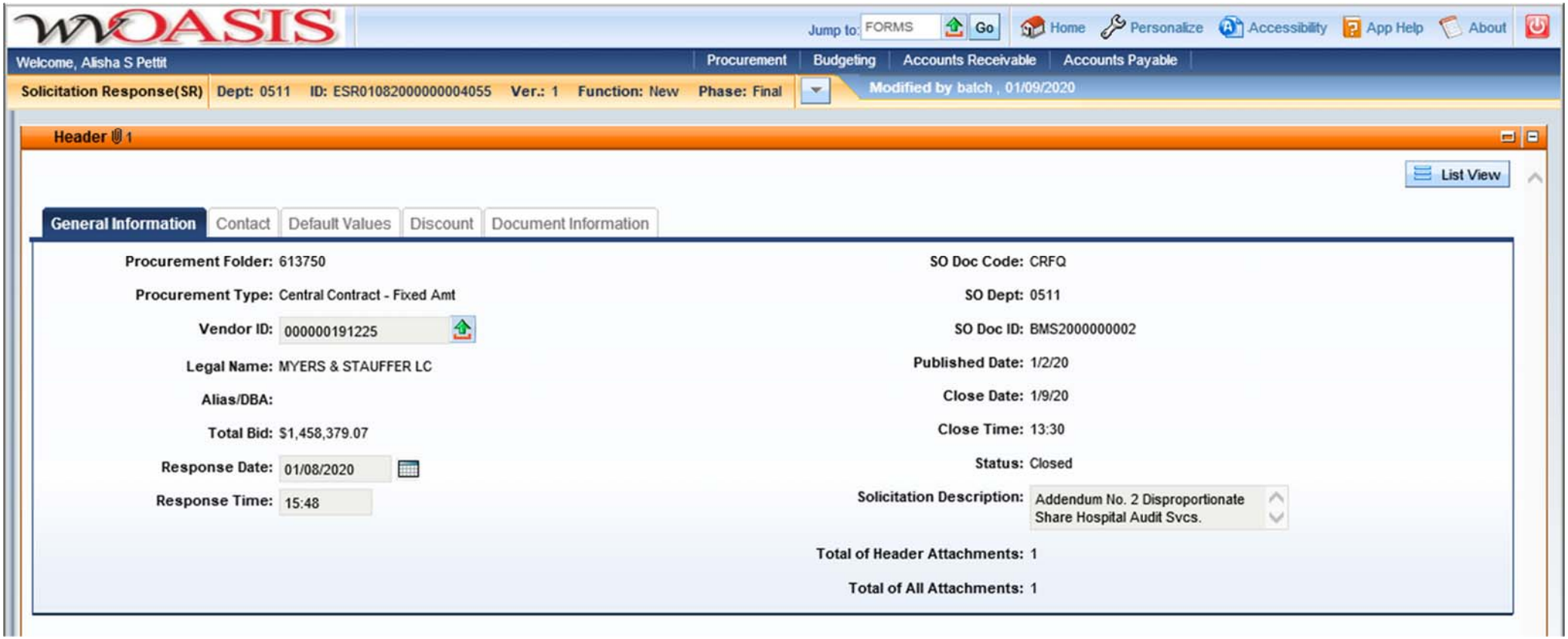
The following documentation is an electronically-submitted vendor response to an advertised solicitation from the *West Virginia Purchasing Bulletin* within the Vendor Self-Service portal at ***wvOASIS.gov***. As part of the State of West Virginia's procurement process, and to maintain the transparency 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.


wvOASIS
Jump to: FORMS Go
Home
Personalize
Accessibility
App Help
About
Welcome, Alisha S Pettit
Procurement
Budgeting
Accounts Receivable
Accounts Payable
Solicitation Response(SR) Dept: 0511 ID: ESR01082000000004055 Ver.: 1 Function: New Phase: Final
Modified by batch , 01/09/2020
Header 1
List View
General Information
Contact
Default Values
Discount
Document Information
Procurement Folder: 613750
Procurement Type: Central Contract - Fixed Amt
Vendor ID: 000000191225
Legal Name: MYERS & STAUFFER LC
Alias/DBA:
Total Bid: $1,458,379.07
Response Date: 01/08/2020
Response Time: 15:48
SO Doc Code: CRFQ
SO Dept: 0511
SO Doc ID: BMS2000000002
Published Date: 1/2/20
Close Date: 1/9/20
Close Time: 13:30
Status: Closed
Solicitation Description: Addendum No. 2 Disproportionate Share Hospital Audit Svcs.
Total of Header Attachments: 1
Total of All Attachments: 1

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

State of West Virginia
Solicitation Response

Proc Folder : 613750

Solicitation Description : Addendum No. 2 Disproportionate Share Hospital Audit Svcs.

Proc Type : Central Contract - Fixed Amt

Date issued	Solicitation Closes	Solicitation Response	Version
	2020-01-09 13:30:00	SR 0511 ESR01082000000004055	1

VENDOR

000000191225

MYERS & STAUFFER LC

Solicitation Number: CRFQ 0511 BMS2000000002

Total Bid : $1,458,379.07 **Response Date:** 2020-01-08 **Response Time:** 15:48:54

Comments:

FOR INFORMATION CONTACT THE BUYER

Brittany E Ingraham

(304) 558-2157
brittany.e.ingraham@wv.gov

Signature on File **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 for SFY2017				$417,637.15

Comm Code	Manufacturer	Specification	Model #
84111600			

Extended Description : Audit Services SFY2017 (07/01/2016-06/30/2017)

Line	Comm Ln Desc	Qty	Unit Issue	Unit Price	Ln Total Or Contract Amount
2	Audit for SFY2018				$336,711.61

Comm Code	Manufacturer	Specification	Model #
84111600			

Extended Description : Audit Services SFY2018 (07/01/2017-06/30/2018)

Line	Comm Ln Desc	Qty	Unit Issue	Unit Price	Ln Total Or Contract Amount
3	Audit for SFY2019				$346,812.96

Comm Code	Manufacturer	Specification	Model #
84111600			

Extended Description : Audit Services SFY2019 (07/01/2018-06/30/2019)

Line	Comm Ln Desc	Qty	Unit Issue	Unit Price	Ln Total Or Contract Amount
4	Audit for SFY2020				$357,217.35

Comm Code	Manufacturer	Specification	Model #
84111600			

Extended Description : Audit Services SFY2020 (07/01/2019-06/30/2020)

STATE OF WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES

Bureau for Medical Services

Disproportionate Share Hospital Audit Services

CRFQ No. 0511 BMS2000000002

January 9, 2020

Myers and Stauffer LC
10200 Grand Central Avenue, Suite 200
Owings Mills, MD 21117
800.505.1698
www.myersandstauffer.com

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

January 9, 2020

Ms. Brittany Ingraham
West Virginia Department of Administration
Purchasing Division
2019 Washington Street, East
Charleston, WV 25305

Dear Ms. Ingraham and Members of the Evaluation Committee:

Myers and Stauffer LC is pleased to provide our proposal in response to the Centralized Request for Quotation (CRFQ) No. 0511 BMS2000000002 to conduct disproportionate share hospital (DSH) audit services for the West Virginia Department of Health and Human Resources, Bureau for Medical Services (BMS).

Our experience in and understanding of the services requested in the CRFQ is unmatched. We have conducted this work longer than any other firm in the nation, as we were the first firm to be engaged by a state to perform a DSH audit, pursuant to the Draft Rule (August 2005) and Final Rule (December 2008). We are the largest DSH audit firm in the country with active engagements in 40 states where we are conducting current DSH work. We also have past DSH experience with West Virginia. BMS will benefit from the breadth and depth of our national DSH experience when it comes to addressing critical DSH issues and interacting with the Centers for Medicare & Medicaid Services (CMS). Our DSH assistance varies based on the individual state and methodology and includes services such as sending and receiving survey information; developing and managing databases to calculate DSH eligibility and payment levels; performing desk and on-site reviews of reported uninsured services and payments received; preparing and issuing DSH examination reports in compliance with CMS requirements 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.

We look forward to working with BMS on this important initiative. If I can be of further assistance, please contact me at 800.505.1698 or jkraft@mslc.com.

Sincerely,

John D. Kraft

John Kraft, CPA
Member

10200 Grand Central Ave., Ste 200 | Owings Mills, MD 21117
PH 410.356.9256 | PH 800.505.1698 | FX 410.356.0188
www.myersandstauffer.com

Table of Contents

We are a limited liability company organized in the state of Kansas in 1977. In the fall of 1998, we entered into a transaction with Century Business Services, Inc. (CBIZ), which resulted in the creation of CBIZ M&S Consulting Services, LLC. CBIZ M&S Consulting Services, LLC is wholly-owned by CBIZ, Inc. As part of this business model, Myers and Stauffer acquires office space, personnel, and other business resources from CBIZ M&S Consulting Services, LLC. These resources, including personnel and consultants, are assigned exclusively to serve the clients of Myers and Stauffer. Myers and Stauffer is wholly-owned by its partners.

The American Institute of Certified Public Accountants (AICPA) has reviewed our business structure and refers to this model as an alternative practice structure. AICPA professional standards provide specific guidance regarding independence within alternative practice structure firms. These professional standards are published in the Independence, Integrity, and Objectivity section of the AICPA Code of Professional Conduct at ET Section 1.220.020. We fully comply with this, and all other professional standards.

Certification and Signature Page

DESIGNATED CONTACT: Vendor appoints the individual identified in this Section as the Contract Administrator and the initial point of contact for matters relating to this Contract.

John D. Kraft, Member
(Name, Title)
John D. Kraft, Member
(Printed Name and Title)
10200 Grand Central Ave., Ste. 200, Owings Mills, MD 21117
(Address)
Phone: 800.505.1698 Fax: 410.356.0188
(Phone Number)/ (Fax Number)
JKraft@mslc.com
(email address)

CERTIFICATION AND SIGNATURE: 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)
John D. Kraft, Member
(Authorized Signature) (Representative Name, Title)

John D. Kraft, Member
(Printed Name and Title of Authorized Representative)

1/6/20
(Date)

Phone: 800.505.1698 Fax: 410.356.0188
(Phone Number) (Fax Number)

Revised 11/14/2019

Signed Addendum Acknowledgement Form

ADDENDUM ACKNOWLEDGEMENT FORM

SOLICITATION NO.: CRFQ 0511 BMs2000000002

Instructions: Please acknowledge receipt of all addenda issued with this solicitation by completing this addendum acknowledgment form. Check the box next to each addendum received and sign below. Failure to acknowledge addenda may result in bid disqualification.

Acknowledgment: I hereby acknowledge receipt of the following addenda and have made the necessary revisions to my proposal, plans and/or specification, etc.

Addendum Numbers Received:
(Check the box next to each addendum received)

☑ Addendum No. 1	☐ Addendum No. 6
☑ Addendum No. 2	☐ Addendum No. 7
☐ Addendum No. 3	☐ Addendum No. 8
☐ Addendum No. 4	☐ Addendum No. 9
☐ Addendum No. 5	☐ Addendum No. 10

I understand that failure to confirm the receipt of addenda may be cause for rejection of this bid. I further understand that any verbal representation made or assumed to be made during any oral discussion held between Vendor's representatives and any state personnel is not binding. Only the information issued in writing and added to the specifications by an official addendum is binding.

Myers and Stauffer LC
Company

John D. Kraft
Authorized Signature

1/8/20
Date

NOTE: This addendum acknowledgement should be submitted with the bid to expedite document processing.

Revised 11/14/2019

CRFQ

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: 613750

Doc Description: Disproportionate Share Hospital Audit Services

Proc Type: Central Contract - Fixed Amt

Date Issued	Solicitation Closes	Solicitation No	Version
2019-12-16	2020-01-07 13:30:00	CRFQ 0511 BMS2000000002	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
10200 Grand Central Avenue, Ste. 200
Owings Mills, MD 21117
Ph: 800.505.1698

FOR INFORMATION CONTACT THE BUYER

April E Battle
(304) 558-0067
april.e.battle@wv.gov

Signature X John D. Kraft **FEIN #** 48-1164042 **DATE** 1/8/20

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

Page : 1

FORM ID : WV-PRC-CRFQ-001

INVOICE TO	SHIP TO
PROCUREMENT OFFICER - 304-356-4861 HEALTH AND HUMAN RESOURCES BUREAU FOR MEDICAL SERVICES 350 CAPITOL ST, RM 251 CHARLESTON WV25301-3709 US	PROCUREMENT OFFICER - 304-356-4861 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 for SFY2017	1	1	$ 417,637.15	$ 417,637.15

Comm Code	Manufacturer	Specification	Model #
84111600			

Extended Description :
Audit Services SFY2017 (07/01/2016-06/30/2017)

INVOICE TO	SHIP TO
PROCUREMENT OFFICER - 304-356-4861 HEALTH AND HUMAN RESOURCES BUREAU FOR MEDICAL SERVICES 350 CAPITOL ST, RM 251 CHARLESTON WV25301-3709 US	PROCUREMENT OFFICER - 304-356-4861 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 for SFY2018	1	1	$ 336,711.61	$ 336,711.61

Comm Code	Manufacturer	Specification	Model #
84111600			

Extended Description :
Audit Services SFY2018 (07/01/2017-06/30/2018)

INVOICE TO	SHIP TO
PROCUREMENT OFFICER - 304-356-4861 HEALTH AND HUMAN RESOURCES BUREAU FOR MEDICAL SERVICES 350 CAPITOL ST, RM 251 CHARLESTON WV25301-3709 US	PROCUREMENT OFFICER - 304-356-4861 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 for SFY2019	1	1	$ 346,812.96	$ 346,812.96

Comm Code	Manufacturer	Specification	Model #
84111600			

Extended Description :
Audit Services SFY2019 (07/01/2018-06/30/2019)

INVOICE TO	SHIP TO
PROCUREMENT OFFICER - 304-356-4861 HEALTH AND HUMAN RESOURCES BUREAU FOR MEDICAL SERVICES 350 CAPITOL ST, RM 251 CHARLESTON WV25301-3709 US	PROCUREMENT OFFICER - 304-356-4861 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 for SFY2020	1	1	$ 357,217.35	$ 357,217.35

Comm Code	Manufacturer	Specification	Model #
84111600			

Extended Description :
Audit Services SFY2020 (07/01/2019-06/30/2020)

SCHEDULE OF EVENTS

Line	Event	Event Date
1	Questions Due	2019-12-27

	Document Phase	Document Description	Page 4 of 4
BMS2000000002	Final	Disproportionate Share Hospital Audit Services	

ADDITIONAL TERMS AND CONDITIONS

See attached document(s) for additional Terms and Conditions

Addendum 1

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: 613750

Doc Description: Addendum No. 1 Disproportionate Share Hospital Audit Svcs.

