cost report year end dates (should only include those that weren't previously submitted).
  - If these are incorrect, please call Myers and Stauffer and request a new copy.

Section B

- Answer all OB questions using drop-down boxes.

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MYERS AND STAUFFER LC

DSH SURVEY PART I – DSH YEAR DATA

Section C

- Report any Medicaid supplemental payments, including UPL and Non-Claim Specific payments, for the state fiscal year. Do NOT include DSH payments.

Certification

- Answer the "Retain DSH" question but please note that IGTs and CPEs are not a basis for answering the question "No".
- Enter contact information.
- Have CEO or CFO sign this section after completion of Part II of the survey.

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7

12/2/2015

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DSH YEAR SURVEY PART II SECTION D – GENERAL INFORMATION

Submit one copy of the part II survey for each cost report year not previously submitted.

- **Question #2 – An "X" should be shown in the column of the cost report year survey you are preparing.**
  - If you have multiple years listed, you will need to prepare multiple surveys).
  - If there is an error in the year ends, contact Myers and Stauffer to send out a new copy.
- **Question #3 – This question may be already answered based on pre-loaded HCRIS data. If your hospital is going to update the cost report data to a more recent version of the cost report, select the status of the cost report you are using with this drop-down box.**

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MYERS AND STAUFFER

DSH YEAR SURVEY PART II SECTION E, MISC. PAYMENT INFO.

- 1011 Payments - You must report your Section 1011 payments included in payments on Exhibit B (posted at the patient level), and payments received but not included in Exhibit B (not posted at the patient level), and separate the 1011 payments between hospital services and non-hospital services (non-hospital services include physician services).
- If your facility received DSH payments from another state (other than your home state) these payments must be reported on this section of the survey (calculate amount for the cost report period).
- Enter in total cash basis patient payment totals from Exhibit B as instructed. These are check totals to compare to the supporting Exhibit B.

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8

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MYERS AND STAUFFER

DSH YEAR SURVEY PART II
SECTION F MIUR/LIUR

- The state must report your actual MIUR and LIUR for the DSH year - data is needed to calculate the MIUR/LIUR.
- Section F-1: Total hospital days from cost report. Myers and Stauffer will pre-load CMS HCRIS cost report data into this section. If it is incorrect or doesn't agree to a more recently audited version of the cost report, please correct as needed and update question #3 in Section D.
- Section F-2: If cash subsidies are specified for I/P or O/P services, record them as such, otherwise record entire amount as unspecified.
- Section F-2: Report charity care charges based on your own hospital financials or the definition used for your state DSH payment (support must be submitted).

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MYERS AND STAUFFER

DSH YEAR SURVEY PART II
SECTION F, MIUR/LIUR

Section F-3: Report hospital revenues and contractual adjustments.

- Myers and Stauffer will pre-load CMS HCRIS cost report data into this section. If it is incorrect or doesn't agree to a more recently audited version of the cost report, please correct as needed and update question #3 in Section D.
- Totals should agree with the cost report worksheets G-2 and G-3. If not, provide an explanation with the survey.
- Contractuals by service center are set-up to calculate based on total revenues and the total contractuals from G-3. If you have contractuals by service center or the calculation does not reasonably state the contractual split between hospital and non-hospital, overwrite the formulas as needed and submit the necessary support.

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MYERS AND STAUFFER

NEW

DSH YEAR SURVEY PART II
SECTION F, MIUR/LIUR

Section F-3: Reconciling Items Necessary for Proper Calculation of LIUR

- Bad debt and charity care write-offs not included on G-3, line 2 should be entered on lines 28 and 29 so they can be properly excluded in calculating net patient service revenue utilized in the LIUR.
- Medicaid DSH payments and state and local patient care cash subsidies included on G-3, line 2 should be entered on line 30 and 31 so they can be properly excluded in calculating net patient service revenue also.
- Medicaid Provider Tax included on G-3, line 2 should be entered on line 32 so it can be properly excluded in calculating net patient service revenue.

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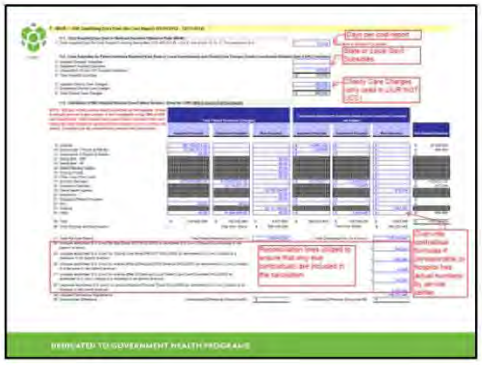

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9

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DSH YEAR SURVEY PART II SECTION G, COST REPORT DATA

- Calculation of Routine Cost Per Diems
  - Days
  - Cost
- Calculation of Ancillary Cost-to-Charge Ratios
  - Charges
  - Cost

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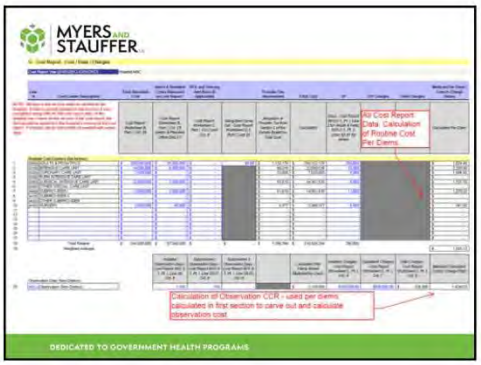

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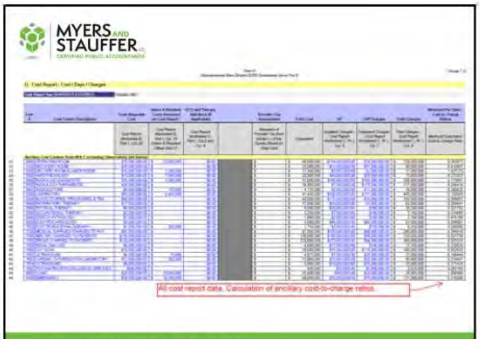

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MYERS AND STAUFFER LC

DSH SURVEY PART II SECTION H, IN-STATE MEDICAID

- Enter inpatient (routine) days, I/P and O/P charges, and payments. The form will calculate cost and shortfall / long-fall for:
  - In-State FFS Medicaid Primary *(Traditional Medicaid).*
  - In-State Medicaid Managed Care Primary *(Medicaid MCO).*
  - In-State Medicare FFS Cross-Overs *(Traditional Medicare with Traditional Medicaid Secondary).*
  - In-State Other Medicaid Eligibles *(would include Medicare MCO/Medicaid secondary, private insurance/Medicaid secondary and other Medicaid not included elsewhere).*

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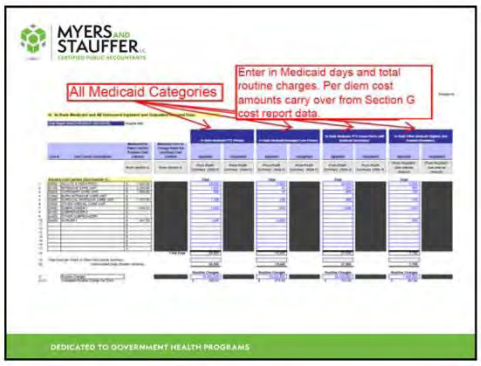
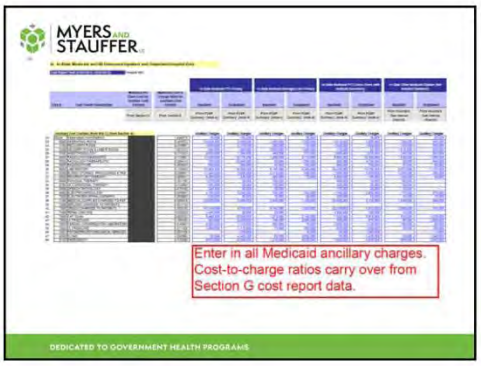
10

12/2/2015


MYERS AND STAUFFER LC
All Medicaid Categories
Enter in Medicaid days and total routine charges. Per diem cost amounts carry over from Section G cost report data.
DEDICATED TO GOVERNMENT HEALTH PROGRAMS


MYERS AND STAUFFER LC
Enter in all Medicaid ancillary charges. Cost-to-charge ratios carry over from Section G cost report data.
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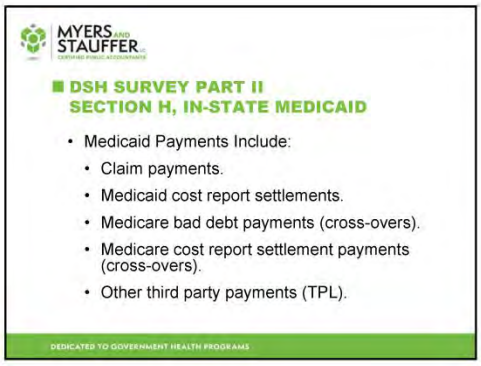
MYERS AND STAUFFER LC
DSH SURVEY PART II
SECTION H, IN-STATE MEDICAID
Medicaid Payments Include:
Claim payments.
Medicaid cost report settlements.
Medicare bad debt payments (cross-overs).
Medicare cost report settlement payments (cross-overs).
Other third party payments (TPL).
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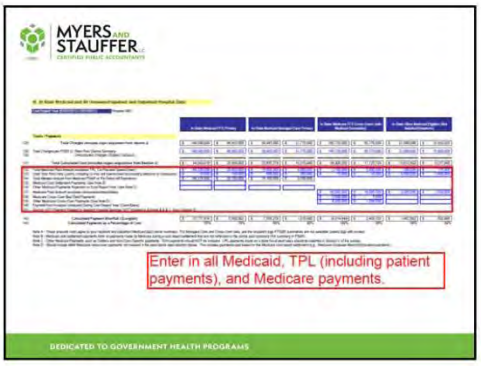

MYERS AND STAUFFER LC
Enter in all Medicaid, TPL (including patient payments), and Medicare payments.
DEDICATED TO GOVERNMENT HEALTH PROGRAMS

11

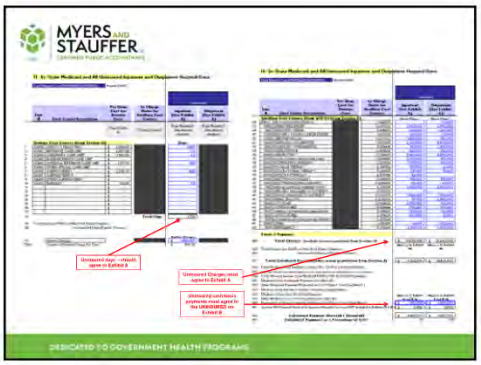
12/2/2015

MYERS AND STAUFFER

DSH SURVEY PART II SECTION H, UNINSURED

- Report uninsured services, patient days (by routine cost center) and ancillary charges by cost center.
- Survey form Exhibit A shows the data elements that need to be collected and provided to Myers and Stauffer.
- For uninsured payments, enter the uninsured hospital patient payment totals from your Survey form Exhibit B. Do NOT pick up the non-hospital or insured patient payments in Section H even though they are reported in Exhibit B.