Proc Type: Central Contract - Fixed Amt

Date Issued	Solicitation Closes	Solicitation No	Version
2019-12-23	2020-01-07 13:30:00	CRFQ 0511 BMS2000000002	2

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
10200 Grand Central Avenue, Ste. 200
Owings Mills, MD 21117
PH: 800.505.1698

FOR INFORMATION CONTACT THE BUYER

Brittany E Ingraham
(304) 558-2157
brittany.e.ingraham@wv.gov

Signature X John D. Kraft **FEIN #** 48-1164042 **DATE** 1/8/20

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

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

ADDITIONAL INFORMATION:

Addendum No. 1 - issued to change the buyer to Brittany Ingraham.

Question deadline remains 12/27/2019 at 3:00 pm EST.

Questions should be submitted in accordance with Item No. 4 on the Instructions to Vendor Submitting Bids to Brittany Ingraham via email at Brittany.E.Ingraham@wv.gov. Phone number is 304-558-0067.

No other changes.

INVOICE TO	SHIP TO
PROCUREMENT OFFICER - 304-356-4861 HEALTH AND HUMAN RESOURCES BUREAU FOR MEDICAL SERVICES 350 CAPITOL ST, RM 251 CHARLESTON WV25301-3709 US	PROCUREMENT OFFICER - 304-356-4861 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 for SFY2017	1	1	$ 417,637.15	$ 417,637.15

Comm Code	Manufacturer	Specification	Model #
84111600			

Extended Description :
Audit Services SFY2017 (07/01/2016-06/30/2017)

INVOICE TO	SHIP TO
PROCUREMENT OFFICER - 304-356-4861 HEALTH AND HUMAN RESOURCES BUREAU FOR MEDICAL SERVICES 350 CAPITOL ST, RM 251 CHARLESTON WV25301-3709 US	PROCUREMENT OFFICER - 304-356-4861 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 for SFY2018	1	1	$ 336,711.61	$ 336,711.61

Comm Code	Manufacturer	Specification	Model #
84111600			

Extended Description :
Audit Services SFY2018 (07/01/2017-06/30/2018)

INVOICE TO	SHIP TO
PROCUREMENT OFFICER - 304-356-4861 HEALTH AND HUMAN RESOURCES BUREAU FOR MEDICAL SERVICES 350 CAPITOL ST, RM 251 CHARLESTON WV25301-3709 US	PROCUREMENT OFFICER - 304-356-4861 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 for SFY2019	1	1	$ 346,812.96	$ 346,812.96

Comm Code	Manufacturer	Specification	Model #
84111600			

Extended Description :
Audit Services SFY2019 (07/01/2018-06/30/2019)

INVOICE TO	SHIP TO
PROCUREMENT OFFICER - 304-356-4861 HEALTH AND HUMAN RESOURCES BUREAU FOR MEDICAL SERVICES 350 CAPITOL ST, RM 251 CHARLESTON WV25301-3709 US	PROCUREMENT OFFICER - 304-356-4861 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 for SFY2020	1	1	$ 357,217.35	$ 357,217.35

Comm Code	Manufacturer	Specification	Model #
84111600			

Extended Description :
Audit Services SFY2020 (07/01/2019-06/30/2020)

SCHEDULE OF EVENTS

Line	Event	Event Date
1	Questions Due	2019-12-27

	Document Phase	Document Description	Page 4
BMS2000000002	Final	Addendum No. 1 Disproportionate Share Hospital Audit Svcs.	of 4

ADDITIONAL TERMS AND CONDITIONS

See attached document(s) for additional Terms and Conditions

Addendum 2

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: 613750

Doc Description: Addendum No. 2 Disproportionate Share Hospital Audit Svcs.

Proc Type: Central Contract - Fixed Amt

Date Issued	Solicitation Closes	Solicitation No	Version
2020-01-02	2020-01-09 13:30:00	CRFQ 0511 BMS2000000002	3

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
10200 Grand Central Avenue, Ste. 200
Owings Mills, MD 21117
PH: 800.505.1698

FOR INFORMATION CONTACT THE BUYER

Brittany E Ingraham
(304) 558-2157
brittany.e.ingraham@wv.gov

Signature X John D. Kight **FEIN #** 48-1164042 **DATE** 1/8/20

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

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

ADDITIONAL INFORMATION:

Addendum No. 2 - issued to:

1. Publish vendor questions and agency responses.

2. Modify the bid opening date as follows:
   Bid Opening WAS: 1/7/2020 at 1:30 PM
   Bid Opening IS NOW: 1/9/2020 at 1:30 PM

No other changes.

INVOICE TO	SHIP TO
PROCUREMENT OFFICER - 304-356-4861 HEALTH AND HUMAN RESOURCES BUREAU FOR MEDICAL SERVICES 350 CAPITOL ST, RM 251 CHARLESTON WV25301-3709 US	PROCUREMENT OFFICER - 304-356-4861 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 for SFY2017	1	1	$ 417,637.15	$ 417,637.15

Comm Code	Manufacturer	Specification	Model #
84111600			

Extended Description :
Audit Services SFY2017 (07/01/2016-06/30/2017)

INVOICE TO	SHIP TO
PROCUREMENT OFFICER - 304-356-4861 HEALTH AND HUMAN RESOURCES BUREAU FOR MEDICAL SERVICES 350 CAPITOL ST, RM 251 CHARLESTON WV25301-3709 US	PROCUREMENT OFFICER - 304-356-4861 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 for SFY2018	1	1	$ 336,711.61	$ 336,711.61

Comm Code	Manufacturer	Specification	Model #
84111600			

Extended Description :
Audit Services SFY2018 (07/01/2017-06/30/2018)

INVOICE TO	SHIP TO
PROCUREMENT OFFICER - 304-356-4861 HEALTH AND HUMAN RESOURCES BUREAU FOR MEDICAL SERVICES 350 CAPITOL ST, RM 251 CHARLESTON WV25301-3709 US	PROCUREMENT OFFICER - 304-356-4861 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 for SFY2019	1	1	$ 346,812.96	$ 346,812.96

Comm Code	Manufacturer	Specification	Model #
84111600			

Extended Description :
Audit Services SFY2019 (07/01/2018-06/30/2019)

INVOICE TO	SHIP TO
PROCUREMENT OFFICER - 304-356-4861 HEALTH AND HUMAN RESOURCES BUREAU FOR MEDICAL SERVICES 350 CAPITOL ST, RM 251 CHARLESTON WV25301-3709 US	PROCUREMENT OFFICER - 304-356-4861 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 for SFY2020	1	1	$ 357,217.35	$ 357,217.35

Comm Code	Manufacturer	Specification	Model #
84111600			

Extended Description :
Audit Services SFY2020 (07/01/2019-06/30/2020)

SCHEDULE OF EVENTS

Line	Event	Event Date
1	Questions Due	2019-12-27

	Document Phase	Document Description	Page 4
BMS2000000002	Final	Addendum No. 2 Disproportionate Share Hospital Audit Svcs.	of 4

ADDITIONAL TERMS AND CONDITIONS

See attached document(s) for additional Terms and Conditions

Executive Summary

Myers and Stauffer is a nationally-based certified public accounting (CPA) firm dedicated to serving the reimbursement and compliance needs of our government health care clients. We have nearly 900 associates located in 19 offices nationwide that collectively manage active engagements with public health agencies in 49 states, including engagements in West Virginia.

We specialize in providing audit, rate setting, consulting, program integrity, and other operational support services to state Medicaid agencies. Through these opportunities, we have prevented unnecessary program expenditures; identified hundreds of millions of dollars of inappropriate payments and recoveries; assisted in the development of state reimbursement systems; performed eligibility audits and analyses; defended audit findings from providers' administrative and judicial challenges; and performed data management and analysis services to assist our clients in better managing their programs.

We were founded and continue to 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 people, 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 turnaround time.

Myers and Stauffer was established in 1977 and provides operational support services to public health care and social service agencies. Throughout our more than 42 years, we have assisted state Medicaid

programs with complex data management, compliance, and reimbursement issues for long-term care (LTC) facilities, hospitals, home health agencies (HHAs), federally qualified health centers (FQHCs), rural health clinics, pharmacies, physicians, and other practitioners. We have current engagements with Medicaid and other public agencies in 49 states and U.S. territories, and the Centers for Medicare & Medicaid Services (CMS), the U.S. Department of Justice, and state Medicaid Fraud Control Units. We are the largest CPA firm performing regulatory health care services exclusively for government agencies. The vast majority of our client engagements have been continued for greater than 10 years, which is a clear indication of our clients' ongoing satisfaction with the services we provide.

Why Myers and Stauffer is Best Suited to Serve BMS

- ***In-depth Knowledge of the DSH Audits.*** *Our DSH team has a depth of experience in DSH auditing and consulting – including serving as a prior contractor for DSH engagements in West Virginia and 40 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 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 to provide our clients with guidance and assistance in a manner that other firms simply cannot match. We also closely monitor the West Virginia legislature and the national health care regulatory environment regarding Medicaid compliance and program integrity matters. This allows us to keep a current knowledge base of legislative interests in this area and any relevant inquiries that BMS receives.*
- ***Knowledge of the West Virginia Department of Health and Human Resources (the Department) Operations.*** *We have worked effectively with the Department on various auditing and consulting issues and have established solid working relationships throughout the agency. Through our past and current work with BMS, 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 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 42-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 also in 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 Centralized Request for Quotation (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 of 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 that has limited its practice to specializing in work with government health care agencies, thereby minimizing possible conflicts of interest. Our more

than 42 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)

Proof of CPA License (3.1.1)

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

7/1/2019 Firm Verification: Details - WV Board of Accountancy

West Virginia
Board of Accountancy

Firm Verification: Details

Firm License Information

Firm Name	MYERS AND STAUFFER LC
Address	700 W 47TH ST STE 1100
City	KANSAS CITY
State	MO
Zip	64112
County	
Permit Number	[redacted]
Effective Date	07/01/2019
Current Status	Active
Expiration Date	06/30/2020

Authorization to Perform Attest/Compilation Services

Active	06/30/2020

Page Updated: 11/27/2017 2:52:36 PM

© 2019 WV Board of Accountancy. All Rights Reserved.

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, Public Company Accounting Oversight Board, 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*.

Medicaid Agency and Hospital Independence (3.1.3)

We attest that our firm meets all independence standards referenced in CRFQ Section 3.1.2 and that our firm is independent of the West Virginia DSH program and the hospitals listed in *Attachment 6*.

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.

Experience (3.1.4)

Primary Audit Firm

Myers and Stauffer has been conducting DSH audit work longer than any other firm in the nation, as we were the first firm to be engaged by a state to audit pursuant to the Draft Rule (issued in August 2005) and Final Rule (issued in December 2008). Starting with our first DSH audit client in 2006, we have grown to be a national leader in assisting states with their DSH programs. We are currently engaged with 40 Medicaid programs to perform their DSH audit and engaged with 14 state Medicaid programs to calculate DSH payments on an annual basis. In addition, from 2010 through 2015, we worked with the Department to complete the DSH audit reports for state rate plan years 2005 through 2012 and provided recommendations to improve DSH program procedures. We were instrumental in developing the initial 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.

We have the resources, experience, and expertise to perform this engagement as the primary audit firm without the use of subcontractors.

As shown in the following table, our DSH team has 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. For each of these clients, we perform the federally-mandated independent certified audits of the state's Medicaid DSH program, compliant with the requirement of 42 Code of Federal Regulations (CFR) Parts 445 and 447, and the Final Rule, 73 FR 77904, published December 19, 2008.

Myers and Stauffer: DSH Audit and Consulting Experience
State Plan Rate Years 2005 – 2016

State Medicaid Client	Dates of Service	Audit Performed for State Plan Rate Year											
		2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016
Alabama Medicaid Agency	2010 – 2012	✓	✓	✓	✓	✓							
Alaska Department of Health and Social Services*	2009 – 2020	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Arizona Health Care Cost Containment System*	2018 – 2019											✓	✓
Arkansas Department of Human Services*	2009 – 2023	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
California Department of Health Care Services*	2016 – 2019									✓	✓	✓	✓
Colorado Department of Health Care Policy & Financing*	2011 – 2021			✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Connecticut Department of Social Services*	2011 – 2020				✓	✓	✓	✓	✓	✓	✓	✓	✓
District of Columbia Department of Health Care Finance	2009 – 2011	✓	✓	✓									
Florida Agency for Health Care Administration*	2014 – 2022							✓	✓	✓	✓	✓	✓
Georgia Department of Community Health*	2009 – 2020	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓

Myers and Stauffer: DSH Audit and Consulting Experience State Plan Rate Years 2005 – 2016													
State Medicaid Client	Dates of Service	Audit Performed for State Plan Rate Year											
		2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016
Hawaii Department of Human Services*	2009 – 2020	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Idaho Department of Health and Welfare*	2009 – 2020	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Illinois Department of Health Care and Family Services*	2010 – 2019	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Indiana Family and Social Services Administration*	2009 – 2021	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Kansas Department of Health and Environment*	2009 – 2022	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Kentucky Cabinet for Health and Family Services*	2009 – 2020	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Louisiana Department of Health*	2009 – 2022	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Maine Department of Health and Human Services*	2016 – 2020							✓	✓	✓	✓	✓	✓
Maryland Department of Health*	2009 – 2020	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Massachusetts Executive Office of Health and Human Services	2008	✓											
Michigan Department of Health and Human Services*	2009 – 2023	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Minnesota Department of Human Services*	2015 – 2020							✓	✓	✓	✓	✓	✓
Mississippi Office of the Governor*	2009 – 2019	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Missouri Department of Social Services*	2010 – 2021	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓

Myers and Stauffer: DSH Audit and Consulting Experience State Plan Rate Years 2005 – 2016													
State Medicaid Client	Dates of Service	Audit Performed for State Plan Rate Year											
		2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016
Montana Department of Public Health and Human Services*	2009 – 2023	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Nebraska Department of Health and Human Services*	2009 – 2020	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Nevada Department of Health and Human Services*	2009 – 2021	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
New Hampshire Department of Health and Human Services*	2009 – 2021	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
New Jersey Department of Human Services*	2012 – 2019	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
New Mexico Human Services Department*	2009 – 2021	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
North Carolina Department of Health and Human Services*	2009 – 2020	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
North Dakota Department of Human Services*	2009 – 2025	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Ohio Department of Medicaid*	2010 – 2021	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Oklahoma Health Care Authority*	2009 – 2023	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Oregon Department of Human Services*	2009 – 2023	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Rhode Island Department of Human Services*	2010 – 2022	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
South Carolina Department of Health and Human Services*	2006 – 2021	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Tennessee Department of Finance and Administration*	2010 – 2020			✓	✓	✓	✓	✓	✓	✓	✓	✓	✓