DEDICATED TO GOVERNMENT HEALTH PROGRAMS



DEDICATED TO GOVERNMENT HEALTH PROGRAMS

MYERS AND STAUFFER

DSH SURVEY PART II – SECTION H, IN-STATE MEDICAID AND UNINSURED

- Additional Edits
  - In the far right column, you will see an edit message if your total charges or days by cost center exceed those reported from the cost report in Section G of the survey. Please clear these edits prior to filing the survey.
  - Calculated payments as a percentage of cost by payor (at bottom).
    - Review percentage for reasonableness.

MYERS AND STAUFFER

DSH SURVEY PART II SECTION I, OUT OF STATE MEDICAID

- Report Out-of-State Medicaid days, ancillary charges and payments.
- Report in the same format as Section H. Days, charges and payments received must agree to the other state's PS&R (or similar) claim payment summary. If no summary is available, submit Exhibit C (hospital data) as support.
- If your hospital provided services to several other states, please consolidate your data and provide support for your survey responses.

12

12/2/2015

MYERS AND STAUFFER

DSH SURVEY PART II – SECTIONS J & K, ORGAN ACQUISITION

- Total organ acquisition cost and total useable organs will be pre-loaded from HCRIS data. If it is incorrect or doesn't agree to a more recently audited version of the cost report, please correct as needed and update question #3 in Section D.
- These schedules should be used to calculate organ acquisition cost for Medicaid (in-state and out-of-state) and uninsured.
- Summary claims data (PS&R) or similar documents and provider records (organ counts) must be provided to support the charges and useable organ counts reported on the survey. The data for uninsured organ acquisitions should be reported separately from the Exhibit A.

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MYERS AND STAUFFER

DSH SURVEY PART II - SECTIONS J & K, ORGAN ACQUISITION

- All organ acquisition charges should be reported in Sections J & K of the survey and should be EXCLUDED from Section H & I of the survey. (days should also be excluded from H & I)
- Medicaid and uninsured charges/days included in the cost report D-4 series as part of the total organ acquisition charges/days, must be excluded from Sections H & I of the survey.

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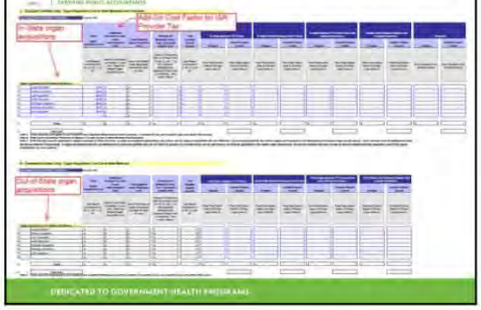
MYERS AND STAUFFER



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DSH SURVEY PART II SECTION L, PROVIDER TAXES

- **Federal Register / Vol. 75, No. 157 dated Monday, August 16, 2010 (CMS-1498-F)**
  - Discussion on costs of provider taxes as allowable costs for CAHs. (page 50362)
  - CMS is concerned that, even if a particular tax may be an allowable cost that is related to the care of Medicare beneficiaries, providers may not, in fact, "incur" the entire amount of these assessed taxes. (page 50363)

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13

12/2/2015

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DSH SURVEY PART II SECTION L, PROVIDER TAXES

"This clarification will not have an effect of disallowing any particular tax but rather make clear that our **Medicare contractors** will continue to **make a determination** of whether a provider tax is allowable, on a **case-by-case basis**, using our current and longstanding reasonable cost principles. In addition, the **Medicare contractors** will continue to determine if an adjustment to the amount of allowable provider taxes is warranted to account for payments a provider receives that are associated with the assessed tax." (emphasis added)

MYERS AND STAUFFER

DSH SURVEY PART II SECTION L, PROVIDER TAXES

- Due to Medicare cost report tax adjustments, an adjustment to cost may be necessary to properly reflect the Medicaid and uninsured share of the provider tax assessment for some hospitals.
- Medicaid and uninsured share of the provider tax assessment is an allowable cost for Medicaid DSH even if Medicare offsets some of the tax.

MYERS AND STAUFFER

DSH SURVEY PART II SECTION L, PROVIDER TAXES

- The Medicaid DSH audit rule clearly indicates that the portion of permissible provider taxes applicable to Medicaid and uninsured is an allowable cost for the Medicaid DSH UCC. (FR Vol. 73, No. 245, Friday, Dec. 19, 2008, page 77923)
- By "permissible", they are referring to a "valid" tax in accordance with 42 CFR §433.68(b).

MYERS AND STAUFFER

DSH SURVEY PART II SECTION L, PROVIDER TAXES

- *Ober Kaler 2005 and 2006 Illinois Tax Groups v. Blue Cross Blue Shield Association/National Government Services, ¶82,616, (Mar. 30, 2010)* supports allowing the provider taxes to be treated differently for Medicare than for Medicaid.
- *Abraham Lincoln Memorial Hospital v. Sebelius*, No. 11-2809 (7th Cir. October 16, 2012) also states that because the two programs are independent of one another, CMS's decisions with respect to a State's Medicaid program are not controlling on how CMS interprets the application of Medicare provisions.

14

12/2/2015

MYERS AND STAUFFER LC

DSH SURVEY PART II SECTION L, PROVIDER TAXES

- Section L is used to report allowable Medicaid Provider Tax.
- Added to assist in reconciling total provider tax expense reported in the cost report and the amount actually incurred by a hospital (paid to the state).
- Complete the section using cost report data and hospital's own general ledger.

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

MYERS AND STAUFFER LC

DSH SURVEY PART II SECTION L, PROVIDER TAXES

- All permissible provider tax not included in allowable cost on the cost report will be added back and allocated to the Medicaid and uninsured UCC on a reasonable basis (e.g., charges).

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MYERS AND STAUFFER LC

DSH SURVEY PART II SECTION L, PROVIDER TAXES

- At a minimum the following should still be excluded from the final tax expense:
  - Additional payments paid into the association "pool" should NOT be included in the tax expense.
  - Association fees.
  - Non-hospital taxes (e.g., nursing home and pharmacy taxes).

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MYERS AND STAUFFER LC

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

15

12/2/2015

MYERS AND STAUFFER

EXHIBIT A – UNINSURED CHARGES/DAYS BY REVENUE CODE

- Survey form Exhibit A has been designed to assist hospitals in collecting and reporting all uninsured charges and routine days needed to cost out the uninsured services.
  - Total hospital charges / routine days from Exhibit A must agree to the total entered in Section H of the survey.
  - Must be for dates of service in the cost report fiscal year.
  - Line item data must be at patient date of service level with multiple lines showing revenue code level charges.

MYERS AND STAUFFER

EXHIBIT A - UNINSURED

- Exhibit A:
  - Include Primary Payor Plan, Secondary Payor Plan, Provider #, Account # (unique by visit), Birth Date, SSN, and Gender , Name, Admit, Discharge, Service Indicator, Revenue Code, Total Charges (by revenue code), Days (by revenue code), Patient Payments, TPL, Claim Status fields, and Medical Record #.
  - A complete list (key) of payor plans is required to be submitted separately with the survey.

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EXHIBIT A - UNINSURED

- Claim Status (Column R) is the same as the prior year – need to indicate if Exhausted / Non-Covered Insurance claims are being included under the December 3, 2014 final DSH rule.
  - If exhausted / non-covered insurance services are included on Exhibit A, then they must also be included on Exhibit B for patient payments.
- Submit Exhibit A in the format shown either in Excel or a CSV file using the tab or | (pipe symbol above the enter key).

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16

12/2/2015

MYERS AND STAUFFER

EXHIBIT B – ALL PATIENT PAYMENTS (SELF-PAY) ON A CASH BASIS

- Survey form Exhibit B has been designed to assist hospitals in collecting and reporting all patient payments received on a cash basis.
  - Exhibit B should include all patient payments regardless of their insurance status.
  - Total patient payments from this exhibit are entered in Section E of the survey.
  - Insurance status should be noted on each patient payment so you can sub-total the uninsured hospital patient payments and enter them in Section H of the survey.

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

MYERS AND STAUFFER

EXHIBIT B – ALL PATIENT PAYMENTS (SELF-PAY) ON A CASH BASIS

- Patient payments received for uninsured services need to be reported on a cash basis.
  - For example, a cash payment received during the 2012 cost report year that relates to a service provided in the 2005 cost report year, must be used to reduce uninsured cost for the 2012 cost report year.

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

MYERS AND STAUFFER

EXHIBIT B – ALL PATIENT PAYMENTS (SELF-PAY) ON A CASH BASIS

- Exhibit B
  - Include *Primary Payor Plan, Secondary Payor Plan, Payment Transaction Code, Provider #, Account # (unique by visit), Birth Date, SSN,* and *Gender, Admit, Discharge, Date of Collection, Amount of Collection, 1011 Indicator, Service Indicator, Hospital Charges, Physician Charges, Non-Hospital Charges, Insurance Status, Claim Status, Calculated Collection, and Medical Record #* fields.
    - A separate "key" for all payment transaction codes should be submitted with the survey.
- Submit Exhibit B in the format shown using Excel or a CSV file using the tab or | (pipe symbol above the enter key).

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17

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EXHIBIT C – HOSPITAL-PROVIDED MEDICAID DATA

- Medicaid data reported on the survey must be supported by a third-party paid claims summary such as a PS&R, Managed Care Plan provided report, or state-run paid claims report.
  - If not available, the hospital must submit the detail behind the reported survey data in the Exhibit C format. Otherwise, the data may not be allowed in the final UCC.

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EXHIBIT C – HOSPITAL-PROVIDED MEDICAID DATA

- Types of data that may require an Exhibit C are as follows:
  - Self-reported Medicaid MCO data (Section H).
  - Self-reported Medicaid/Medicare cross-over data (Section H).
  - Self-reported "Other" Medicaid eligibles (Section H). This includes Medicare MCO/Medicaid, private insurance/Medicaid, and any other Medicaid eligible population not included elsewhere.
  - All self-reported Out-of-State Medicaid categories (Section I).

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EXHIBIT C – HOSPITAL-PROVIDED MEDICAID DATA

- Exhibit C
  - Include *Primary Payor Plan, Secondary Payor Plan, Hospital MCD #, Account # (unique by visit), Patient's MCD Recipient #, DOB, Social, Gender, Name, Admit, Discharge, Service Indicator, Rev Code, Total Charges, Days, Medicare Payments, Medicaid Payments, TPL Payments, Self-Pay Payments, Sum All Payments, and Medical Record #* fields.
    - A complete list (key) of payor plans is required to be submitted separately with the survey.
  - Submit Exhibit C in the format shown using Excel or a CSV file using the tab or | (pipe symbol above the enter key).

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Exhibit C – MEDICAID ELIGIBLE POPULATIONS (Example Medicaid Managed Care)

18

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DSH SURVEY PART I – DSH YEAR DATA

Checklist

- Separate tab in Part I of the survey.
- Should be completed after Part I and Part II surveys are prepared.
- Includes list of all supporting documentation that needs to be submitted with the survey for audit.
- Includes Myers and Stauffer address and phone numbers.

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DSH SURVEY PART I – DSH YEAR DATA

Submission Checklist

1. Electronic copy of the DSH Survey Part I – DSH Year Data.
2. Electronic copy of the DSH Survey Part II – Cost Report Year Data.
3. Electronic Copy of Exhibit A – Uninsured Charges/Days.
   - *Must be in Excel (.xls or .xlsx) or CSV (.csv) using either a TAB or | (pipe symbol above the ENTER key).*
4. Description of logic used to compile Exhibit A. Include a copy of all financial classes and payor plan codes utilized during the cost report period and a description of which codes were included or excluded if applicable.

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DSH SURVEY PART I – DSH YEAR DATA

Submission Checklist (cont.)

5. Electronic Copy of Exhibit B – Self-Pay Payments.
   - *Must be in Excel (.xls or .xlsx) or CSV (.csv) using either a TAB or | (pipe symbol above the ENTER key).*
6. Description of logic used to compile Exhibit B. Include a copy of all transaction codes utilized to post payments during the cost reporting period and a description of which codes were included or excluded if applicable.

MYERS AND STAUFFER

DSH SURVEY PART I – DSH YEAR DATA

Submission Checklist (cont.)

7. Electronic copy of Exhibit C for hospital-generated data (includes Medicaid eligibles, Medicare cross-over, Medicaid MCO, Other Medicaid eligible, or Out-Of-State Medicaid data that isn't supported by a state-provided or MCO-provided report).
   - *Must be in Excel (.xls or .xlsx) or CSV (.csv) using either a TAB or | (pipe symbol above the ENTER key).*
8. Description of logic used to compile each Exhibit C. Include a copy of all financial classes and payor plan codes utilized during the cost report period and a description of which codes were included or excluded if applicable.

19

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DSH SURVEY PART I – DSH YEAR DATA

Submission Checklist (cont.)

9. Copies of all out-of-state Medicaid fee-for-service PS&Rs (Remittance Advice Summary or Paid Claims Summary including cross-overs) if applicable.
10. Copies of all out-of-state Medicaid managed care PS&Rs (Remittance Advice Summary or Paid Claims Summary including cross-overs) if applicable.
11. Copies of in-state Medicaid managed care PS&Rs (Remittance Advice Summary or Paid Claims Summary including cross-overs) if applicable.

MYERS AND STAUFFER

DSH SURVEY PART I – DSH YEAR DATA

Submission Checklist (cont.)

12. Support for Section 1011 (Undocumented Alien) payments if not applied at patient level in Exhibit B.
13. Documentation supporting out-of-state DSH payments received. Examples may include remittances, detailed general ledgers, or add-on rates.
14. Financial statements to support total charity care charges and state / local govt. cash subsidies reported.
15. Revenue code cross-walk used to prepare cost report.

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DSH SURVEY PART I – DSH YEAR DATA

Submission Checklist (cont.)

16. A detailed working trial balance used to prepare each cost report (including revenues).
17. A detailed revenue working trial balance by payor/contract. The schedule should show charges, contractual adjustments, and revenues by payor plan and contract (e.g., Medicare, each Medicaid agency payor, each Medicaid Managed care contract).
18. Electronic copy of all cost reports used to prepare each DSH Survey Part II.
19. Documentation supporting cost report payments calculated for Medicaid/Medicare cross-overs (dual eligibles).

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20

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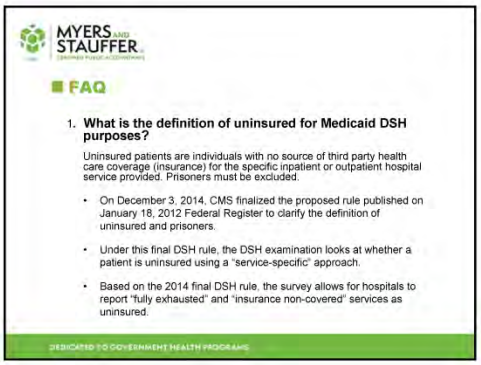
MYERS AND STAUFFER
FAQ
1. What is the definition of uninsured for Medicaid DSH purposes?
Uninsured patients are individuals with no source of third party health care coverage (insurance) for the specific inpatient or outpatient hospital service provided. Prisoners must be excluded.
• On December 3, 2014, CMS finalized the proposed rule published on January 18, 2012 Federal Register to clarify the definition of uninsured and prisoners.
• Under this final DSH rule, the DSH examination looks at whether a patient is uninsured using a "service-specific" approach.
• Based on the 2014 final DSH rule, the survey allows for hospitals to report "fully exhausted" and "insurance non-covered" services as uninsured.
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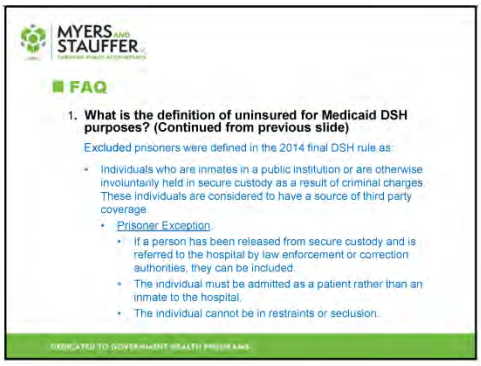
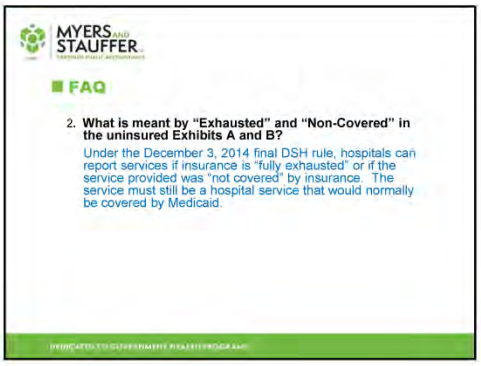
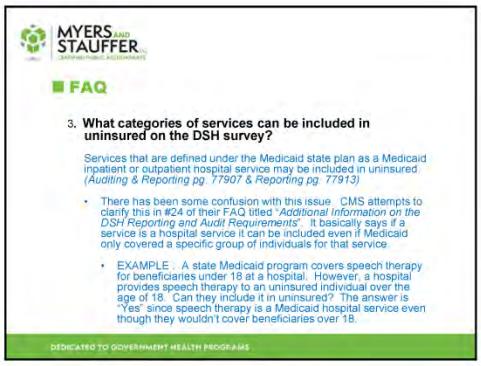

MYERS AND STAUFFER
FAQ
1. What is the definition of uninsured for Medicaid DSH purposes? (Continued from previous slide)
Excluded prisoners were defined in the 2014 final DSH rule as:
• Individuals who are inmates in a public institution or are otherwise involuntarily held in secure custody as a result of criminal charges. These individuals are considered to have a source of third party coverage.
• Prisoner Exception:
• If a person has been released from secure custody and is referred to the hospital by law enforcement or correction authorities, they can be included.
• The individual must be admitted as a patient rather than an inmate to the hospital.
• The individual cannot be in restraints or seclusion.