Myers and Stauffer: DSH Audit and Consulting Experience State Plan Rate Years 2005 – 2016													
State Medicaid Client	Dates of Service	Audit Performed for State Plan Rate Year											
		2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016
Texas Health and Human Services Commission*	2009 – 2021	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Vermont Agency of Human Services	2010 – 2011	✓	✓	✓	✓								
Virginia Department of Medical Assistance Services*	2009 – 2023	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Washington Health Care Authority*	2009 – 2022	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
West Virginia Health Care Authority	2010 – 2015	✓	✓	✓	✓	✓	✓	✓	✓				
Wisconsin Department of Health Services*	2012 – 2020					✓	✓	✓	✓	✓	✓	✓	✓
Wyoming Department of Health*	2009 – 2020	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
**Denotes current DSH audit client.*													

We have included letters from three state clients verifying successful completion and acceptance by CMS in *Appendix B: CMS Acceptance.*

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 current state Medicaid DSH payment experience includes:

- *Alabama Medicaid Agency.*
- *Colorado Department of Health Care Policy & Financing.*
- *Georgia Department of Community Health.*
- *Idaho Division of Medicaid, Department of Health and Welfare.*

- *Indiana Family and Social Services Administration.*
- *Iowa Department of Human Services.*
- *Kansas Department of Health and Environment, Division of Health Care Finance.*
- *Kentucky Cabinet for Health and Family Services.*
- *Louisiana Department of Health.*
- *Mississippi Division of Medicaid.*
- *Missouri Department of Social Services.*
- *Nebraska Department of Health and Human Services.*
- *New Mexico Human Services Department.*
- *North Carolina Department of Health and Human Services.*

Engagement Partner DSH Experience

The engagement partner has been working on Medicaid DSH audits since before the 2008 DSH Final Rule, covering more than 10 years of experience and 12 DSH audit years. These DSH audits have involved working with each of the hospital DSH types eligible including acute care, critical access, institutes for mental disease (IMD) (psychiatric), LTC hospitals, rehabilitation hospitals and children's hospitals. The engagement partner meets and exceeds the requirement of five years prior federal Medicaid DSH audit experience for each of the DSH types. Below, we have summarized the engagement partners' five years of DSH audit experience by hospital type, noting states and years.

- *Acute Care (DSH Years 2012 – 2016) – Connecticut, New Hampshire, Oregon, Rhode Island, South Carolina, West Virginia.*
- *Critical Access Hospital (DSH Years 2012 – 2016) – New Hampshire, Oregon, South Carolina, West Virginia.*
- *Children's (DSH Years 2012 – 2016) – Connecticut, Oregon, South Carolina.*
- *IMD (DSH Years 2012 – 2016) – Connecticut, New Hampshire, Oregon, Rhode Island, South Carolina, West Virginia.*
- *LTC Hospital (DSH Years 2012 – 2016) – Connecticut, Rhode Island, South Carolina.*
- *Rehabilitation Hospital (DSH Years 2008 – 2014) – New Hampshire.*

We have included the details by hospital type, state, hospital name, and year in *Appendix C: Engagement Partner Experience by Hospital Type.*

Organizational Chart and Resumes (3.2)

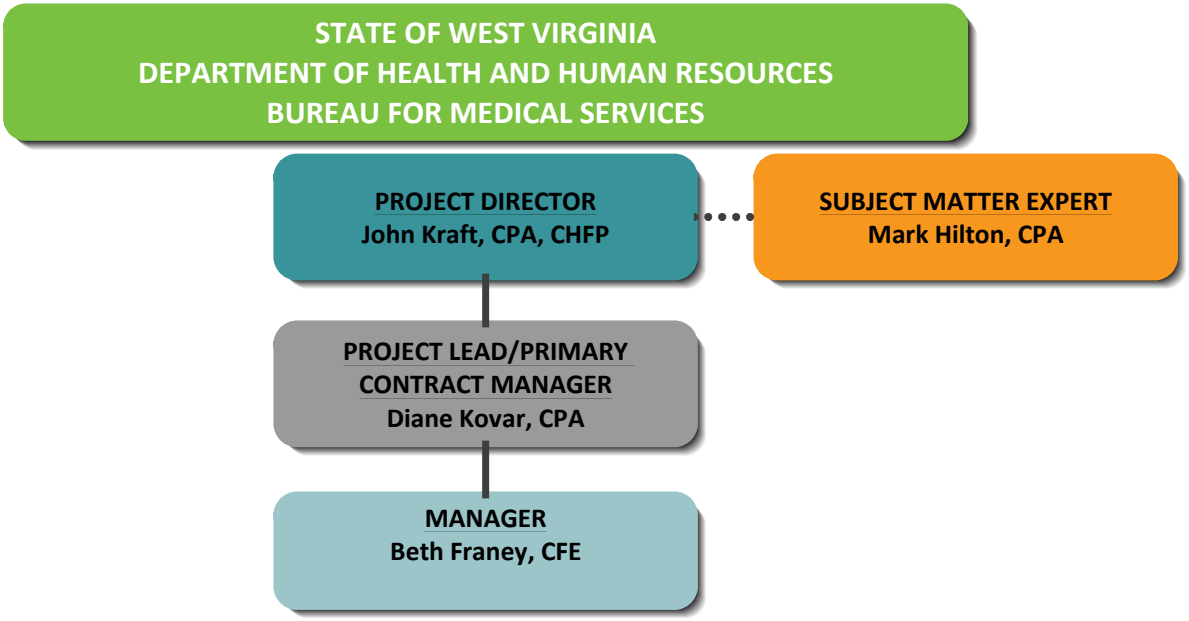
Myers and Stauffer is committed to performing this work within the desired time periods established in the CRFQ and have available the resources to efficiently manage this project. Our practice is well-rounded in terms of relevant experience and scope of services provided, and we do not experience the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

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 Organizational Chart

We are pleased to propose the following team members for this project, many of whom have provided DSH payment, DSH auditing, rate setting, cost report analysis, and consulting services to our other DSH clients in recent years. The following organizational chart shows the specific staff structure proposed for this project. We are pleased to present such a strong, experienced leadership team to this project. The following chart outlines the qualifications of the professional staff assigned to lead this project. Project team resumes are also included following our staffing chart. All project team members are full-time, experienced, professional staff dedicated to Medicaid program projects.



Resumes

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 to exceed your expectations. On the following page, we have included a brief summary of our key management staff and their roles. We have included resumes for all key management staff in *Appendix D: 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**
John Kraft, CPA *Member*	***Project Director/ Engagement Partner:*** 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. Kraft has performed Medicare and Medicaid audit, desk review and rate calculation services. He previously managed the DSH audit contract for West Virginia. He plays a key role in managing our DSH audit contracts with the states of Connecticut, New Hampshire, Oregon, Rhode Island, and South Carolina. He also currently manages Medicaid cost settlement audit contracts for the states of Georgia, New Hampshire, New Jersey, South Carolina, and Vermont. 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. He has been a key participant in health care litigation support.
Mark Hilton, CPA *Member*	***Subject Matter Expert:*** Mr. Hilton will be available to assist BMS as a subject matter expert on the technical requirements of the DSH rule.	36 years	✓	Mr. Hilton previously served as a project director for the DSH audit contract with West Virginia. He serves as the project director for our DSH audit contracts with the states of Colorado, New Hampshire, Rhode Island, South Carolina, and Tennessee. Mr. Hilton has been an active participant in developing the protocols for applying the DSH Audit Rule. He led 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 and the CMS personnel responsible for implementing the DSH Final Rule.
Diane Kovar, CPA *Senior Manager*	***Project Lead/Primary Contract Manager:*** Ms. Kovar will work with 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, oversee the activities of project staff, and be available to BMS staff on a daily basis.	21 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 prior West Virginia DSH audits, she has managed DSH audits in Connecticut, Oregon, New Hampshire, Rhode Island, and South Carolina. 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:*** Ms. Franey will be available to serve as a	13 years	✓	Ms. Franey has worked in the Medicare and Medicaid audit and investigation arena for

Myers and Stauffer: Proposed Key Staff				
Team Member	**Role in Project**	**Health Care Exp.**	**Exp. with WV**	**Qualifications**
Manager	contact for hospitals and assist with directing the work of staff auditors and accountants.			more than six years. She has performed and reviewed DSH desk reviews for Colorado, Connecticut, Massachusetts, Oregon, New Hampshire, Rhode Island, South Carolina, Tennessee, Vermont, and West Virginia, and Medicaid cost settlements for South Carolina. She has also performed health care litigation support and fraud investigation in federal health care programs.

Staff Training (3.2.1)

Since many of the issues typically encountered during a DSH engagement are not taught in a classroom, nor are they discussed in periodicals, 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 AICPA.

Our personnel participate in general and industry-specific continuing professional education and development activities to ensure we are always at the forefront of any complex or changing health care-related issues. These activities enable staff to not only satisfy, but also to go beyond their assigned responsibilities and fulfill applicable continuing professional education 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 AICPA requirements, state boards of accountancy, and regulatory agencies in establishing the firm's continuing professional education 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.*

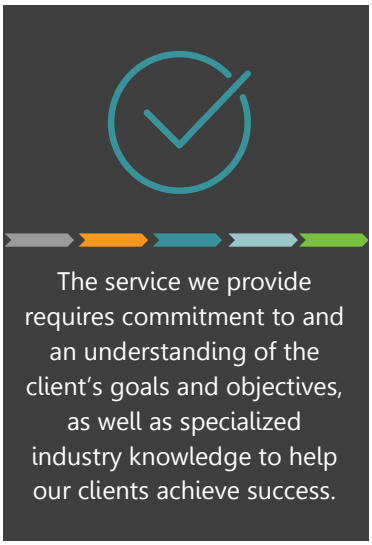
Our professionals who are CPAs are required to complete 40 hours annually of continuing professional education. In addition, those employees who work on GAGAS engagements are required to complete in 80 hours every two years of continuing professional education. At least 24 hours of the 80 hours must be in subjects directly related to governmental 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 receive relevant training throughout the year. We have included CPE documentation for our key management staff in *Appendix D: Resumes.*

Finally, all training is managed so 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 Qualifications (CRFQ Section 4)

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, several legislative amendments have defined, refined, and limited states' use and implementation of the DSH provisions, including:

- *The Omnibus Budget Reconciliation Act of 1986, which stated that Health Care Finance Administration 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 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).*

While the DSH audit process has been around for several years, the rules and guidance continues to be challenged and updated by the courts and CMS. To perform accurate and efficient DSH audits, it is imperative that we stay current on all federal guidance and court cases. Myers and Stauffer reviews all federal policy guidance and issues client alerts as soon as possible. Examples of current federal DSH audit guidance are as follows:

- *Final DSH Audit Rule: December 19, 2008 (73 FR 77904).*
- *DSH audit correcting amendment: April 24, 2009 (74 FR 18656).*
- *Uninsured definition change: December 3, 2014 (79 FR 71679).*
- *Third-party payments in DSH: April 3, 2017 (82 FR 16114).*
- *Additional Information on the DSH Reporting and Audit Requirements (FAQ) issued by CMS in February of 2010.*
- *Additional Information on the DSH Reporting and Audit Requirements Part 2 (FAQ) issued by CMS April 7, 2014.*
- *Additional Information on application of FAQ 33 and 34 issued by CMS December 31, 2018.*

In addition to understanding the DSH guidance listed above, a DSH audit requires our staff to understand various Medicaid regulations related to bona fide insurance, provider taxes, physician costs, bankruptcy, Medicare cost reports, delivery system reform incentive payments, health IT payments, prisoners, non-Title XIX programs, DSH allotment reductions, and certified/licensed hospital units.

Even with all of the guidance issued by CMS and others, there are still areas in the DSH audit rules that may be interpreted differently by one or more parties. In cases where states and hospitals demonstrate that certain regulations are not clear, we attempt to resolve the issues with CMS. If we cannot resolve an issue, we will adjust cost, if possible, based on best available information and add a data caveat to the independent audit report for CMS to review.

Currently, the courts are hearing many cases related to the CMS guidance referred to as "FAQ 33" and "FAQ 34," which required us to include third-party payments and Medicare payments as part of the uncompensated care cost calculations in the DSH audit. On December 31, 2018, CMS withdrew the guidance related to these FAQs. Myers and Stauffer immediately reacted to this by drafting a client alert letter and meeting with our clients to address the CMS notification in detail and the options states have to address the FAQ withdrawal.

Myers and Stauffer performs the federally-mandated independent certified audits of the Medicaid DSH programs for numerous states, compliant with the requirement of 42 CFR Parts 445 and 447, and the Final Rule, 73 FR 77904, published December 19, 2008. We also provide additional support to our state clients through our extensive DSH experience and continually monitoring of current regulatory developments that may impact our state clients.

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.

Because the subject matter of this engagement is not that of typical historical financial statements, an examination is the most appropriate reporting framework under current professional standards. We will conduct our examination in accordance with attestation standards established by the AICPA and the standards applicable to attestation engagements contained in Government Auditing Standards issued by the Comptroller General of the United States (Yellow Book standards).

Our examination program will comply with 42 U.S.C. Section 1923(j)(2) and will be subject to BMS' approval a minimum of 30 calendar days prior to beginning fieldwork. We will perform all examination procedures to render an opinion on the six DSH verifications and issue an examination report. Please see *Section 4.1.4: Work Plan* for more details. Travel and incidental costs will be included 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 more than 13 years of experience conducting DSH audits – including five years as BMS' 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 adhere to specific timelines to ensure that the engagement is completed and reports are issued on or before the CMS guidelines. For state fiscal year 2017, we will complete our work procedures by September 30, 2020. We will then complete a draft report by October 31, 2020, and a final report by November 30, 2020. 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, State Medicaid Enterprise Systems payment and utilization data, Medicare 2552-10 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 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 E: 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 B: 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 use the following DSH examination approach:

- *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 state Medicaid Enterprise Systems 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.

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 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 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 IMDs, 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 DSH 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.