MYERS AND STAUFFER
FAQ
2. What is meant by "Exhausted" and "Non-Covered" in the uninsured Exhibits A and B?
Under the December 3, 2014 final DSH rule, hospitals can report services if insurance is "fully exhausted" or if the service provided was "not covered" by insurance. The service must still be a hospital service that would normally be covered by Medicaid.

21

12/2/2015


MYERS AND STAUFFER
FAQ
3. What categories of services can be included in uninsured on the DSH survey?
Services that are defined under the Medicaid state plan as a Medicaid inpatient or outpatient hospital service may be included in uninsured. (Auditing & Reporting pg. 77907 & Reporting pg. 77913)
• There has been some confusion with this issue. CMS attempts to clarify this in #24 of their FAQ titled "Additional Information on the DSH Reporting and Audit Requirements". It basically says if a service is a hospital service it can be included even if Medicaid only covered a specific group of individuals for that service.
• EXAMPLE : A state Medicaid program covers speech therapy for beneficiaries under 18 at a hospital. However, a hospital provides speech therapy to an uninsured individual over the age of 18. Can they include it in uninsured? The answer is "Yes" since speech therapy is a Medicaid hospital service even though they wouldn't cover beneficiaries over 18.
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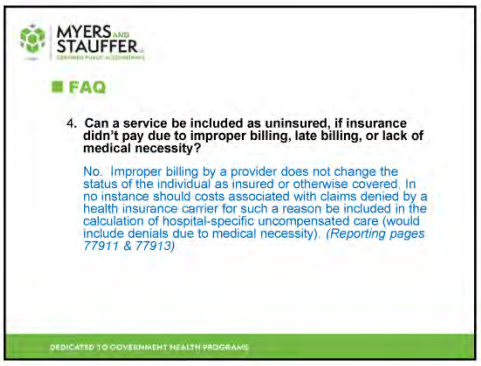
MYERS AND STAUFFER
FAQ
4. Can a service be included as uninsured, if insurance didn't pay due to improper billing, late billing, or lack of medical necessity?
No. Improper billing by a provider does not change the status of the individual as insured or otherwise covered. In no instance should costs associated with claims denied by a health insurance carrier for such a reason be included in the calculation of hospital-specific uncompensated care (would include denials due to medical necessity). (Reporting pages 77911 & 77913)
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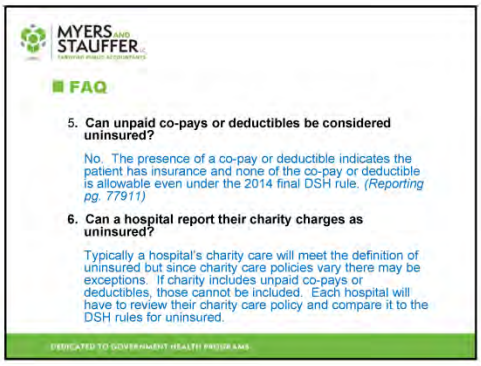
MYERS AND STAUFFER
FAQ
5. Can unpaid co-pays or deductibles be considered uninsured?
No. The presence of a co-pay or deductible indicates the patient has insurance and none of the co-pay or deductible is allowable even under the 2014 final DSH rule. (Reporting pg. 77911)
6. Can a hospital report their charity charges as uninsured?
Typically a hospital's charity care will meet the definition of uninsured but since charity care policies vary there may be exceptions. If charity includes unpaid co-pays or deductibles, those cannot be included. Each hospital will have to review their charity care policy and compare it to the DSH rules for uninsured.
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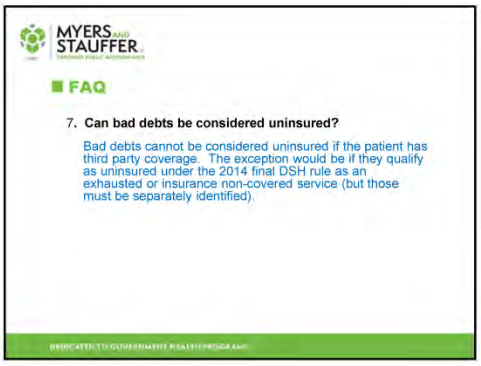
MYERS AND STAUFFER
FAQ
7. Can bad debts be considered uninsured?
Bad debts cannot be considered uninsured if the patient has third party coverage. The exception would be if they qualify as uninsured under the 2014 final DSH rule as an exhausted or insurance non-covered service (but those must be separately identified).

22

12/2/2015

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FAQ

8. How do IMDs (Institutes for Mental Disease) report patients between 22-64 that are not Medicaid-eligible due to their admission to the IMD?

- Many states remove individuals between the ages of 22 and 64 from Medicaid eligibility rolls; if so these costs should be reported as uncompensated care for the uninsured. If these individuals are reported on the Medicaid eligibility rolls, they should be reported as uncompensated care for the Medicaid population. *(Reporting pg. 77929 and CMS Feb. 2010 FAQ #28 – Additional Information on the DSH Reporting and Audit Requirements)*
- Per CMS FAQ, if the state removes a patient from the Medicaid rolls and they have Medicare, they cannot be included in the DSH UCC.
  - Under the 2014 final DSH rule, these patients may be included in the DSH UCC if Medicare is exhausted.

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FAQ

9. Can a hospital report services covered under automobile polices as uninsured?

Not if the automobile policy pays for the service. We interpret the phrase "who have health insurance (or other third party coverage)" to broadly refer to individuals who have creditable coverage consistent with the definitions under 45 CFR Parts 144 and 146, as well as individuals who have coverage based upon a legally liable third party payer. The phrase would not include individuals who have insurance that provides only excepted benefits, such as those described in 42 CFR 146.145, unless that insurance actually provides coverage for the hospital services at issue (such as when an automobile liability insurance policy pays for a hospital stay). *(Reporting pages 77911 & 77916)*

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FAQ

10. How are patient payments to be reported on Exhibit B?

Cash-basis! Exhibit B should include patient payments collected during the cost report period (cash-basis). Under the DSH rules, uninsured cost must be offset by uninsured cash-basis payments.

11. Does Exhibit B include only uninsured patient payments or ALL patient payments?

ALL patient payments. Exhibit B includes all cash-basis patient payments so that testing can be done to ensure no payments were left off of the uninsured. The total patient payments on Exhibit B should reconcile to your total self-pay payments collected during the cost report year.

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MYERS AND STAUFFER LC

FAQ

12. Should we include state and local government payments for indigent in uninsured on Exhibit B?

Uninsured payments do not include payments made by State-only or local only government programs for services provided to indigent patients (no Federal share or match). *(Reporting pg. 77914)*

13. Can physician services be included in the DSH survey?

Physician costs that are billed as physician professional services and reimbursed as such should not be considered in calculating the hospital-specific DSH limit. *(Reporting pg. 77904)*

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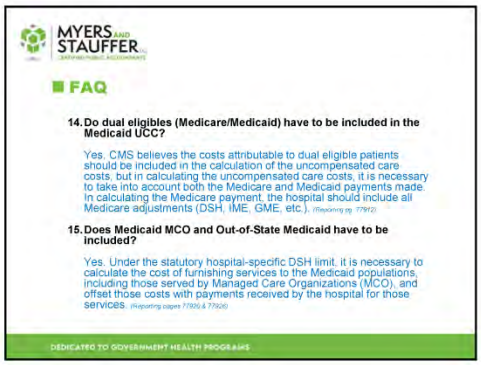
23

12/2/2015


MYERS AND STAUFFER
FAQ
14. Do dual eligibles (Medicare/Medicaid) have to be included in the Medicaid UCC?
Yes. CMS believes the costs attributable to dual eligible patients should be included in the calculation of the uncompensated care costs, but in calculating the uncompensated care costs, it is necessary to take into account both the Medicare and Medicaid payments made. In calculating the Medicare payment, the hospital should include all Medicare adjustments (DSH, IME, GME, etc.). (Reporting pg. 77972)
15. Does Medicaid MCO and Out-of-State Medicaid have to be included?
Yes. Under the statutory hospital-specific DSH limit, it is necessary to calculate the cost of furnishing services to the Medicaid populations, including those served by Managed Care Organizations (MCO), and offset those costs with payments received by the hospital for those services. (Reporting pages 77926 & 77926)
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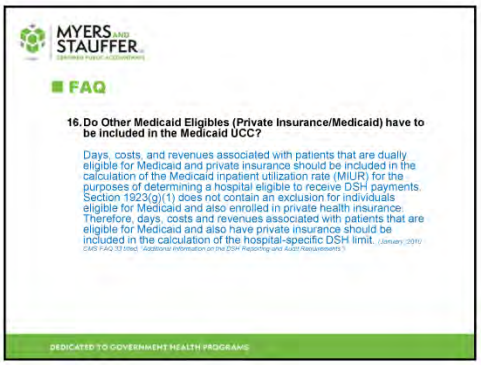
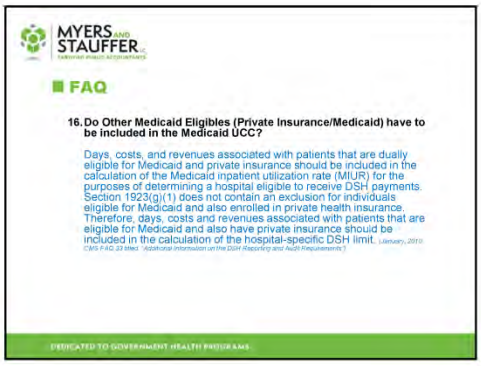

MYERS AND STAUFFER
FAQ
16. Do Other Medicaid Eligibles (Private Insurance/Medicaid) have to be included in the Medicaid UCC?
Days, costs, and revenues associated with patients that are dually eligible for Medicaid and private insurance should be included in the calculation of the Medicaid inpatient utilization rate (MIUR) for the purposes of determining a hospital eligible to receive DSH payments. Section 1923(g)(1) does not contain an exclusion for individuals eligible for Medicaid and also enrolled in private health insurance. Therefore, days, costs and revenues associated with patients that are eligible for Medicaid and also have private insurance should be included in the calculation of the hospital-specific DSH limit. (January 2010 CMS FAQ 33 titled "Additional Information on the DSH Reporting and Audit Requirements")
DEDICATED TO GOVERNMENT HEALTH PROGRAMS


MYERS AND STAUFFER
FAQ
16. Do Other Medicaid Eligibles (Private Insurance/Medicaid) have to be included in the Medicaid UCC?
Days, costs, and revenues associated with patients that are dually eligible for Medicaid and private insurance should be included in the calculation of the Medicaid inpatient utilization rate (MIUR) for the purposes of determining a hospital eligible to receive DSH payments. Section 1923(g)(1) does not contain an exclusion for individuals eligible for Medicaid and also enrolled in private health insurance. Therefore, days, costs and revenues associated with patients that are eligible for Medicaid and also have private insurance should be included in the calculation of the hospital-specific DSH limit. (January 2010 CMS FAQ 33 titled "Additional Information on the DSH Reporting and Audit Requirements")
DEDICATED TO GOVERNMENT HEALTH PROGRAMS


MYERS AND STAUFFER
CONTACT INFORMATION
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Dkovar@mslc.com
Myers and Stauffer LC
400 Redland Court, Suite 300
Owings Mills, MD 21117
800-505-1698
DEDICATED TO GOVERNMENT HEALTH PROGRAMS

24

Appendix I: Additional Information

RFQ No. BMS1600000001

STATE OF WEST VIRGINIA
Purchasing Division

PURCHASING AFFIDAVIT

MANDATE: Under W. Va. Code §5A-3-10a, no contract or renewal of any contract may be awarded by the state or any of its political subdivisions to any vendor or prospective vendor when the vendor or prospective vendor or a related party to the vendor or prospective vendor is a debtor and: (1) the debt owed is an amount greater than one thousand dollars in the aggregate; or (2) the debtor is in employer default.

EXCEPTION: The prohibition listed above does not apply where a vendor has contested any tax administered pursuant to chapter eleven of the W. Va. Code, workers' compensation premium, permit fee or environmental fee or assessment and the matter has not become final or where the vendor has entered into a payment plan or agreement and the vendor is not in default of any of the provisions of such plan or agreement.

DEFINITIONS:

"Debt" means any assessment, premium, penalty, fine, tax or other amount of money owed to the state or any of its political subdivisions because of a judgment, fine, permit violation, license assessment, defaulted workers' compensation premium, penalty or other assessment presently delinquent or due and required to be paid to the state or any of its political subdivisions, including any interest or additional penalties accrued thereon.

"Employer default" means having an outstanding balance or liability to the old fund or to the uninsured employers' fund or being in policy default, as defined in W. Va. Code § 23-2c-2, failure to maintain mandatory workers' compensation coverage, or failure to fully meet its obligations as a workers' compensation self-insured employer. An employer is not in employer default if it has entered into a repayment agreement with the Insurance Commissioner and remains in compliance with the obligations under the repayment agreement.

"Related party" means a party, whether an individual, corporation, partnership, association, limited liability company or any other form or business association or other entity whatsoever, related to any vendor by blood, marriage, ownership or contract through which the party has a relationship of ownership or other interest with the vendor so that the party will actually or by effect receive or control a portion of the benefit, profit or other consideration from performance of a vendor contract with the party receiving an amount that meets or exceed five percent of the total contract amount.

AFFIRMATION: By signing this form, the vendor's authorized signer affirms and acknowledges under penalty of law for false swearing (*W. Va. Code* §61-5-3) that neither vendor nor any related party owe a debt as defined above and that neither vendor nor any related party are in employer default as defined above, unless the debt or employer default is permitted under the exception above.

WITNESS THE FOLLOWING SIGNATURE:

Vendor's Name: Myers and Stauffer LC

Authorized Signature: Mark K. Hilt Date: 12/4/15

State of Missouri

County of Jackson, to-wit:

Taken, subscribed, and sworn to before me this 4th day of December, 2015.

My Commission expires June 29, 2019.

AFFIX SEAL HERE

NOTARY PUBLIC

ALEX MONTILEONE
Notary Public, Notary Seal
State of Missouri
Jackson County
Commission # 15636459
My Commission Expires June 29, 2019

Purchasing Affidavit (Revised 07/01/2012)

Rev. 04/14

State of West Virginia

VENDOR PREFERENCE CERTIFICATE

Certification and application* is hereby made for Preference in accordance with ***West Virginia Code***, §5A-3-37. (Does not apply to construction contracts). ***West Virginia Code***, §5A-3-37, provides an opportunity for qualifying vendors to request (at the time of bid) preference for their residency status. Such preference is an evaluation method only and will be applied only to the cost bid in accordance with the ***West Virginia Code***. This certificate for application is to be used to request such preference. The Purchasing Division will make the determination of the Vendor Preference, if applicable.

1. **Application is made for 2.5% vendor preference for the reason checked:**
___ Bidder is an individual resident vendor and has resided continuously in West Virginia for four (4) years immediately preceding the date of this certification; **or,**
___ Bidder is a partnership, association or corporation resident vendor and has maintained its headquarters or principal place of business continuously in West Virginia for four (4) years immediately preceding the date of this certification; or 80% of the ownership interest of Bidder is held by another individual, partnership, association or corporation resident vendor who has maintained its headquarters or principal place of business continuously in West Virginia for four (4) years immediately preceding the date of this certification; **or,**
___ Bidder is a nonresident vendor which has an affiliate or subsidiary which employs a minimum of one hundred state residents and which has maintained its headquarters or principal place of business within West Virginia continuously for the four (4) years immediately preceding the date of this certification; **or,**

2. **Application is made for 2.5% vendor preference for the reason checked:**
___ Bidder is a resident vendor who certifies that, during the life of the contract, on average at least 75% of the employees working on the project being bid are residents of West Virginia who have resided in the state continuously for the two years immediately preceding submission of this bid; **or,**

3. **Application is made for 2.5% vendor preference for the reason checked:**
___ Bidder is a nonresident vendor employing a minimum of one hundred state residents or is a nonresident vendor with an affiliate or subsidiary which maintains its headquarters or principal place of business within West Virginia employing a minimum of one hundred state residents who certifies that, during the life of the contract, on average at least 75% of the employees or Bidder's affiliate's or subsidiary's employees are residents of West Virginia who have resided in the state continuously for the two years immediately preceding submission of this bid; **or,**

4. **Application is made for 5% vendor preference for the reason checked:**
___ Bidder meets either the requirement of both subdivisions (1) and (2) or subdivision (1) and (3) as stated above; **or,**

5. **Application is made for 3.5% vendor preference who is a veteran for the reason checked:**
___ Bidder is an individual resident vendor who is a veteran of the United States armed forces, the reserves or the National Guard and has resided in West Virginia continuously for the four years immediately preceding the date on which the bid is submitted; **or,**

6. **Application is made for 3.5% vendor preference who is a veteran for the reason checked:**
___ Bidder is a resident vendor who is a veteran of the United States armed forces, the reserves or the National Guard, if, for purposes of producing or distributing the commodities or completing the project which is the subject of the vendor's bid and continuously over the entire term of the project, on average at least seventy-five percent of the vendor's employees are residents of West Virginia who have resided in the state continuously for the two immediately preceding years.

7. **Application is made for preference as a non-resident small, women- and minority-owned business, in accordance with *West Virginia Code* §5A-3-59 and *West Virginia Code of State Rules*.**
___ Bidder has been or expects to be approved prior to contract award by the Purchasing Division as a certified small, women- and minority-owned business.

Bidder understands if the Secretary of Revenue determines that a Bidder receiving preference has failed to continue to meet the requirements for such preference, the Secretary may order the Director of Purchasing to: (a) reject the bid; or (b) assess a penalty against such Bidder in an amount not to exceed 5% of the bid amount and that such penalty will be paid to the contracting agency or deducted from any unpaid balance on the contract or purchase order.

By submission of this certificate, Bidder agrees to disclose any reasonably requested information to the Purchasing Division and authorizes the Department of Revenue to disclose to the Director of Purchasing appropriate information verifying that Bidder has paid the required business taxes, provided that such information does not contain the amounts of taxes paid nor any other information deemed by the Tax Commissioner to be confidential.

Under penalty of law for false swearing (West Virginia Code, §61-5-3), Bidder hereby certifies that this certificate is true and accurate in all respects; and that if a contract is issued to Bidder and if anything contained within this certificate changes during the term of the contract, Bidder will notify the Purchasing Division in writing immediately.

Bidder: Myers and Stauffer LC * **Signed:** Mark K. Wilt

Date: December 8, 2015 **Title:** Member

Please note that this form is not applicable to Myers and Stauffer.

Client#: 52154 MYERSTA

ACORD™ CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY) 05/11/2015

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AFFIRMATIVELY OR NEGATIVELY AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW. THIS CERTIFICATE OF INSURANCE DOES NOT CONSTITUTE A CONTRACT BETWEEN THE ISSUING INSURER(S), AUTHORIZED REPRESENTATIVE OR PRODUCER, AND THE CERTIFICATE HOLDER.

IMPORTANT: If the certificate holder is an ADDITIONAL INSURED, the policy(ies) must be endorsed. If SUBROGATION IS WAIVED, subject to the terms and conditions of the policy, certain policies may require an endorsement. A statement on this certificate does not confer rights to the certificate holder in lieu of such endorsement(s).