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. 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 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 chooses a consultant with a long history of assisting states in addressing the complexities of their Medicaid DSH programs.

The audit process established by CMS requires the state to recoup any DSH funds 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 methodologies for estimating hospitals DSH limits and DSH payment methodologies, our DSH experience will enable us to assist with refining these 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 Enterprise Systems claims runs or hospital generated claims detail).

Compilation of DSH Payments. We will obtain from the 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. In the second phase, we will establish risk thresholds that, if exceeded, will potentially cause the hospital to be selected for expanded procedures review.

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 Medicaid Enterprise Systems.*
- *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 procedures 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 and the methods for providing it. Needed information may include patient financial and medical records, financial statements, and supporting general ledgers, and 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 were required to return all or part 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, and 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 June 30 and the hospital fiscal year ends December 31, it is acceptable to use six months of the DSH limit calculated for the hospital fiscal year end that covers the start of the state plan rate year and six 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 F: 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 which 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, and 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 and 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.

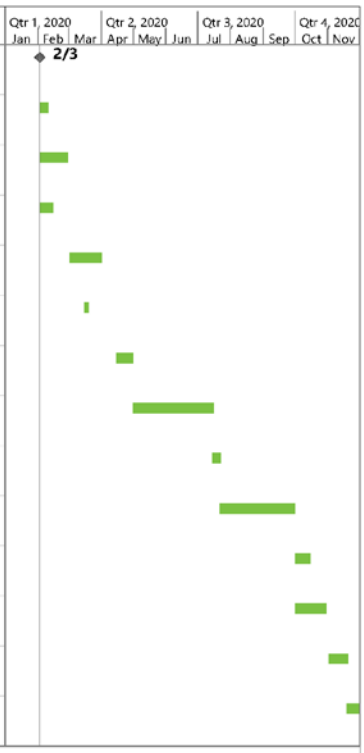
A detailed description of the methodology used in calculating the hospital-specific DSH limits will be included in the documentation maintained for the state agency. The description will include the definition of incurred inpatient and outpatient hospital costs. Much of this information will be contained 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 Report on DSH Verifications (which includes a comparison of each hospital's actual uncompensated care costs for the examination period and the actual DSH payments made), the Schedule of Data Caveats Relating to the DSH Verifications (if applicable) and the schedule of hospital-specific data elements specified by CMS in the Final Rule.

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

Task Name	Purpose	Start	Finish
Approximate Date Contract Begins		Mon 2/3/20	Mon 2/3/20
Meet with State to discuss project and timelines	To explain nature of procedures, answer questions, and obtain initial information	Mon 2/3/20	Mon 2/10/20
Update DSH survey tool to reflect any changes needed in the future and obtain necessary state approvals	To ensure appropriate data collection and approvals	Mon 2/3/20	Fri 2/28/20
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	Mon 2/3/20	Fri 2/14/20
Conduct annual DSH hospital training	To educate and provide instructions to hospitals on DSH examination and requested information.	Mon 3/2/20	Tue 3/31/20
Send DSH surveys to hospitals	Information on which hospital-specific procedures will be performed	Mon 3/16/20	Thu 3/19/20
Obtain survey data from the hospitals	Information on which hospital-specific procedures will be performed	Wed 4/15/20	Thu 4/30/20
Conduct desk reviews on the surveys	Ensure the data used to determine hospital-specific DSH limits is proper	Fri 5/1/20	Wed 7/15/20
Using risk-based approach, select hospitals for expanded procedures	Conduct planning to ensure for an efficient examination with the proper level of coverage	Wed 7/15/20	Wed 7/22/20
Completed expanded procedure desk reviews	Ensure the data used to determine hospital-specific DSH limits is proper	Wed 7/22/20	Wed 9/30/20
Perform senior management review of desk reviews and expanded desk reviews	To perform independent review of workpapers to ensure that quality standards are met	Thu 10/1/20	Thu 10/15/20
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	Thu 10/1/20	Fri 10/30/20
Meet with state to discuss draft examination report and findings	Discuss results of procedures with state representatives and allow adequate time for response	Mon 11/2/20	Thu 11/19/20
Issue final examination report with state responses for submission to CMS	Summarize findings and comply with the DSH Audit Rule	Thu 11/19/20	Mon 11/30/20



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.

Deliverables (CFRQ Section 4.2)

Electronic Final Examination Report (4.2.1)

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.

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 (formerly 18) data elements for each hospital.

Bound Final Examination Report (4.2.3)

We will issue a bound examination report upon request from BMS within 10 business days that expresses an opinion on the six verifications established in the Final Rule and meet all CMS requirements.

Exit Conference (4.2.4)

We will conduct an exit conference, via web conference or conference call, with the Department 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 sufficient time to meet the annual CMS DSH deadline of completing the report by December 31 of each year.

In addition, we will include the BMS' responses in the final electronic (and bound) report when it is issued.

Management Letter (4.2.5)

We will give BMS and applicable DSH hospitals an opportunity to provide a written response to management letter comments. Identified contacts for BMS and applicable DSH hospitals 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 provided through working directly with hospital and state personnel is evidenced by the increase in efficiency with respect to the examination process. Our training success is also evidenced by continued requests from state clients and state hospital associations for us to provide training each year to update the hospitals on current developments and new CMS guidance.

We have developed a comprehensive training program based on our knowledge and experience providing DSH audits to 40 states. Our training achieves two objectives each year. The first objective is to cover the technical aspects of the DSH Audit Rule and what the hospitals and the State need to do to comply. This includes current updates to the DSH audit rule that CMS publishes. The second objective is to provide training on the examination process and documentation requirements to make the process as efficient as possible, thus minimizing the administrative burden on all parties whenever possible. 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. These trainings can be provided to hospitals in a live audience setting, or via a webinar. The webinar can also be recorded for later viewing. The PowerPoint slides utilized during the training session are also made available to the hospitals to use as a reference during DSH survey completion.

See *Sections 4.2.6.1 – 4.2.6.3* for details on our training plan for West Virginia.

Ensuring Training Objectives (4.2.6.1)

We have developed a comprehensive training program based on our knowledge and experience providing DSH audits to 40 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 they begin their part of the audit.

Sample Training Materials (4.2.6.2)

We have provided sample training materials in *Appendix G: Sample Training Materials*. These materials have been used in our presentations to Michigan, New Hampshire, 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 fieldwork. For the 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 be issued, or regulation, guidance, or

interpretation changes arise, we will conduct training via webinar within six weeks of the update for the initial engagement and any optional renewal periods.

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 additional cost.

Pricing Page

We have included our price estimate on the following page. Our pricing is based on our understanding of your request and our previous experience conducting DSH audits for 40 states, many of which had a diverse hospital community similar to West Virginia's in terms of hospital types, size and sophistication of management.

Exhibit A: PRICING PAGE
All inclusive price for each audit period:

SFY 2017 (July 1, 2016 – June 30, 2017)

				Total Cost for Audit Period SFY2017
Total Cost SFY2017 Audit				$ 417,637.15

Optional Renewal Periods:

SFY 2018 (July 1, 2017 – June 30, 2018)

				Total Cost for Audit Period SFY2018
Total Cost SFY2018 Audit				$ 336,711.61

SFY 2019 (July 1, 2018 – June 30, 2019)

				Total Cost for Audit Period SFY2019
Total Cost SFY2019 Audit				$ 346,812.96

SFY 2020 (July 1, 2019 – June 30, 2020)

				Total Cost for Audit Period SFY2020
Total Cost SFY2020 Audit				$ 357,217.35

Grand Total for four (4) Year Contract Period (A+B+C+D)

$ 1,458,379.07

Notes

1. The Vendors Grand Total Not to Exceed Cost will include all general and administrative staffing (secretarial, clerical, etc.), travel, supplies and other resource costs necessary to perform all services within the scope of this procurement.
2. The cost bid proposal will be evaluated based on the Grand Total.
3. The Vendor will invoice monthly in arrears. Payment will be issued in equal monthly increments during the contract period for each audit year, with the last payment withheld until a final audit report is delivered and accepted by the Bureau.

Myers and Stauffer LC
(Company)

John D. Kraft, Member
(Representative Name, Title)

Ph: 800.505.1698 / Fax: 410.356.0188
(Contact Phone/Fax Number)

1/8/2020
(Date)

Additional Information (CRFQ Section 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:

Diane Kovar, CPA
Senior Manager
PH: 410.581.4544
FX: 410.356.0188
Email: dkovar@mslc.com

Appendix

- *Appendix A: Myers and Stauffer Quality Control Manual, Chapter 2: Ethical Requirements.*
- *Appendix B: CMS Acceptance.*
- *Appendix C: Engagement Partner Experience by Hospital Type.*
- *Appendix D: Resumes.*
- *Appendix E: Hospital Schedule.*
- *Appendix F: Sample DSH Survey Tool.*
- *Appendix G: Sample Training Materials.*
- *Appendix H: Purchasing Affidavit.*
- *Appendix I: Certificates of Insurance.*
- *Appendix J: Disclosure of Interested Parties.*

Appendix A: Myers and Stauffer Quality Control Manual, Chapter 2: Ethical Requirements

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:

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:

1. 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.

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

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

4. 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).

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

6. 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.

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

When facing situations that raise potential independence threats not specifically addressed by independence rules, one should report the matter to the Quality Control Chair. Such threats will be evaluated by reference to the *AICPA Code of Professional Conduct Part 1, Members in Public Practice*, to determine whether an independence breach exists. When necessary,

appropriate authorities from AICPA or state CPA societies will be consulted. The firm will take appropriate action to mitigate the threat.

Notwithstanding the preceding guidance and list of prohibited transactions, at the Quality Control Chair'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:

1. 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. The Quality Control Chair is responsible for obtaining and reviewing this representation for completeness and information relating to identified threats to ethical requirements. If a potential threat is identified, the Quality Control Chair communicates relevant information to management so it can take appropriate action to address identified threats. Documentation of resolution is filed in the employee's personnel folder.

2. Requiring all personnel to promptly notify the Quality Control Chair 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 AICPA *Code of Professional Conduct* is contained in the *AICPA Professional Standards* and is available on The Cube under Other Info – Reference Material Library. Authoritative resources and advice of the Quality Control Chair should be consulted when one is not sure if a transaction, event, or circumstance may be a violation or should be reported.

3. 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.

4. Requiring independence representations from other CPA firms when necessary. During the course of performing an accounting, auditing, or attestation 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 accountants. On the other hand, if another accountant performs a segment of our accounting and attestation engagement, a separate independence representation is required from such accountant.

5. 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.

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

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

8. 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 Chair. 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.

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

It is the policy of the firm that we will evaluate each project's scope of services to identify relationships that create threats to independence. We will take appropriate action to reduce threats to an acceptable level, or if considered appropriate, to withdraw from the engagement and/or client relationship.

The firm implements this policy through the following procedures:

1. Projects will be reviewed annually to determine if the project includes both attest and non-attest services. Projects that include attest and non-attest services will be evaluated to determine if independence is impaired by providing both services. This evaluation will be performed by a senior manager or above in charge of the project prior to engaging and annually thereafter.

2. Assigning the Quality Control Committee the primary responsibility of reviewing engagement independence determinations. If a conflict arises between the Quality Control Committee's assessment and the initial evaluation, the Executive Committee has the ultimate authority to make independence determinations.

3. Project independence decisions will be made and documented at the contract level.

Table 1: Selected Rules in the AICPA Code of Professional Conduct
These rules apply to all personnel and come from the *AICPA Professional Standards*.

CHAPTER 2
ETHICAL REQUIREMENTS

April 27, 2018

Description of Rule	Professional Standards
Responsibilities	ET §0.300.020
The Public Interest	ET §0.300.030
Integrity	ET §0.300.040
Objectivity, Independence	ET §0.300.050
Due Care	ET §0.300.060
Scope, Nature of Services	ET §0.300.070
Rule 1.200 Independence	ET §1.200.001
Rule 1.100 Integrity and Objectivity	ET §1.100.001
Ethical Conflicts	ET §1.000.020 and 2.000.020

Independence, Integrity, and Objectivity Representation

Personnel Name _____ Office Location _____

INSTRUCTIONS: This representation should be completed when hired and annually thereafter. It is required for all professional personnel including seasonal, part-time, and contract employees or outside engagement quality control reviewers employed by the firm. This representation and attachments should be routed to the Quality Control Chair to review and file in the individual's personnel folder.

I have read and understand the firm's policies and procedures regarding relevant ethical requirements as stated in the firm's Quality Control Manual. I represent that:

1. I am familiar with and will adhere to the independence, integrity, and objectivity rules, regulations, and interpretations of the American Institute of Certified Public Accountants *AICPA Professional Standards* (*Code of Professional Conduct*) at Part 1, Section 1.100 Integrity and Objectivity and Section 1.200 Independence; the firm's Ethical Requirements policies and procedures; and Generally Accepted Government Auditing Standards, when applicable. If I am a CPA, I am familiar with and will adhere to relevant AICPA Professional Standards and requirements of state boards of accountancy and CPA societies for states germane to my practice area.

2. Except as described in No. 6 below, I am not aware of any prohibited investments, transactions, or relationships with any health care providers that have provided or currently provide services to Medicare or Medicaid beneficiaries.

3. Any situation where I am either not independent or I am unsure whether I am independent is listed and explained in the first two columns of No. 6 below.

4. Any situation in which I am not able to determine or unsure as to whether I am able to exercise objectivity in performing an engagement is listed and explained in the first two columns of No. 6.

5. I am not currently under any investigation or disciplinary proceeding, and no such matter is pending with the AICPA or any other professional organization or regulatory agency. There are no matters that would cause a reasonable person to conclude that I lack integrity in the performance of my professional responsibilities.

6.

Client or Provider	Possible Issues	Resolution
•		
•		
•		

(If more than three client or provider issues are present, attach an additional page listing each situation.)

Signature Date

For Administrative Use Only
Reviewed by the Quality Control Chair: Date:

Appendix B: CMS Acceptance

Kerrin A. Rounds
Acting Commissioner

Meredith J. Telus
Director

STATE OF NEW HAMPSHIRE
DEPARTMENT OF HEALTH AND HUMAN SERVICES
BUREAU OF IMPROVEMENT & INTEGRITY

129 PLEASANT STREET, CONCORD, NH 03301
603-271-9622 1-800-852-3345 Ext. 9622
Fax: 603-271-8113 TDD Access: 1-800-735-2964
www.dhhs.nh.gov

December 23, 2019

Dear Sir/Madam:

I am writing on behalf of the New Hampshire Department of Health and Human Services (DHHS) 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 LC (or its predecessor PHBV Partners/Clifton Gunderson) has served DHHS since 2009. By my signature on this letter, I certify that Myers and Stauffer LC and/or its predecessor PHBV Partners/Clifton Gunderson successfully completed all DSH audit requirements for the state plan years noted below and that these audit reports were accepted by the Centers for Medicare & Medicaid Services:

- SFY 2012
- SFY 2013
- SFY 2014
- SFY 2015

Please feel free to contact me if you have any questions at 603.271.9622 or by email at meredith.telus@dhhs.nh.gov.

Sincerely,

Meredith Telus

Meredith Telus
Director, Program Planning and Integrity

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

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
Healthy Connections MEDICAID

Henry McMaster GOVERNOR
Joshua D. Baker DIRECTOR
P.O. Box 8206 • Columbia, SC 29202
www.scdhhs.gov

December 30, 2019

Dear Sir/Madam:

I am writing on behalf of the South Carolina Department of Health and Human Services (DHHS) to provide a professional confirmation regarding Myers and Stauffer LC's disproportionate share hospital (DSH) audit work for the state of South Carolina.

Myers and Stauffer LC (or its predecessor PHBV Partners/Clifton Gunderson) has served DHHS since 2006. By my signature on this letter, I certify that Myers and Stauffer LC and/or its predecessor PHBV Partners/Clifton Gunderson successfully completed all DSH audit requirements for the state plan years noted below and that these audit reports were accepted by the Centers for Medicare & Medicaid Services:

- SFY 2012
- SFY 2013
- SFY 2014
- SFY 2015

Please feel free to contact me if you have any questions at 803.898.1023 or by email at saxon@scdhhs.gov.

Sincerely,

Jeff Saxon
Program Manager III
South Carolina Department of Health and Human Services
1801 Main Street
Columbia, SC 29201

South Carolina Department of Health and Human Services *Better care. Better value. Better health.*

KAREN KIMSEY
DIRECTOR

COMMONWEALTH of VIRGINIA
Department of Medical Assistance Services

804-786-7933
www.dmas.virginia.gov

December 30, 2019

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 Myers and Stauffer LC and/or its predecessor PHBV Partners/Clifton Gunderson successfully completed all DSH audit requirements for the state plan years noted below and that these audit reports were accepted by the Centers for Medicare & Medicaid Services:

- SFY 2012
- SFY 2013
- SFY 2014
- SFY 2015

Please feel free to contact me if you have any questions at 804.371.2446 or by email at chandra.shrestha@dmas.virginia.gov.

Sincerely,

CMShrestha

Chandra Shrestha
Reimbursement Audit Manager
Provider Reimbursement Division
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, VA 23219

600 EAST BROAD STREET • SUITE 1300 • RICHMOND, VIRGINIA 23219 • 800-343-0634 (TDD)

Appendix C: Engagement Partner Experience by Hospital Type

Acute Care Providers Connecticut						
Facility	**2012**	**2013**	**2014**	**2015**	**2016**	**Grand Total**
Bridgeport Hospital	1	1	1		1	4
Bristol Hospital	1	1				2
Charlotte Hungerford Hospital	1	1				2
Danbury Hospital	1	1				2
Day Kimball Hospital	1	1	1	1	1	5
Greenwich Hospital Association	1	1				2
Griffin Hospital	1	1				2
Hartford Hospital	1	1				2
Hospital of Central CT (Former NBGH)	1	1				2
Hospital Of St Raphael	1					1
John Dempsey Hospital	1	1	1	1	1	5
Johnson Memorial Hospital	1	1				2
Lawrence & Memorial Hospital	1	1				2
Manchester Memorial Hospital	1	1				2
Middlesex Hospital	1	1				2
Midstate Medical Center	1	1				2
Milford Hospital	1	1				2
New Milford Hospital	1	1				2
Norwalk Hospital	1	1				2
Rockville General Hospital	1	1				2

Acute Care Providers Connecticut						
Facility	**2012**	**2013**	**2014**	**2015**	**2016**	**Grand Total**
Sharon Hospital/Essent Healthcare	1	1				2
St. Francis Hospital Medical Center	1	1				2
St. Mary's Hospital	1	1		1	1	4
St. Vincent's Medical Center	1	1				2
Stamford Hospital	1	1				2
Waterbury Hospital	1	1		1		3
William W Backus Hospital	1	1				2
Windham Comm Mem Hospital	1	1				2
Yale New Haven Hospital	1	1	1		1	4
	29	**28**	**4**	**4**	**5**	**70**

Acute Care Providers New Hampshire						
Facility	**2012**	**2013**	**2014**	**2015**	**2016**	**Grand Total**
Catholic Medical Center			1	1	1	3
Concord Hospital Inc.			1	1	1	3
Elliot Hospital			1	1	1	3
Exeter Hospital			1	1	1	3
Frisbie Memorial Hospital	1	1	1	1	1	5
Lakes Region General Hospital			1	1	1	3
Mary Hitchcock Memorial Hospital	1	1	1	1	1	5
Parkland Medical Center			1	1	1	3
Portsmouth Regional Hospital			1	1	1	3
Southern New Hampshire Medical Center			1	1	1	3
St Joseph Hospital			1	1	1	3
The Cheshire Medical Center			1	1	1	3
Wentworth Douglass Hospital			1	1	1	3
	2	**2**	**13**	**13**	**13**	**43**

Acute Care Providers Oregon						
Facility	**2012**	**2013**	**2014**	**2015**	**2016**	**Grand Total**
Adventist Medical Center-Portland	1	1	1	1	1	5
Ashland Community Hospital	1	1	1	1	1	5
Bay Area Hospital	1	1	1	1	1	5
Good Samaritan Hospital Corvallis	1	1	1	1	1	5
Kaiser Sunnyside Medical Center	1	1	1	1		4
Legacy Emanuel Hospital & Health Center	1	1	1	1	1	5
Legacy Good Samaritan Hospital & Medical Center	1	1	1	1	1	5
Legacy Meridian Park Hospital	1	1	1	1	1	5
Legacy Mount Hood Medical Center	1	1	1	1	1	5
McKenzie-Willamette Medical Center	1	1	1	1	1	5
Mercy Medical Center	1	1	1	1	1	5
Mid-Columbia Medical Center	1	1	1	1	1	5
Oregon Health Sciences University	1	1	1	1	1	5
Providence Medford Medical Center	1	1	1	1	1	5
Providence Milwaukie Hospital	1	1	1	1		4
Providence Newberg Medical Center	1	1	1	1	1	5

Acute Care Providers Oregon						
Facility	**2012**	**2013**	**2014**	**2015**	**2016**	**Grand Total**
Providence Portland Medical Center	1	1	1	1	1	5
Providence St Vincent Medical Center					1	1
Providence Willamette Falls Medical Center			1	1	1	3
Rogue Regional Medical Center	1	1	1	1	1	5
Sacred Heart Medical Center at Riverbend	1	1	1	1	1	5
Sacred Heart Medical Center University District	1	1	1	1	1	5
Saint Alphonsus Medical Center-Ontario	1	1	1	1	1	5
Salem Hospital	1	1	1	1	1	5
Samaritan Albany General Hospital	1	1	1	1	1	5
Santiam Memorial Hospital	1	1	1	1	1	5
Silverton Hospital	1	1	1	1	1	5
Sky Lakes Medical Center	1	1	1	1	1	5
St Charles Medical Center - Bend	1	1	1	1	1	5
St Charles Medical Center - Redmond	1	1	1	1	1	5
St Vincent Medical Center	1	1	1	1		4
Three Rivers Community Hospital	1	1	1	1	1	5
Tuality Healthcare	1	1	1	1	1	5

Acute Care Providers Oregon						
Facility	**2012**	**2013**	**2014**	**2015**	**2016**	**Grand Total**
Willamette Falls Medical Center	1	1				2
Willamette Valley Medical Center	1	1				2
	33	**33**	**32**	**32**	**30**	**160**

Acute Care Providers Rhode Island						
Facility	**2012**	**2013**	**2014**	**2015**	**2016**	**Grand Total**
Kent County Memorial Hospital	1	1	1	1	1	5
Landmark Medical Center	1	1	1	1	1	5
Memorial Hospital Of Rhode Island	1	1	1	1	1	5
Newport Hospital	1	1	1	1	1	5
Our Lady Of Fatima Hospital (Previous Name - St. Joseph Health Services)	1	1	1	1	1	5
Rhode Island Hospital	1	1	1	1	1	5
Roger Williams Hospital	1	1	1	1	1	5
South County Hospital	1	1	1	1	1	5
The Miriam Hospital	1	1	1	1	1	5
The Westerly Hospital	1	1	1	1	1	5
Women & Infants Hospital	1	1	1	1	1	5
	11	**11**	**11**	**11**	**11**	**55**

Acute Care Providers South Carolina						
Facility	**2012**	**2013**	**2014**	**2015**	**2016**	**Grand Total**
Aiken Regional Medical Center	1	1	1	1	1	5
AnMed Health	1	1	1	1	1	5
Bamberg County Memorial	1					1
Baptist Easley Hospital	1	1	1	1	1	5
Barnwell County Hospital (Southern Palmetto Hospital)	1					1
Beaufort Memorial Hospital	1	1	1	1	1	5
Cannon Memorial Hospital	1	1	1	1	1	5
Carolina Pines Regional Medical Center	1	1	1	1	1	5
Chester Regional Medical Center	1	1				2
Chesterfield General Hospital	1	1	1	1		4
CHS - Florence	1	1	1	1	1	5
Clarendon Memorial Hospital	1	1	1	1	1	5
Coastal Carolina Medical Center	1	1	1	1	1	5
Colleton Medical Center	1	1	1	1	1	5
Conway Hospital	1	1	1	1	1	5
East Cooper Regional Medical Center	1	1	1	1	1	5
Georgetown Memorial Hospital	1	1	1	1	1	5
GHS Laurens County Memorial Hospital		1	1	1	1	4

Acute Care Providers South Carolina						
Facility	**2012**	**2013**	**2014**	**2015**	**2016**	**Grand Total**
Grand Strand Regional Medical Center	1	1	1	1	1	5
Greenville Hospital Center	1	1	1	1	1	5
Greer Memorial Hospital	1	1	1	1	1	5
Hampton Regional Medical Center	1	1	1	1	1	5
Hillcrest Memorial Hospital	1	1	1	1	1	5
Hilton Head Hospital	1	1	1	1	1	5
Kershaw County Medical Center	1	1	1	1	1	5
Lake City Community Hospital	1	1	1	1	1	5
Laurens County Hospital	1					1
Lexington Medical Center	1	1	1	1	1	5
Loris Community Hospital / McLeod Loris/Seacoast Hospital	2					2
Marion County Medical Center	1	1	1	1	1	5
Marlboro Park Hospital	1	1	1	1		4
Mary Black Health System - Gaffney (Upstate Carolina)				1	1	2
Mary Black Memorial Hospital	1	1	1	1	1	5
McLeod Cheraw (Chesterfield)				1	1	2
McLeod Health Clarendon					1	1

Acute Care Providers South Carolina						
Facility	**2012**	**2013**	**2014**	**2015**	**2016**	**Grand Total**
McLeod Loris/Seacoast Hospital		1	1	1	1	4
McLeod Regional Medical Center	1	1	1	1	1	5
McLeod Regional Medical Center - Dillon	1	1	1	1	1	5
Medical University Hospital	1	1	1	1	1	5
Mount Pleasant Hospital	1	1	1	1	1	5
Newberry County Memorial Hospital	1	1	1	1	1	5
Oconee Memorial Hospital	1	1	1	1	1	5
Palmetto Baptist - Parkridge			1			1
Palmetto Health Baptist - Columbia	1	1	1	1	1	5
Palmetto Health Baptist - Parkridge				1	1	2
Palmetto Health Richland	1	1	1	1	1	5
Patewood Memorial Hospital	1	1	1	1	1	5
Pelham Medical Center		1	1	1	1	4
Piedmont Medical Center	1	1	1	1	1	5
Providence (Sisters of Charity)	1	1	1	1	1	5
Roper Hospital	1	1	1	1	1	5
Self Regional Healthcare	1	1	1	1	1	5

Acute Care Providers South Carolina						
Facility	**2012**	**2013**	**2014**	**2015**	**2016**	**Grand Total**
Southern Palmetto (Barnwell)		1	1	1	1	4
Spartanburg Regional Medical Center	1	1	1	1	1	5
Springs Memorial Hospital	1	1	1	1	1	5
St Francis Health System	1	1	1			3
St Francis Hospital Inc.				1	1	2
St Francis Xavier Hospital	1	1	1	1	1	5
The Regional Medical Center	1	1	1	1	1	5
Trident Regional Medical Center	1	1	1	1	1	5
Tuomey Healthcare	1	1	1			3
Tuomey Regional Medical Center				1	1	2
Union Medical Center (Wallace Thomson)					1	1
Upstate Carolina Medical Center (Novant Health Gaffney)	1	1	1			3
Village Hospital (Myers and Stauffer note: Pelham Medical Center)	1					1
Waccamaw Community Hospital	1	1	1	1	1	5
Wallace Thomson Hospital	1	1	1	1		4
	56	**54**	**54**	**55**	**54**	**273**

Acute Care Providers West Virginia						
Facility	**2012**	**2013**	**2014**	**2015**	**2016**	**Grand Total**
Beckley Appalachian Regional Hospital	1					1
Bluefield Regional Medical Center	1					1
Cabell-Huntington Hospital	1					1
Camc-Teays Valley (Putnam General)	1					1
Camden-Clark Memorial Hospital	1					1
Charleston Area Medical Center	1					1
City Hospital	1					1
Davis Memorial Hospital	1					1
Fairmont General Hospital	1					1
Greenbrier Valley Medical Center	1					1
Jackson General Hospital	1					1
Logan Regional Medical Center	1					1
Monongalia General Hospital	1					1
Ohio Valley General Hospital	1					1
Pleasant Valley Hospital	1					1
Princeton Community Hospital	1					1
Raleigh General Hospital	1					1
Reynolds Memorial Hospital	1					1
St. Francis Hospital	1					1
St. Joseph's Hospital/Buckhannon	1					1
St. Mary's Medical Center, Inc.	1					1
Stonewall Jackson Memorial Hospital	1					1
Summersville Memorial Hospital	1					1