PRODUCER CBIZ Insurance Services 9755 Patuxent Woods Drive Suite 200 Columbia, MD 21046	CONTACT NAME: PHONE (A/C, No, Ext): 610-862-2249 FAX (A/C, No): E-MAIL ADDRESS: DLCBIZRISK&Consulting@cbiz.com
INSURED Myers and Stauffer, LC 700 W. 47th Street, Suite 1100 Kansas City, MO 64112	INSURER(S) AFFORDING COVERAGE — NAIC # INSURER A : Hartford Casualty Insurance Co — 29424 INSURER B : INSURER C : INSURER D : INSURER E : INSURER F :

COVERAGES CERTIFICATE NUMBER: REVISION NUMBER:

THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR LTR	TYPE OF INSURANCE	ADDL INSR	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS	
A	GENERAL LIABILITY			42SBAUH8895	05/01/2015	05/01/2016	EACH OCCURRENCE	$1,000,000
	[X] COMMERCIAL GENERAL LIABILITY						DAMAGE TO RENTED PREMISES (Ea occurrence)	$300,000
	[ ] CLAIMS-MADE [X] OCCUR						MED EXP (Any one person)	$10,000
							PERSONAL & ADV INJURY	$1,000,000
							GENERAL AGGREGATE	$2,000,000
	GEN'L AGGREGATE LIMIT APPLIES PER:						PRODUCTS - COMP/OP AGG	$2,000,000
	[ ] POLICY [ ] PRO-JECT [ ] LOC							$
A	AUTOMOBILE LIABILITY			42SBAUH8895	05/01/2015	05/01/2016	COMBINED SINGLE LIMIT (Ea accident)	$1,000,000
	[ ] ANY AUTO						BODILY INJURY (Per person)	$
	[ ] ALL OWNED AUTOS [ ] SCHEDULED AUTOS						BODILY INJURY (Per accident)	$
	[X] HIRED AUTOS [X] NON-OWNED AUTOS						PROPERTY DAMAGE (Per accident)	$
								$
A	[X] UMBRELLA LIAB [X] OCCUR			42SBAUH8895	05/01/2015	05/01/2016	EACH OCCURRENCE	$4,000,000
	EXCESS LIAB [ ] CLAIMS-MADE						AGGREGATE	$4,000,000
	[ ] DED [X] RETENTION $10000							$
	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY Y / N						WC STATU-TORY LIMITS [ ] OTH-ER	
	ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? [ ] N / A						E.L. EACH ACCIDENT	$
	(Mandatory in NH)						E.L. DISEASE - EA EMPLOYEE	$
	If yes, describe under DESCRIPTION OF OPERATIONS below						E.L. DISEASE - POLICY LIMIT	$

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (Attach ACORD 101, Additional Remarks Schedule, if more space is required)

M & S Consulting

CERTIFICATE HOLDER	CANCELLATION
Department of Administration, Purchasing Division Attn: Robert P Kilpatrick 2019 Washington Street East Charleston, WV 25305-0130	SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS. AUTHORIZED REPRESENTATIVE CBIZ Insurance Services, Inc.

ACORD 25 (2010/05) 1 of 1 The ACORD name and logo are registered marks of ACORD
#S1104457/M1104448 PLC

ACORD

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY) 12/04/15

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AFFIRMATIVELY OR NEGATIVELY AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW. THIS CERTIFICATE OF INSURANCE DOES NOT CONSTITUTE A CONTRACT BETWEEN THE ISSUING INSURER(S), AUTHORIZED REPRESENTATIVE OR PRODUCER, AND THE CERTIFICATE HOLDER.

IMPORTANT: If the certificate holder is an ADDITIONAL INSURED, the policy(ies) must be endorsed. If SUBROGATION IS WAIVED, subject to the terms and conditions of the policy, certain policies may require an endorsement. A statement on this certificate does not confer rights to the certificate holder in lieu of such endorsement(s).

PRODUCER	CONTACT NAME:
Aon Insurance Services 200 East Randolph Street Chicago, IL 60601	PHONE (A/C, No, Ext): FAX (A/C, No): E-MAIL ADDRESS:
	INSURER(S) AFFORDING COVERAGE — NAIC #
	INSURER A : Continental Casualty Company (CNA)
INSURED Myers and Stauffer LC 700 W. 47th Street, Suite 1100 Kansas City, Mo 64112.	INSURER B :
	INSURER C :
	INSURER D :
	INSURER E :
	INSURER F :

COVERAGES CERTIFICATE NUMBER: REVISION NUMBER:

THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR LTR	TYPE OF INSURANCE	ADDL INSR	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS	
	GENERAL LIABILITY						EACH OCCURRENCE	$
	☐ COMMERCIAL GENERAL LIABILITY						DAMAGE TO RENTED PREMISES (Ea occurrence)	$
	☐ CLAIMS-MADE ☐ OCCUR						MED EXP (Any one person)	$
							PERSONAL & ADV INJURY	$
							GENERAL AGGREGATE	$
	GEN'L AGGREGATE LIMIT APPLIES PER:						PRODUCTS - COMP/OP AGG	$
	☐ POLICY ☐ PRO-JECT ☐ LOC							$
	AUTOMOBILE LIABILITY						COMBINED SINGLE LIMIT (Ea accident)	$
	☐ ANY AUTO						BODILY INJURY (Per person)	$
	☐ ALL OWNED AUTOS ☐ SCHEDULED AUTOS						BODILY INJURY (Per accident)	$
	☐ HIRED AUTOS ☐ NON-OWNED AUTOS						PROPERTY DAMAGE (Per accident)	$
								$
	☐ UMBRELLA LIAB ☐ OCCUR						EACH OCCURRENCE	$
	☐ EXCESS LIAB ☐ CLAIMS-MADE						AGGREGATE	$
	☐ DED ☐ RETENTION $							$
	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY Y / N						☐ WC STATU-TORY LIMITS ☐ OTH-ER	
	ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? ☐ N / A						E.L. EACH ACCIDENT	$
	(Mandatory in NH)						E.L. DISEASE - EA EMPLOYEE	$
	If yes, describe under DESCRIPTION OF OPERATIONS below						E.L. DISEASE - POLICY LIMIT	$
A	Professional Liability Insurance			ABF 188181819	12/31/14	12/31/15	$1,000,000 Per Claim and in the Annual Aggregate	

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (Attach ACORD 101, Additional Remarks Schedule, if more space is required)

CERTIFICATE HOLDER	CANCELLATION
State of West Virginia 2019 Washington Street East Charleston, WV 25305	SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS. AUTHORIZED REPRESENTATIVE

Client#: 2372 CBIZINC

ACORD™ CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY) 10/14/2015

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AFFIRMATIVELY OR NEGATIVELY AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW. THIS CERTIFICATE OF INSURANCE DOES NOT CONSTITUTE A CONTRACT BETWEEN THE ISSUING INSURER(S), AUTHORIZED REPRESENTATIVE OR PRODUCER, AND THE CERTIFICATE HOLDER.

IMPORTANT: If the certificate holder is an ADDITIONAL INSURED, the policy(ies) must be endorsed. If SUBROGATION IS WAIVED, subject to the terms and conditions of the policy, certain policies may require an endorsement. A statement on this certificate does not confer rights to the certificate holder in lieu of such endorsement(s).

PRODUCER	CONTACT NAME:
CBIZ Insurance Services, Inc. 700 West 47th Street, Suite 1100 Kansas City, MO 64112 816 945-5500	PHONE (A/C, No, Ext): - FAX (A/C, No): E-MAIL ADDRESS: DLCBIZRisk&Consulting@cbiz.com
	INSURER(S) AFFORDING COVERAGE — NAIC #
	INSURER A : Hartford Insurance- Comml Lines
INSURED CBIZ, Inc. and subsidiaries 6050 Oak Tree Blvd., South, Suite 500 Cleveland, OH 44131	INSURER B : INSURER C : INSURER D : INSURER E : INSURER F :

COVERAGES CERTIFICATE NUMBER: REVISION NUMBER:

THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR LTR	TYPE OF INSURANCE	ADDL INSR	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS	
	GENERAL LIABILITY						EACH OCCURRENCE	$
	☐ COMMERCIAL GENERAL LIABILITY						DAMAGE TO RENTED PREMISES (Ea occurrence)	$
	☐ CLAIMS-MADE ☐ OCCUR						MED EXP (Any one person)	$
							PERSONAL & ADV INJURY	$
	GEN'L AGGREGATE LIMIT APPLIES PER:						GENERAL AGGREGATE	$
	☐ POLICY ☐ PRO-JECT ☐ LOC						PRODUCTS - COMP/OP AGG	$
								$
	AUTOMOBILE LIABILITY						COMBINED SINGLE LIMIT (Ea accident)	$
	☐ ANY AUTO						BODILY INJURY (Per person)	$
	☐ ALL OWNED AUTOS ☐ SCHEDULED AUTOS						BODILY INJURY (Per accident)	$
	☐ HIRED AUTOS ☐ NON-OWNED AUTOS						PROPERTY DAMAGE (Per accident)	$
								$
	☐ UMBRELLA LIAB ☐ OCCUR						EACH OCCURRENCE	$
	☐ EXCESS LIAB ☐ CLAIMS-MADE						AGGREGATE	$
	☐ DED ☐ RETENTION $							$
A	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY Y / N			37WNS46900	09/30/2015	09/30/2016	X WC STATU-TORY LIMITS ☐ OTH-ER	
A	ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? N	N / A		37WBRS46901WI	09/30/2015	09/30/2016	E.L. EACH ACCIDENT	$1,000,000
	(Mandatory in NH) If yes, describe under DESCRIPTION OF OPERATIONS below						E.L. DISEASE - EA EMPLOYEE	$1,000,000
							E.L. DISEASE - POLICY LIMIT	$1,000,000

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (Attach ACORD 101, Additional Remarks Schedule, If more space is required)

M & S Consulting

CERTIFICATE HOLDER	CANCELLATION
DHHR Office of Purchasing Attn: Robert Price One Davis Square, Suite 100 Charleston, WV 25301	SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS. AUTHORIZED REPRESENTATIVE CBIZ Insurance Services, Inc.