Acute Care Providers West Virginia						
Facility	**2012**	**2013**	**2014**	**2015**	**2016**	**Grand Total**
Thomas Memorial Hospital	1					1
United Hospital Center, Inc.	1					1
Weirton Medical Center, Inc.	1					1
Welch Community Hospital	1					1
West Virginia University Hospitals	1					1
Wetzel County Hospital	1					1
Wheeling Hospital, Inc.	1					1
Williamson Memorial Hospital	1					1
	31					**31**
GRAND TOTAL	**162**	**128**	**114**	**115**	**113**	**632**

Critical Access Hospital Providers New Hampshire						
Facility	**2012**	**2013**	**2014**	**2015**	**2016**	**Grand Total**
Alice Peck Day Memorial Hospital	1	1	1	1	1	5
Androscoggin Valley Hospital	1	1	1			3
Cottage Hospital	1	1	1	1	1	5
Franklin Regional Hospital	1	1	1	1	1	5
Huggins Hospital	1	1	1	1	1	5
Littleton Regional Hospital	1	1	1	1	1	5
Monadnock Community Hospital	1	1	1	1	1	5
New London Hospital	1	1	1	1	1	5
Speare Memorial Hospital	1	1	1	1	1	5
The Memorial Hospital	1	1	1	1	1	5
Upper Connecticut Valley Hospital	1	1	1			3
Valley Regional Hospital	1	1	1	1	1	5
Weeks Medical Center	1	1	1	1	1	5
	13	**13**	**13**	**11**	**11**	**61**

Critical Access Hospital Providers Oregon						
Facility	**2012**	**2013**	**2014**	**2015**	**2016**	**Grand Total**
Blue Mountain Hospital	1	1	1	1		4
Columbia Memorial Hospital	1	1	1	1	1	5
Coquille Valley Hospital	1	1	1	1		4
Cottage Grove Community Hospital	1	1	1	1	1	5
Curry General Hospital	1	1	1	1		4
Good Shepherd Medical Center	1	1	1	1	1	5
Grande Ronde Hospital	1	1	1	1	1	5
Harney District Hospital	1	1	1	1		4
Hood River Memorial Hospital	1	1	1	1	1	5
Lake Health District	1	1	1	1		4
Lower Umpqua Hospital	1	1	1	1		4
Mountain View Hospital (St Charles Madras)	1	1				2
North Lincoln Hospital	1	1				2
Peace Harbor Hospital	1	1	1	1	1	5
Pioneer Memorial Hospital (Heppner)	1	1	1	1		4
Pioneer Memorial Hospital (Prineville)	1	1	1	1		4
Providence Seaside Hospital	1	1	1	1	1	5
Saint Alphonsus Medical Center - Baker	1	1	1	1	1	5

Critical Access Hospital Providers Oregon						
Facility	**2012**	**2013**	**2014**	**2015**	**2016**	**Grand Total**
Samaritan Lebanon Community Hospital	1	1	1	1	1	5
Samaritan North Lincoln Hospital			1	1	1	3
Samaritan Pacific Communities Hospital	1	1	1	1	1	5
Southern Coos General Hospital	1	1	1	1		4
St Anthony Hospital	1	1	1	1	1	5
St Charles Madras (Mountain View Hospital)			1	1	1	3
Tillamook County General Hospital	1	1	1	1	1	5
Wallowa County Health Care District	1	1	1	1		4
West Valley Hospital	1	1	1	1		4
	25	**25**	**25**	**25**	**14**	**114**

Critical Access Hospital Providers South Carolina						
Facility	**2012**	**2013**	**2014**	**2015**	**2016**	**Grand Total**
Abbeville Area Memorial Hospital	1	1	1	1	1	5
Allendale County Hospital	1	1	1	1	1	5
Edgefield County Hospital	1	1	1	1	1	5
Fairfield Memorial Hospital	1	1	1	1	1	5
Williamsburg Regional Hospital	1	1	1	1	1	5
	5	**5**	**5**	**5**	**5**	**25**

Critical Access Hospital Providers West Virginia						
Facility	**2012**	**2013**	**2014**	**2015**	**2016**	**Grand Total**
Boone Memorial Hospital	1					1
Braxton County Memorial Hospital	1					1
Broaddus Hospital	1					1
Grafton City Hospital	1					1
Grant Memorial Hospital	1					1
Hampshire Memorial Hospital	1					1
Jefferson Memorial Hospital	1					1
Minnie Hamilton Health Care Center	1					1
Montgomery General Hospital	1					1
Morgan County War Memorial Hospital	1					1
Plateau Medical Center	1					1
Pocahontas Memorial Hospital	1					1
Potomac Valley Hospital	1					1
Preston Memorial Hospital	1					1
Roane General Hospital	1					1
Sistersville General Hospital	1					1
Summers County Appalachian Regional Hospital	1					1
Webster County Memorial Hospital	1					1
	18					**18**
GRAND TOTAL	**61**	**43**	**43**	**41**	**30**	**218**

Children's Hospital Providers						
Facility	**2012**	**2013**	**2014**	**2015**	**2016**	**Grand Total**
Connecticut						
CT Children's Medical Center	1	1	1	1	1	5
Oregon						
Shriners Hospitals for Children		1	1	1	1	4
South Carolina						
Shriner's Hospitals for Children				1	1	2
GRAND TOTAL	**1**	**2**	**2**	**3**	**3**	**11**

Institute for Mental Disease Providers						
Facility	**2012**	**2013**	**2014**	**2015**	**2016**	**Grand Total**
Connecticut						
CT Mental Health Center	1	1	1	1	1	5
CT Valley Hospital	1	1	1	1	1	5
Southwest CT Mental Health System	1	1	1	1	1	5
New Hampshire						
New Hampshire Hospital	1	1	1	1	1	5
Oregon						
Oregon State Hospital	1	1	1	1	1	5
Rhode Island						
Butler Hospital	1	1	1	1	1	5
Emma P Bradley Hospital	1	1	1	1	1	5
South Carolina						
Bryan Psychiatric Hospital	1	1	1	1	1	5
Patrick B Harris Psychiatric Hospital	1	1	1	1	1	5
William S Hall Psychiatric Institute	1	1	1	1	1	5
West Virginia						
Highland Hospital	1					1
Mildred Mitchell-Bateman Hospital	1					1
River Park Hospital	1					1
William R. Sharpe Jr. Hospital	1					1
GRAND TOTAL	**14**	**10**	**10**	**10**	**10**	**54**

LTC Hospital Providers						
Facility	**2012**	**2013**	**2014**	**2015**	**2016**	**Grand Total**
Connecticut						
CT Veteran's Home and Hospital	1	1	1	1	1	5
Rhode Island						
Eleanor Slater Hospital	1	1	1	1	1	5
South Carolina						
North Greenville Long-Term Acute Care Hospital	1	1	1	1	1	5
GRAND TOTAL	**3**	**3**	**3**	**3**	**3**	**15**

Rehabilitation Hospital Providers New Hampshire						
Facility	**2008**	**2009**	**2010**	**2011**	**2014**	**Grand Total**
Healthsouth Rehabilitation Hospital	1	1	1	1	1	5
Northeast Rehabilitation Hospital	1	1	1	1	1	5
GRAND TOTAL	**2**	**2**	**2**	**1**	**2**	**9**

Appendix D: Resumes

John Kraft, CPA, CHFP

Member

Summary

Mr. Kraft, member (owner/partner) with Myers and Stauffer, has performed Medicare and Medicaid audit, desk review, and rate calculation services. He plays a key role in managing the firm's DSH and Medicaid cost settlement audit contracts in numerous states by providing high-level strategic input to ensure successful completion of each project. In addition, he has provided litigation support for our state Medicaid clients' cost report appeals. He has also performed various cost report audit services for CareFirst of Maryland, the former Medicare fiscal intermediary. He has also been a key participant in our health care litigation support practice area.

Education

B.S., Accounting and Economics, Towson University, 1986

Experience

33 years' professional experience

Affiliations

American Health Lawyers Association
American Institute of Certified Public Accountants
Healthcare Financial Management Association
Maryland Association of Certified Public Accountants

Licenses/Certifications

Certified Public Accountant
Certified Healthcare Financial Professional

Relevant Work Experience

West Virginia Department of Health & Human Resources (2010 – 2015)
DSH Examinations in accordance with Generally Accepted Government Auditing Standards (GAGAS)

- Managed completion of DSH audits and related examination reports and oversees development of standard procedures and work papers and data collection procedures.
- Identified audit risk areas and cost effective audit strategies.
- Managed audit teams and set workload objectives and deadlines.
- Advised client on complex DSH issues.
- Conducted DSH training for hospital and state personnel.

Connecticut Department of Social Services (2010 – Present)
Medicaid DSH Examination

- Manages completion of DSH audits and related examination reports and oversees development of standard procedures and work papers and data collection procedures.
- Identifies audit risk areas and cost effective audit strategies.
- Manages audit teams and sets workload objectives and deadlines.
- Advises clients on complex DSH issues.

New Hampshire Department of Health and Human Services (2010 – Present)
Medicaid DSH Examination conducted in accordance with GAGAS

- Manages completion of DSH audits and related examination reports and oversees development of standard procedures and work papers and data collection procedures.
- Identifies audit risk areas and cost effective audit strategies.
- Manages audit teams and sets workload objectives and deadlines.
- Advises clients on complex DSH issues.
- Conducts DSH training for hospital and state personnel.

Oregon Health Authority (2010 – Present)
Medicaid DSH Examination conducted in accordance with GAGAS

- Manages completion of DSH audits and related examination reports and oversees development of standard procedures and work papers and data collection procedures.
- Identifies audit risk areas and cost effective audit strategies.
- Manages audit teams and sets workload objectives and deadlines.
- Advises clients on complex DSH issues.
- Conducts DSH training for hospital and state personnel.

Rhode Island Department of Human Services (2010 – Present)
Medicaid DSH Examination conducted in accordance with GAGAS

- Manages completion of DSH audits and related examination reports and oversees development of standard procedures and work papers and data collection procedures.
- Identifies audit risk areas and cost effective audit strategies.
- Manages audit teams and sets workload objectives and deadlines.
- Advises clients on complex DSH issues.

South Carolina Department of Health and Human Services (2006 – Present)
Medicaid DSH Examination conducted in accordance with GAGAS

- Manages completion of DSH audits and related examination reports and oversees development of standard procedures and work papers and data collection procedures.
- Identifies audit risk areas and cost effective audit strategies.
- Manages audit teams and sets workload objectives and deadlines.
- Advises clients on complex DSH issues.
- Conducts DSH training for hospital and state personnel.
- Provide testimony on DSH related appeals.

South Carolina Department of Health and Human Services (2006 – Present)
Medicaid Cost Report Settlements – Agreed-Upon Procedures conducted in accordance with GAGAS

- Manages and reviews field audits and desk reviews of hospital Medicaid cost reports and related cost settlement calculations.
- Provides appeal and litigation support services; oversees development of standard work papers, procedures, engagement planning guides and workload objectives.
- Experienced with health financial systems (HFS) cost-reporting software.

John Kraft CPE (Yellow Book) January 1, 2018 – Present			
Program	**Completion Date**	**Sponsor Name**	**Credits**
GAAS Guide – Audit Programs	12/3/2019	Checkpoint Learning	1.0
Cost Report/DSH Conference – Managers 2019	11/21/2019	Myers and Stauffer LC	13.0
Ethics for CPAs	5/21/2019	Checkpoint Learning	4.0
Software Basics – Provider	3/27/2019	Health Financial Systems	1.0
Institute on Medicare and Medicaid Payment Issues 2019	3/22/2019	American Health Lawyers Association (AHLA)	21.0
124 Cost Allocation and Apportionment	12/12/2018	Myers and Stauffer LC	1.0
Benford's Law – The Fraud Detective	12/12/2018	Checkpoint Learning	1.0
105 Agreed-Upon Procedures	12/11/2018	Myers and Stauffer LC	1.0
202 – Audit Documentation II	9/19/2018	Myers and Stauffer LC	2.0
229 HCBS Reimbursement, Cost Reports, and Claims Review	9/18/2018	Myers and Stauffer LC	1.0
212 Inpatient Hospital Reimbursement	9/17/2018	Myers and Stauffer LC	1.0
207 – Intro To GAGAS	9/13/2018	Myers and Stauffer LC	1.0
121 – Capital Costs in a Medicaid Audit	9/12/2018	Myers and Stauffer LC	1.5
133 Electronic Health Record (EHR) Medicaid Incentive Payment Program	9/10/2018	Myers and Stauffer LC	1.5
117 Introduction to the Medicare Cost Report	7/3/2018	Myers and Stauffer LC	2.5
115 Introduction to Medicaid	6/14/2018	Myers and Stauffer LC	1.5
116 Introduction to Medicare	6/13/2018	Myers and Stauffer LC	1.0
Institute on Medicare and Medicaid Payment Issues 2018	3/24/2018	AHLA	21.5
Mission Impossible: Completing the Proper HHA Medicare Cost Report	3/7/2018	Health Financial Systems	1.5
Medicare Auditor – Providers	2/7/2018	Health Financial Systems	1.0
Credits Per Year: 2019 – 40 credits, 2018 – 40 credits		**Total Credits**	**80**

Mark Hilton, CPA

Member

Summary

Mr. Hilton has extensive experience related exclusively to performing health care related services and applying Medicare and Medicaid principles of reimbursement including cost report audits. Since 1998, Mr. Hilton has directed Myers and Stauffer's health care fraud investigation services provided to various agencies of the Department of Justice including the Criminal and Civil divisions of the United States Department of Justice Commercial Litigation Branch, the Federal Bureau of Investigation, and various Assistant United States Attorneys.

Mr. Hilton serves as the current project director for South Carolina DSH and cost settlement contract. He also serves as the project director for our DSH audit contracts with the states of Colorado, Connecticut, New Hampshire, Oregon, Rhode Island, and Tennessee. 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 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 and the CMS personnel responsible for implementing the DSH Final Rule.

Mr. Hilton has an extensive history with performing cost settlements for various types of health care providers including nursing homes. He brings a well-rounded expertise in both Medicare and Medicaid principles of reimbursement and has an in depth knowledge of developing audit and desk review protocols for use in determining final settlements under both programs.

Mr. Hilton is the recipient of Clifton Gunderson's Neal E. Clifton Professionalism Award and was named by Maryland Smart CEO Magazine as one of the region's Top CPAs. Mr. Hilton represented Myers and Stauffer at the 2013 CBIZ Chairman's Conference in recognition of being one of the firm's top leaders.