ACORD 25 (2010/05) 1 of 1 #S1203448/M1201687 The ACORD name and logo are registered marks of ACORD 51LW

WV STATE GOVERNMENT

HIPAA BUSINESS ASSOCIATE ADDENDUM

This Health Insurance Portability and Accountability Act of 1996 (hereafter, HIPAA) Business Associate Addendum ("Addendum") is made a part of the Agreement ("Agreement") by and between the State of West Virginia ("Agency"), and Business Associate ("Associate"), and is effective as of the date of execution of the Addendum.

The Associate performs certain services on behalf of or for the Agency pursuant to the underlying Agreement that requires the exchange of information including protected health information protected by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), as amended by the American Recovery and Reinvestment Act of 2009 (Pub. L. No. 111-5) (the "HITECH Act"), any associated regulations and the federal regulations published at 45 CFR parts 160 and 164 (sometimes collectively referred to as "HIPAA"). The Agency is a "Covered Entity" as that term is defined in HIPAA, and the parties to the underlying Agreement are entering into this Addendum to establish the responsibilities of both parties regarding HIPAA-covered information and to bring the underlying Agreement into compliance with HIPAA.

Whereas it is desirable, in order to further the continued efficient operations of Agency to disclose to its Associate certain information which may contain confidential individually identifiable health information (hereafter, Protected Health Information or PHI); and

Whereas, it is the desire of both parties that the confidentiality of the PHI disclosed hereunder be maintained and treated in accordance with all applicable laws relating to confidentiality, including the Privacy and Security Rules, the HITECH Act and its associated regulations, and the parties do agree to at all times treat the PHI and interpret this Addendum consistent with that desire.

NOW THEREFORE: the parties agree that in consideration of the mutual promises herein, in the Agreement, and of the exchange of PHI hereunder that:

1. **Definitions.** Terms used, but not otherwise defined, in this Addendum shall have the same meaning as those terms in the Privacy, Security, Breach Notification, and Enforcement Rules at 45 CFR Part 160 and Part 164.

    a. **Agency Procurement Officer** shall mean the appropriate Agency individual listed at: http://www.state.wv.us/admin/purchase/vrc/agencyli.html.

    b. **Agent** shall mean those person(s) who are agent(s) of the Business Associate, in accordance with the Federal common law of agency, as referenced in 45 CFR § 160.402(c).

    c. **Breach** shall mean the acquisition, access, use or disclosure of protected health information which compromises the security or privacy of such information, except as excluded in the definition of Breach in 45 CFR § 164.402.

    d. **Business Associate** shall have the meaning given to such term in 45 CFR § 160.103.

    e. **HITECH Act** shall mean the Health Information Technology for Economic and Clinical Health Act. Public Law No. 111-05. 111th Congress (2009).

f. **Privacy Rule** means the Standards for Privacy of Individually Identifiable Health Information found at 45 CFR Parts 160 and 164.

g. **Protected Health Information or PHI** shall have the meaning given to such term in 45 CFR § 160.103, limited to the information created or received by Associate from or on behalf of Agency.

h. **Security Incident** means any known successful or unsuccessful attempt by an authorized or unauthorized individual to inappropriately use, disclose, modify, access, or destroy any information or interference with system operations in an information system.

i. **Security Rule** means the Security Standards for the Protection of Electronic Protected Health Information found at 45 CFR Parts 160 and 164.

j. **Subcontractor** means a person to whom a business associate delegates a function, activity, or service, other than in the capacity of a member of the workforce of such business associate.

2. **Permitted Uses and Disclosures.**

a. **PHI Described.** This means PHI created, received, maintained or transmitted on behalf of the Agency by the Associate. This PHI is governed by this Addendum and is limited to the minimum necessary, to complete the tasks or to provide the services associated with the terms of the original Agreement, and is described in Appendix A.

b. **Purposes.** Except as otherwise limited in this Addendum, Associate may use or disclose the PHI on behalf of, or to provide services to, Agency for the purposes necessary to complete the tasks, or provide the services, associated with, and required by the terms of the original Agreement, or as required by law, if such use or disclosure of the PHI would not violate the Privacy or Security Rules or applicable state law if done by Agency or Associate, or violate the minimum necessary and related Privacy and Security policies and procedures of the Agency. The Associate is directly liable under HIPAA for impermissible uses and disclosures of the PHI it handles on behalf of Agency.

c. **Further Uses and Disclosures**. Except as otherwise limited in this Addendum, the Associate may disclose PHI to third parties for the purpose of its own proper management and administration, or as required by law, provided that (i) the disclosure is required by law, or (ii) the Associate has obtained from the third party reasonable assurances that the PHI will be held confidentially and used or further disclosed only as required by law or for the purpose for which it was disclosed to the third party by the Associate; and, (iii) an agreement to notify the Associate and Agency of any instances of which it (the third party) is aware in which the confidentiality of the information has been breached. To the extent practical, the information should be in a limited data set or the minimum necessary information pursuant to 45 CFR § 164.502, or take other measures as necessary to satisfy the Agency's obligations under 45 CFR § 164.502.

3. **Obligations of Associate.**

a. **Stated Purposes Only.** The PHI may not be used by the Associate for any purpose other than as stated in this Addendum or as required or permitted by law.

b. **Limited Disclosure.** The PHI is confidential and will not be disclosed by the Associate other than as stated in this Addendum or as required or permitted by law. Associate is prohibited from directly or indirectly receiving any remuneration in exchange for an individual's PHI unless Agency gives written approval and the individual provides a valid authorization. Associate will refrain from marketing activities that would violate HIPAA, including specifically Section 13406 of the HITECH Act. Associate will report to Agency any use or disclosure of the PHI, including any Security Incident not provided for by this Agreement of which it becomes aware.

c. **Safeguards.** The Associate will use appropriate safeguards, and comply with Subpart C of 45 CFR Part 164 with respect to electronic protected health information, to prevent use or disclosure of the PHI, except as provided for in this Addendum. This shall include, but not be limited to:

i. Limitation of the groups of its workforce and agents, to whom the PHI is disclosed to those reasonably required to accomplish the purposes stated in this Addendum, and the use and disclosure of the minimum PHI necessary or a Limited Data Set;

ii. Appropriate notification and training of its workforce and agents in order to protect the PHI from unauthorized use and disclosure;

iii. Maintenance of a comprehensive, reasonable and appropriate written PHI privacy and security program that includes administrative, technical and physical safeguards appropriate to the size, nature, scope and complexity of the Associate's operations, in compliance with the Security Rule;

iv. In accordance with 45 CFR §§ 164.502(e)(1)(ii) and 164.308(b)(2), if applicable, ensure that any subcontractors that create, receive, maintain, or transmit protected health information on behalf of the business associate agree to the same restrictions, conditions, and requirements that apply to the business associate with respect to such information.

d. **Compliance With Law.** The Associate will not use or disclose the PHI in a manner in violation of existing law and specifically not in violation of laws relating to confidentiality of PHI, including but not limited to, the Privacy and Security Rules.

e. **Mitigation.** Associate agrees to mitigate, to the extent practicable, any harmful effect that is known to Associate of a use or disclosure of the PHI by Associate in violation of the requirements of this Addendum, and report its mitigation activity back to the Agency.

f. **Support of Individual Rights.**

i. **Access to PHI.** Associate shall make the PHI maintained by Associate or its agents or subcontractors in Designated Record Sets available to Agency for inspection and copying, and in electronic format, if requested, within ten (10) days of a request by Agency to enable Agency to fulfill its obligations under the Privacy Rule, including, but not limited to, 45 CFR § 164.524 and consistent with Section 13405 of the HITECH Act.

ii. **Amendment of PHI.** Within ten (10) days of receipt of a request from Agency for an amendment of the PHI or a record about an individual contained in a Designated Record Set, Associate or its agents or subcontractors shall make such PHI available to Agency for amendment and incorporate any such amendment to enable Agency to fulfill its obligations under the Privacy Rule, including, but not limited to, 45 CFR § 164.526.

iii. **Accounting Rights.** Within ten (10) days of notice of a request for an accounting of disclosures of the PHI, Associate and its agents or subcontractors shall make available to Agency the documentation required to provide an accounting of disclosures to enable Agency to fulfill its obligations under the Privacy Rule, including, but not limited to, 45 CFR §164.528 and consistent with Section 13405 of the HITECH Act. Associate agrees to document disclosures of the PHI and information related to such disclosures as would be required for Agency to respond to a request by an individual for an accounting of disclosures of PHI in accordance with 45 CFR § 164.528. This should include a process that allows for an accounting to be collected and maintained by Associate and its agents or subcontractors for at least six (6) years from the date of disclosure, or longer if required by state law. At a minimum, such documentation shall include:

- the date of disclosure;
- the name of the entity or person who received the PHI, and if known, the address of the entity or person;
- a brief description of the PHI disclosed; and
- a brief statement of purposes of the disclosure that reasonably informs the individual of the basis for the disclosure, or a copy of the individual's authorization, or a copy of the written request for disclosure.

iv. **Request for Restriction**. Under the direction of the Agency, abide by any individual's request to restrict the disclosure of PHI, consistent with the requirements of Section 13405 of the HITECH Act and 45 CFR § 164.522, when the Agency determines to do so (except as required by law) and if the disclosure is to a health plan for payment or health care operations and it pertains to a health care item or service for which the health care provider was paid in full "out-of-pocket."

v. **Immediate Discontinuance of Use or Disclosure.** The Associate will immediately discontinue use or disclosure of Agency PHI pertaining to any individual when so requested by Agency. This includes, but is not limited to, cases in which an individual has withdrawn or modified an authorization to use or disclose PHI.