Education

B.S., Accounting, Liberty University, 1982

Experience

36 years' professional experience

Affiliations

American Health Lawyers Association
American Institute of Certified Public Accountants
Healthcare Financial Management Association
Maryland Association of Certified Public Accountants

Licenses/Certifications

Certified Public Accountant

Relevant Work Experience

For Myers and Stauffer, Mr. Hilton serves as the engagement director or a partner on the following engagements:

West Virginia Department of Health and Human Resources (2010 – 2015)
DSH Examinations

Colorado Department of Health Care Policy and Financing (2010 – Present)
DSH Audit

New Hampshire Department of Health and Human Services (2009 – Present)
DSH Audit

Oregon Health Authority (2009 – Present)
DSH Examination

South Carolina Department of Health and Human Services (2006 – Present)
DSH Audit

South Carolina Department of Health and Human Services (2008 – Present)
Medicaid Cost Report Settlements

Tennessee Department of Finance and Administration (2010 – Present)
DSH Audit and CPE Consulting

U.S. Department of Justice (2013 – Present)
Labat MEGA 4

U.S. Department of Justice (1997 – Present)
Lockheed Martin MEGA 4

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.

"Medicaid Disproportionate Share Audits," South Carolina Hospital Association and state of South Carolina.

"Lessons Learned From Healthcare Fraud Investigations: Case Summaries and Overview," Virginia Program Integrity Division meeting.

Mark Hilton CPE (Yellow Book) January 1, 2018 – Present			
Program	**Completion Date**	**Sponsor Name**	**Credits**
Cost Report/DSH Conference – Managers 2019	11/21/2019	Myers and Stauffer LC	13.0
Cost Report/DSH Conference – Seniors 2019	11/20/2019	Myers and Stauffer LC	9.0
2019 Annual Training Conference	10/18/2019	NHCAA Institute for Health Care Fraud Prevention	17.0
Institute on Medicare and Medicaid Payment Issues 2019	4/22/2019	AHLA	17.0
I Am Supposed to Supervise These People	12/27/2018	Checkpoint Learning	5.0
Microsoft Excel 2013 – Getting Started with Excel	12/27/2018	Checkpoint Learning	5.0
116 Introduction to Medicare	12/27/2018	Myers and Stauffer LC	1.0
115 Introduction to Medicaid	12/27/2018	Myers and Stauffer LC	1.5
Microsoft Access 2016 – Introduction to Microsoft Access 2016-CLMA16	12/27/2018	Checkpoint Learning	5.0
101 M&S Audit Methodology	12/20/2018	Myers and Stauffer LC	1.5
Ethics for CPAs	12/18/2018	Checkpoint Learning	4.0
2018 Annual Training Conference	11/1/2018	NHCAA Institute for Health Care Fraud Prevention	16.0
Institute on Medicare and Medicaid Payment Issues 2018	3/24/2018	AHLA	21.0
Credits Per Year: 2019 – 56 credits, 2018 – 60 credits		**Total Credits**	**116**

Diane Kovar, CPA

Senior Manager

Summary

Ms. Kovar's experience includes health care-related audits, fraud investigations, and litigation support services. She has been the project manager for DSH audits in South Carolina, New Hampshire, Oregon, Rhode Island, Connecticut, and West Virginia. Outside of DSH, she has worked on health care engagements with the Maryland Department of Health and Mental Hygiene and CMS.

Education

B.S., Accounting, Pennsylvania State University, 1998

Experience

21 years' professional experience

Affiliations

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

Licenses/Certifications

Certified Public Accountant

Relevant Work Experience

West Virginia Department of Health & Human Resources (2010 – 2015)
DSH Audit

- As the senior manager that coordinated the 2005 – 2011 Medicaid DSH examinations, was involved in working with the State and hospital contacts in performing annual DSH examinations as required by the DSH Rule. Conducted examinations in accordance with GAGAS.
- Participated in meetings and providing trainings on federal DSH requirements and provided feedback on areas of focus to ensure compliance and consistency with DSH Rule.
- Oversaw and prepared and/or reviewed the performance of procedures on information submitted by the State and hospitals to prepare and issue federally required examination reports.

Connecticut Department of Social Services (2011 – Present)
DSH Audit

- As project manager for several years, was involved in working with the State and hospital contacts in performing annual DSH examinations as required by the DSH Rule.
- Participate in meetings and providing training on federal DSH requirements, provide feedback on areas of focus to ensure compliance and consistency with DSH Rule.
- Oversee and prepare and/or review the performance of procedures on information submitted by the State and hospitals to prepare and issue federally required examination reports.

New Hampshire Department of Health and Human Services (2009 – Present)
DSH Audit

- As the senior manager overseeing the Medicaid DSH examinations, is involved in working with the State and hospital contacts in performing annual DSH examinations as required by the DSH Rule. Conducted examinations in accordance with GAGAS.
- Participate in meetings and provide training on federal DSH requirements, provide feedback on areas of focus to ensure compliance and consistency with DSH Rule.
- Oversee and prepare and/or review the performance of procedures on information submitted by the State and hospitals to prepare and issue federally required examination reports.

Oregon Health Authority (2009 – Present)
DSH Audit

- As the senior manager overseeing the Medicaid DSH examinations, is involved in working with the State and hospital contacts in performing annual DSH examinations as required by the DSH Rule. Conducted examinations in accordance with GAGAS.
- Participate in meetings and provide training on federal DSH requirements, provide feedback on areas of focus to ensure compliance and consistency with DSH Rule.
- Oversee and prepare and/or review the performance of procedures on information submitted by the State and hospitals to prepare and issue federally required examination reports.

Rhode Island Department of Human Services (2010 – Present)
DSH Audit

- As the senior manager overseeing the Medicaid DSH examinations, is involved in working with the State and hospital contacts in performing annual DSH examinations as required by the DSH Rule. Conducted examinations in accordance with GAGAS.
- Participate in meetings and provide training on federal DSH requirements, provide feedback on areas of focus to ensure compliance and consistency with DSH Rule.
- Oversee and prepare and/or review the performance of procedures on information submitted by the State and hospitals to prepare and issue federally required examination reports.

South Carolina Department of Health and Human Services (2006 – Present)
DSH Audit

- As the senior manager overseeing the Medicaid DSH examinations, is involved in working with the State and hospital contacts in performing annual DSH examinations as required by the DSH Rule. Conducted examinations in accordance with GAGAS.
- Participate in meetings and provide training on federal DSH requirements, provide feedback on areas of focus to ensure compliance and consistency with DSH Rule.
- Oversee and prepare and/or review the performance of procedures on information submitted by the State and hospitals to prepare and issue federally required examination reports.

Maryland Department of Health (1998 – 2006)
Audit

- Conducted desk reviews and field audits of FQHCs, residential treatment centers, psychiatric hospitals, state facilities, and alcohol/drug treatment centers.
- Conducted Medicare focus review and desk reviews of hospitals, skilled nursing facilities, and rehabilitation facilities.

Centers for Medicare & Medicaid Services (CMS) (2000 – 2006)
Medicare Advantage Compliance

- Assisted in planning, directing, and completing the CMS CFO audit (FY 2000 – 2004).
- Assisted in planning, directing, and completing the CMS accounts receivable engagement FY 2001.
- Participated in the CMS SAS-70 of a Medicare contractor FY 2003 – 2006.
- Participated in the 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 – 2006.

U.S. Department of Justice (2001 – Present)
Labat MEGA 4

- Provides litigation support.

Diane Kovar CPE (Yellow Book) January 1, 2018 – Present			
Program	**Completion Date**	**Sponsor Name**	**Credits**
143 – PDPM Update	12/18/2019	Myers and Stauffer LC	1.0
NAMPI & NHCAA 2019 Highlights Webinar	12/11/2019	Myers and Stauffer LC	1.0
2019 Auditing Update	12/1/2019	Checkpoint Learning	3.0
125 – DSH Sampling Overview	11/29/2019	Myers and Stauffer LC	1.0
Cost Report/DSH Conference – Managers 2019	11/21/2019	Myers and Stauffer LC	13.0
Ethics: Caesar's Wife: Tipping the Delicate Balance of Leadership and Ethics	5/20/2019	Maryland Association of Certified Public Accountants	1.0
Ethics: Caesar's Wife: Tipping the Delicate Balance of Leadership and Ethics	5/17/2019	Maryland Association of Certified Public Accountants	3.0
126 DSH Analytic Work Paper	5/15/2019	Myers and Stauffer LC	1.0
Institute on Medicare and Medicaid Payment Issues 2019	3/22/2019	AHLA	21.0
Business & Industry Fall Town Hall 2018: CPA 4.0 – How to Survive and Thrive in the Fourth Industrial Age	12/19/2018	The Business Learning Institute, Inc.	4.0
HCRIS Database	4/24/2018	Health Financial Systems	1.0
Management Reports – Providers	4/11/2018	Health Financial Systems	1.0
Institute on Medicare and Medicaid Payment Issues 2018	3/24/2018	AHLA	21.5
Mission Impossible: Completing the Proper HHA Medicare Cost Report	3/7/2018	Health Financial Systems	1.5
Provider Basics/SaFE	2/27/2018	Health Financial Systems	1.0
PEAK Summit Leadership Development Program	2/7/2018	Myers and Stauffer LC	7.0
Credits Per Year: 2019 – 45 credits, 2018 – 37 credits		**Total Credits**	**82**

Beth Franey, CFE

Manager

Summary

Ms. Franey has worked in the Medicare and Medicaid audit and investigation arena for many years. She has performed and reviewed disproportionate share program desk reviews for Massachusetts, South Carolina, Tennessee, West Virginia, Connecticut, Vermont, Colorado, New Hampshire, Oregon and Rhode Island. She manages and oversees Rhode Island and Tennessee's disproportionate share program examinations. She has also performed Medicaid cost settlements for South Carolina and Georgia and performed health care litigation support and fraud investigation in federal health care programs.

Education

B.S., Sociology, Towson University, 1999

Experience

13 years' professional experience

Affiliations

Association of Certified Fraud Examiners

Licenses/Certifications

Certified Fraud Examiner

Relevant Work Experience

West Virginia Department of Health and Human Resources (2010 – 2015)
Medicaid DSH Examinations conducted in accordance with GAGAS

- Performed and reviewed DSH examinations.
- Assisted with preparation of related reports.
- Assisted with managing audit team members.

Colorado Department of Health Care Policy and Financing (2016 – Present)
Medicaid DSH Examinations

- Performed and reviewed DSH examinations.
- Assisted with preparation of related reports.
- Assisted with managing audit team members.

Connecticut Department of Social Services (2014 – Present)
Medicaid DSH Examinations

- Performed and reviewed DSH examinations.
- Assisted with preparation of related reports.
- Assisted with managing audit team members.

New Hampshire Department of Health and Human Services (2014 – Present)
Medicaid DSH Examinations conducted in accordance with GAGAS

- Performed and reviewed DSH examinations.
- Assisted with preparation of related reports.
- Assisted with managing audit team members.

Oregon Health Authority (2014 – Present)
Medicaid DSH Examinations conducted in accordance with GAGAS

- Performed and reviewed DSH examinations.
- Assisted with preparation of related reports.
- Assisted with managing audit team members.

Rhode Island Department of Human Services (2009 – Present)
Medicaid DSH Examinations conducted in accordance with GAGAS

- Performed and reviewed DSH examinations.
- Prepared related reports.
- Oversaw the development of standard procedures and work papers.
- Managed the audit teams while setting and maintaining workload objectives and deadlines.
- Routinely advised state and hospital clients on complex DSH issues.

South Carolina Department of Health and Human Services (2009 – Present)
Medicaid DSH Examinations conducted in accordance with GAGAS

- Performed and reviewed DSH examinations.
- Assisted with preparation of related reports.
- Assisted with managing audit team members.

South Carolina Department of Health and Human Services (2009 – 2013)
Medicaid Cost Report Settlements – Agreed-Upon Procedures conducted in accordance with GAGAS

- Completed desk reviews of Medicaid cost reports to calculate Medicaid settlements.
- Analyzed and adjusted hospital cost reports using HFS software.

Tennessee Department of Finance and Administration (2013 – Present)
Medicaid DSH Examinations

- Performed and reviewed DSH examinations.
- Prepared related reports.
- Oversaw the development of standard procedures and work papers.
- Managed the audit teams while setting and maintaining workload objectives and deadlines.
- Routinely advised state and hospital clients on complex DSH issues.

U.S. Department of Justice (2008 – 2014)

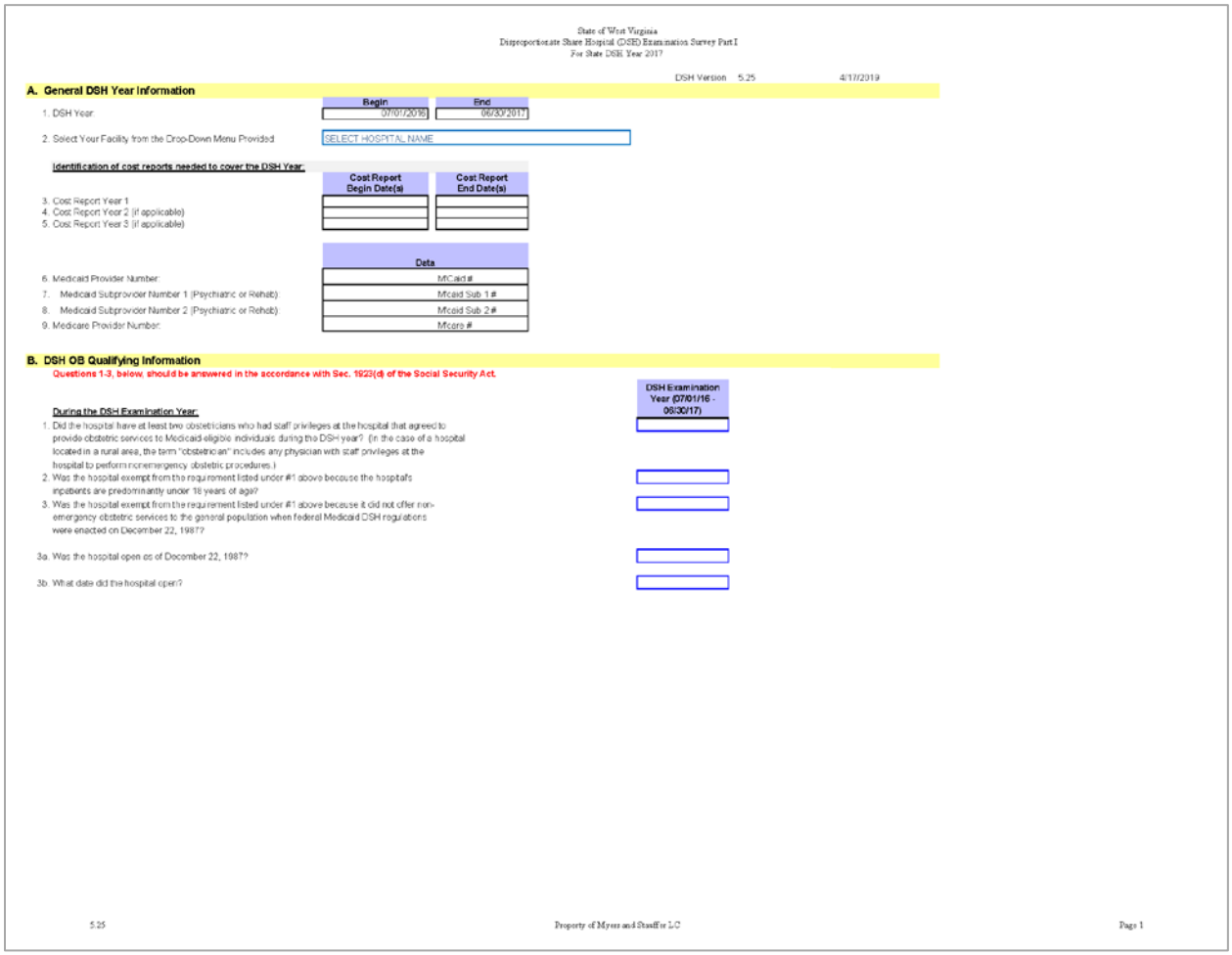
- Provide litigation support for health care fraud investigations requiring in depth review and analysis of financial records.