4

g. **Retention of PHI.** Notwithstanding section 4.a. of this Addendum, Associate and its subcontractors or agents shall retain all PHI pursuant to state and federal law and shall continue to maintain the PHI required under Section 3.f. of this Addendum for a period of six (6) years after termination of the Agreement, or longer if required under state law.

h. **Agent's, Subcontractor's Compliance.** The Associate shall notify the Agency of all subcontracts and agreements relating to the Agreement, where the subcontractor or agent receives PHI as described in section 2.a. of this Addendum. Such notification shall occur within 30 (thirty) calendar days of the execution of the subcontract and shall be delivered to the Agency Procurement Officer. The Associate will ensure that any of its subcontractors, to whom it provides any of the PHI it receives hereunder, or to whom it provides any PHI which the Associate creates or receives on behalf of the Agency, agree to the restrictions and conditions which apply to the Associate hereunder. The Agency may request copies of downstream subcontracts and agreements to determine whether all restrictions, terms and conditions have been flowed down. Failure to ensure that downstream contracts, subcontracts and agreements contain the required restrictions, terms and conditions may result in termination of the Agreement.

j. **Federal and Agency Access.** The Associate shall make its internal practices, books, and records relating to the use and disclosure of PHI, as well as the PHI, received from, or created or received by the Associate on behalf of the Agency available to the U.S. Secretary of Health and Human Services consistent with 45 CFR § 164.504. The Associate shall also make these records available to Agency, or Agency's contractor, for periodic audit of Associate's compliance with the Privacy and Security Rules. Upon Agency's request, the Associate shall provide proof of compliance with HIPAA and HITECH data privacy/protection guidelines, certification of a secure network and other assurance relative to compliance with the Privacy and Security Rules. This section shall also apply to Associate's subcontractors, if any.

k. **Security.** The Associate shall take all steps necessary to ensure the continuous security of all PHI and data systems containing PHI. In addition, compliance with 74 FR 19006 Guidance Specifying the Technologies and Methodologies That Render PHI Unusable, Unreadable, or Indecipherable to Unauthorized Individuals for Purposes of the Breach Notification Requirements under Section 13402 of Title XIII is required, to the extent practicable. If Associate chooses not to adopt such methodologies as defined in 74 FR 19006 to secure the PHI governed by this Addendum, it must submit such written rationale, including its Security Risk Analysis, to the Agency Procurement Officer for review prior to the execution of the Addendum. This review may take up to ten (10) days.

l. **Notification of Breach.** During the term of this Addendum, the Associate shall notify the Agency and, unless otherwise directed by the Agency in writing, the WV Office of Technology immediately by e-mail or web form upon the discovery of any Breach of unsecured PHI; or within 24 hours by e-mail or web form of any suspected Security Incident, intrusion or unauthorized use or disclosure of PHI in violation of this Agreement and this Addendum, or potential loss of confidential data affecting this Agreement. Notification shall be provided to the Agency Procurement Officer at www.state.wv.us/admin/purchase/vrc/agencyli.htm and,

unless otherwise directed by the Agency in writing, the Office of Technology at incident@wv.gov or https://apps.wv.gov/ot/ir/Default.aspx.

The Associate shall immediately investigate such Security Incident, Breach, or unauthorized use or disclosure of PHI or confidential data. Within 72 hours of the discovery, the Associate shall notify the Agency Procurement Officer, and, unless otherwise directed by the Agency in writing, the Office of Technology of: (a) Date of discovery; (b) What data elements were involved and the extent of the data involved in the Breach; (c) A description of the unauthorized persons known or reasonably believed to have improperly used or disclosed PHI or confidential data; (d) A description of where the PHI or confidential data is believed to have been improperly transmitted, sent, or utilized; (e) A description of the probable causes of the improper use or disclosure; and (f) Whether any federal or state laws requiring individual notifications of Breaches are triggered.

Agency will coordinate with Associate to determine additional specific actions that will be required of the Associate for mitigation of the Breach, which may include notification to the individual or other authorities.

All associated costs shall be borne by the Associate. This may include, but not be limited to costs associated with notifying affected individuals.

If the Associate enters into a subcontract relating to the Agreement where the subcontractor or agent receives PHI as described in section 2.a. of this Addendum, all such subcontracts or downstream agreements shall contain the same incident notification requirements as contained herein, with reporting directly to the Agency Procurement Officer. Failure to include such requirement in any subcontract or agreement may result in the Agency's termination of the Agreement.

m. **Assistance in Litigation or Administrative Proceedings.** The Associate shall make itself and any subcontractors, workforce or agents assisting Associate in the performance of its obligations under this Agreement, available to the Agency at no cost to the Agency to testify as witnesses, or otherwise, in the event of litigation or administrative proceedings being commenced against the Agency, its officers or employees based upon claimed violations of HIPAA, the HIPAA regulations or other laws relating to security and privacy, which involves inaction or actions by the Associate, except where Associate or its subcontractor, workforce or agent is a named as an adverse party.

4. **Addendum Administration.**

a. **Term.** This Addendum shall terminate on termination of the underlying Agreement or on the date the Agency terminates for cause as authorized in paragraph (c) of this Section, whichever is sooner.

b. **Duties at Termination.** Upon any termination of the underlying Agreement, the Associate shall return or destroy, at the Agency's option, all PHI received from, or created or received by the Associate on behalf of the Agency that the Associate still maintains in any form and retain no copies of such PHI or, if such return or destruction is not feasible, the Associate shall extend the protections of this Addendum to the PHI and limit further uses and disclosures to the purposes that make the return or destruction of the PHI infeasible. This shall also apply to all agents and subcontractors of Associate. The duty of the Associate and its agents

and subcontractors to assist the Agency with any HIPAA required accounting of disclosures survives the termination of the underlying Agreement.

c. **Termination for Cause.** Associate authorizes termination of this Agreement by Agency, if Agency determines Associate has violated a material term of the Agreement. Agency may, at its sole discretion, allow Associate a reasonable period of time to cure the material breach before termination.

d. **Judicial or Administrative Proceedings.** The Agency may terminate this Agreement if the Associate is found guilty of a criminal violation of HIPAA. The Agency may terminate this Agreement if a finding or stipulation that the Associate has violated any standard or requirement of HIPAA/HITECH, or other security or privacy laws is made in any administrative or civil proceeding in which the Associate is a party or has been joined. Associate shall be subject to prosecution by the Department of Justice for violations of HIPAA/HITECH and shall be responsible for any and all costs associated with prosecution.

e. **Survival.** The respective rights and obligations of Associate under this Addendum shall survive the termination of the underlying Agreement.

5. **General Provisions/Ownership of PHI.**

a. **Retention of Ownership.** Ownership of the PHI resides with the Agency and is to be returned on demand or destroyed at the Agency's option, at any time, and subject to the restrictions found within section 4.b. above.

b. **Secondary PHI.** Any data or PHI generated from the PHI disclosed hereunder which would permit identification of an individual must be held confidential and is also the property of Agency.

c. **Electronic Transmission.** Except as permitted by law or this Addendum, the PHI or any data generated from the PHI which would permit identification of an individual must not be transmitted to another party by electronic or other means for additional uses or disclosures not authorized by this Addendum or to another contractor, or allied agency, or affiliate without prior written approval of Agency.

d. **No Sales.** Reports or data containing the PHI may not be sold without Agency's or the affected individual's written consent.

e. **No Third-Party Beneficiaries.** Nothing express or implied in this Addendum is intended to confer, nor shall anything herein confer, upon any person other than Agency, Associate and their respective successors or assigns, any rights, remedies, obligations or liabilities whatsoever.

f. **Interpretation.** The provisions of this Addendum shall prevail over any provisions in the Agreement that may conflict or appear inconsistent with any provisions in this Addendum. The interpretation of this Addendum shall be made under the laws of the state of West Virginia.

g. **Amendment.** The parties agree that to the extent necessary to comply with applicable law they will agree to further amend this Addendum.

h. **Additional Terms and Conditions.** Additional discretionary terms may be included in the release order or change order process.

7

AGREED:

Name of Agency: Bureau for Medical Services

Signature: _____

Title: _____

Date: _____

Name of Associate: Mark K Hilton

Signature: Mark K. Hilton

Title: Member

Date: 12/8/15

Form - WVBAA-012004
Amended 08.26.2013

APPROVED AS TO FORM THIS 26th
DAY OF December 20 15
Patrick Morrisey
Attorney General
BY _____

8

Appendix A

(To be completed by the Agency's Procurement Officer prior to the execution of the Addendum, and shall be made a part of the Addendum. PHI not identified prior to execution of the Addendum may only be added by amending Appendix A and the Addendum, via Change Order.)

Name of Associate: _____

Name of Agency: Bureau for Medical Services

Describe the PHI (do not include any actual PHI). If not applicable, please indicate the same.

All [types of PHI listed on App. A] in paper, electronic, verbal or any other form. Including, but not limited to:
The claims data contains the following fields of information relating to each service provided: Claim ID, Claim Header Status, Paid Date, Bill Type, Claim Type, Plan Provider Number, Provider Name, Member ID, Member First Name, Member Last Name, Member Middle Name, Control Number, Claim Line Number, Claim Line Status, Date of Service - From, Date of Service - To, Revenue Code, Revenue Code Description, Modifier, Billed Units, Services Units, Line Billed Amount, Line Paid Amount, Coordination of Benefits Amount, Medicare Paid Amount, State Fiscal Year, Total Paid Amount, and End Date.