Beth Franey CPE (Yellow Book) January 1, 2018 – Present			
Program	**Completion Date**	**Sponsor Name**	**Credits**
Getting Auditors In and Out Efficiently	11/26/2019	Checkpoint Learning	1.0
Guarding Against Waste, Fraud, and Abuse	11/24/2019	Checkpoint Learning	3.0
Cost Report/DSH Conference – Managers 2019	11/21/2019	Myers and Stauffer LC	13.0
Analytical Procedures	11/1/2019	Checkpoint Learning	2.0
143 – PDPM Update	11/1/2019	Myers and Stauffer LC	1.0
130 DSH Payment Projects	10/4/2019	Myers and Stauffer LC	1.0
154 DSH Application Acceptability and Upload & Application Reports	9/27/2019	CBIZ, Inc.	2.0
132 DSH Examinations	7/18/2019	CBIZ, Inc.	2.0
126 DSH Analytic Work Paper	5/17/2019	Myers and Stauffer LC	1.0
The Basics of Health Care Accounting and Auditing	5/6/2019	Checkpoint Learning	6.0
119 – CMS Audit and Reimbursement 101	5/3/2019	Myers and Stauffer LC	2.0
117 – CMS Medicare Cost Report	4/26/2019	Myers and Stauffer LC	3.0
2018 Fraud Magazine Quizzes	2/12/2019	Association of Certified Fraud Examiners (ACFE)	10.0
Ethics: General Standards and Acts Discreditable	1/24/2019	Checkpoint Learning	2.0
Fraud 101 – Occupational Frauds Against Organizations	10/4/2018	Checkpoint Learning	2.0
CPAs in Trouble – Ethical Considerations	10/3/2018	Checkpoint Learning	2.0
Management Reports – Providers	4/11/2018	Health Financial Systems	1.0
Institute on Medicare and Medicaid Payment Issues 2018	3/24/2018	AHLA	17.5
Medicare Auditor – Providers	2/7/2018	Health Financial Systems	1.0
Effective Writing for Accountants	2/1/2018	Checkpoint Learning	8.0
Credits Per Year: 2019 – 49 credits, 2018 – 31.5 credits		**Total Credits**	**80.5**

Appendix E: Hospital Schedule

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 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			0
Berkeley Medical Center		0.00%	0.00%		0	0	0	0	0	0	0	0	0	0	0	0	0			0
Bluefield Regional Medical Center		0.00%	0.00%		0	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			0
Braxton County Memorial Hospital		0.00%	0.00%		0	0	0	0	0	0	0	0	0	0	0	0	0			0
Broaddus Hospital		0.00%	0.00%		0	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			0
Camden-Clark Memorial Hospital		0.00%	0.00%		0	0	0	0	0	0	0	0	0	0	0	0	0			0
Charleston Area Medical Center		0.00%	0.00%		0	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			0
Fairmont Regional Medical Center		0.00%	0.00%		0	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			0
Grant Memorial Hospital		0.00%	0.00%		0	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			0
Jackson General Hospital		0.00%	0.00%		0	0	0	0	0	0	0	0	0	0	0	0	0			0
Jefferson Memorial Hospital		0.00%	0.00%		0	0	0	0	0	0	0	0	0	0	0	0	0			0
Logan Regional Medical Center		0.00%	0.00%		0	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			0
Monongalia General Hospital		0.00%	0.00%		0	0	0	0	0	0	0	0	0	0	0	0	0			0
Montgomery General Hospital		0.00%	0.00%		0	0	0	0	0	0	0	0	0	0	0	0	0			0
Ohio Valley Medical Center		0.00%	0.00%		0	0	0	0	0	0	0	0	0	0	0	0	0			0
Plateau Medical Center		0.00%	0.00%		0	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			0
Pocahontas Memorial Hospital		0.00%	0.00%		0	0	0	0	0	0	0	0	0	0	0	0	0			0
Potomac Valley Hospital		0.00%	0.00%		0	0	0	0	0	0	0	0	0	0	0	0	0			0
Preston Memorial Hospital		0.00%	0.00%		0	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			0
Raleigh General Hospital		0.00%	0.00%		0	0	0	0	0	0	0	0	0	0	0	0	0			0
Reynolds Memorial Hospital		0.00%	0.00%		0	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			0
Sistersville General Hospital		0.00%	0.00%		0	0	0	0	0	0	0	0	0	0	0	0	0			0
St. Francis Hospital		0.00%	0.00%		0	0	0	0	0	0	0	0	0	0	0	0	0			0
St. Joseph's Hospital - Buckhannon		0.00%	0.00%		0	0	0	0	0	0	0	0	0	0	0	0	0			0
St. Mary's Medical Center		0.00%	0.00%		0	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			0
Summersville RMC-CAH 2/1/19		0.00%	0.00%		0	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			0
United Hospital Center		0.00%	0.00%		0	0	0	0	0	0	0	0	0	0	0	0	0			0
War Memorial Hospital		0.00%	0.00%		0	0	0	0	0	0	0	0	0	0	0	0	0			0
Webster County Memorial Hospital		0.00%	0.00%		0	0	0	0	0	0	0	0	0	0	0	0	0			0
Weirton Medical Center		0.00%	0.00%		0	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			0
West Virginia University Hospitals		0.00%	0.00%		0	0	0	0	0	0	0	0	0	0	0	0	0			0
Wheeling Hospital		0.00%	0.00%		0	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			0
West Virginia University Hospitals		0.00%	0.00%		0	0	0	0	0	0	0	0	0	0	0	0	0			0
Wheeling Hospital		0.00%	0.00%		0	0	0	0	0	0	0	0	0	0	0	0	0			0
Institutes for Mental Disease																				
Highland Hospital		0.00%	0.00%		0	0	0	0	0	0	0	0	0	0	0	0	0			0
Mildred Mitchell-Bateman Hospital		0.00%	0.00%		0	0	0	0	0	0	0	0	0	0	0	0	0			0
River Park		0.00%	0.00%		0	0	0	0	0	0	0	0	0	0	0	0	0			0
William R. Sharpe Jr. Hospital		0.00%	0.00%		0	0	0	0	0	0	0	0	0	0	0	0	0			0
Out-of-State DSH Hospitals																				
None																				

Appendix F: Sample DSH Survey Tool



State of West Virginia
Disproportionate Share Hospital (DSH) Examination Survey Part I
For State DSH Year 2017

DSH Version 5.25 4/17/2019

A. General DSH Year Information

	Begin	End
1. DSH Year:	07/01/2016	06/30/2017

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:	MCaid #
7. Medicaid Subprovider Number 1 (Psychiatric or Rehab):	Mcaid Sub 1 #
8. Medicaid Subprovider Number 2 (Psychiatric or Rehab):	Mcaid Sub 2 #
9. Medicare Provider Number:	Mcare #

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 Examination Year:	DSH Examination Year (07/01/16 - 06/30/17)
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?	
3a. Was the hospital open as of December 22, 1987?	
3b. What date did the hospital open?	

5.25 Property of Myers and Stauffer LC Page 1

State of West Virginia
Disproportionate Share Hospital (DSH) Examination Survey Part I
For State DSH Year 2017

C. Disclosure of Other Medicaid Payments Received:

1. **Medicaid Supplemental Payments for DSH Year 07/01/2016 - 06/30/2017**
(Should include UPL and Non-Claim Specific payments paid based on the state fiscal year. However, DSH payments should NOT be included.)

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. All Medicaid eligible patients, including those who have private insurance coverage, have been reported on the DSH survey regardless of whether the hospital received payment on the claim. 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:
Name
Title
Telephone Number
E-Mail Address
Mailing Street Address

Outside Preparer:
Name
Title
Firm Name
Telephone Number
E-Mail Address

5:25 Property of Myers and Stauffer LC Page 2

State of West Virginia
Disproportionate Share Hospital (DSH) Examination Survey Part I
For State DSH Year 2017

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 - 07/01/2016 - 06/30/2017
	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 payer 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 payer 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 payer/contract. The schedule should show charges, contractual adjustments, and revenues by payer plan and contract (e.g., Medicare, each Medicaid agency payer, 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)
	18. Documentation supporting Medicaid Managed Care Quality Incentive Payments, or any other Medicaid Managed Care lump sum payments

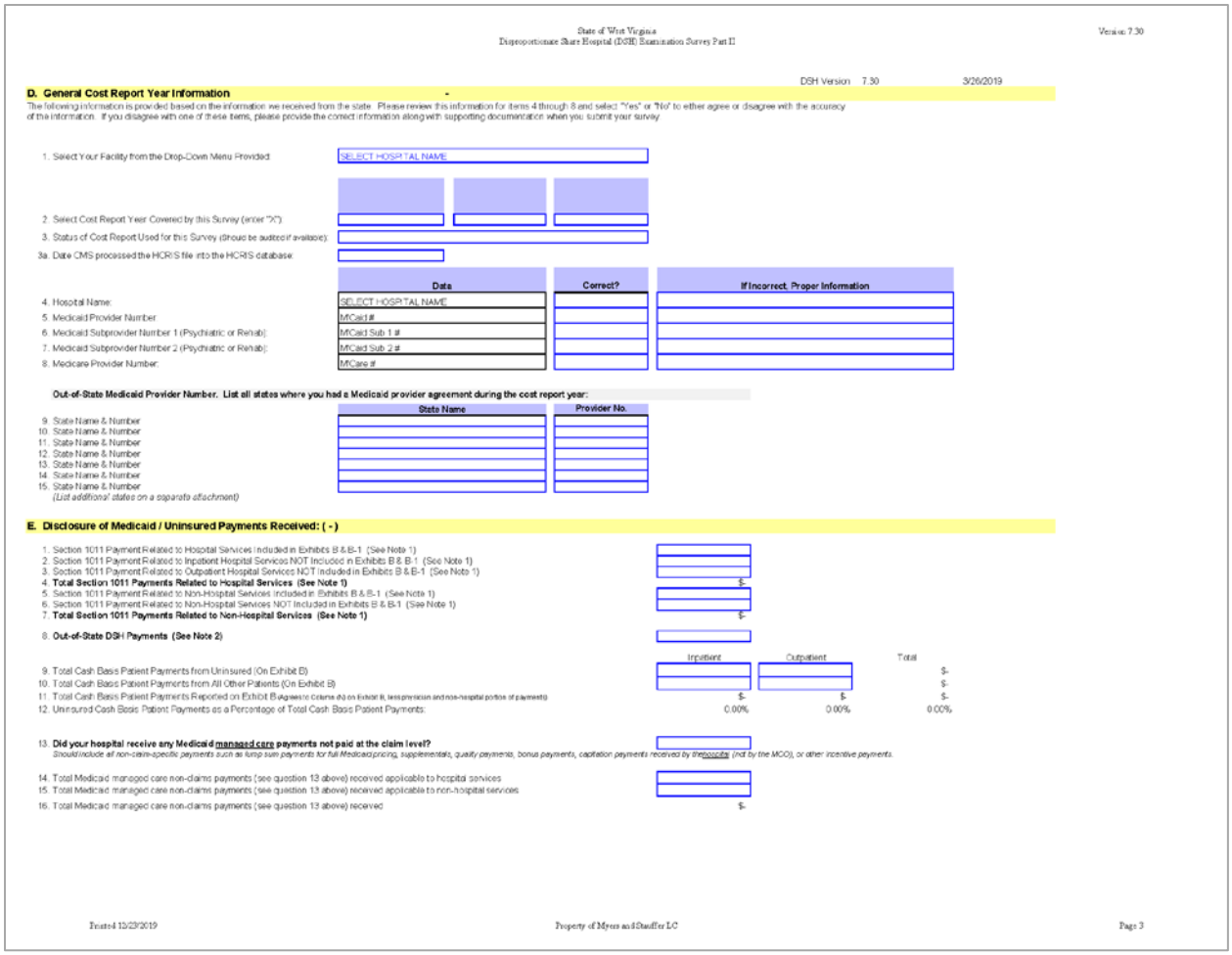
Please upload all checklist items above to the Myers and Stauffer Web Portal. If you are unable to access the Web Portal, please call or email.
Web Portal Address:

https://dsh.msllc.com

All electronic (CD or DVD - CDs or DVDs must be encrypted and/or password protected) and paper documentation can be mailed (using certified or other traceable delivery) to:

Myers and Stauffer LC
ATTN: DSH Examinations
10200 Grand Central Ave., Suite 200
Owings Mills, Maryland 21117
Fax: (410) 356-0188
Phone: (800) 505-1698
E-Mail:

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



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

Version 7.30

DSH Version 7.30 3/26/2019

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"):
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:	MCaid #		
6. Medicaid Subprovider Number 1 (Psychiatric or Rehab):	MCaid Sub 1 #		
7. Medicaid Subprovider Number 2 (Psychiatric or Rehab):	MCaid Sub 2 #		
8. Medicare Provider Number:	MCare #		

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)		

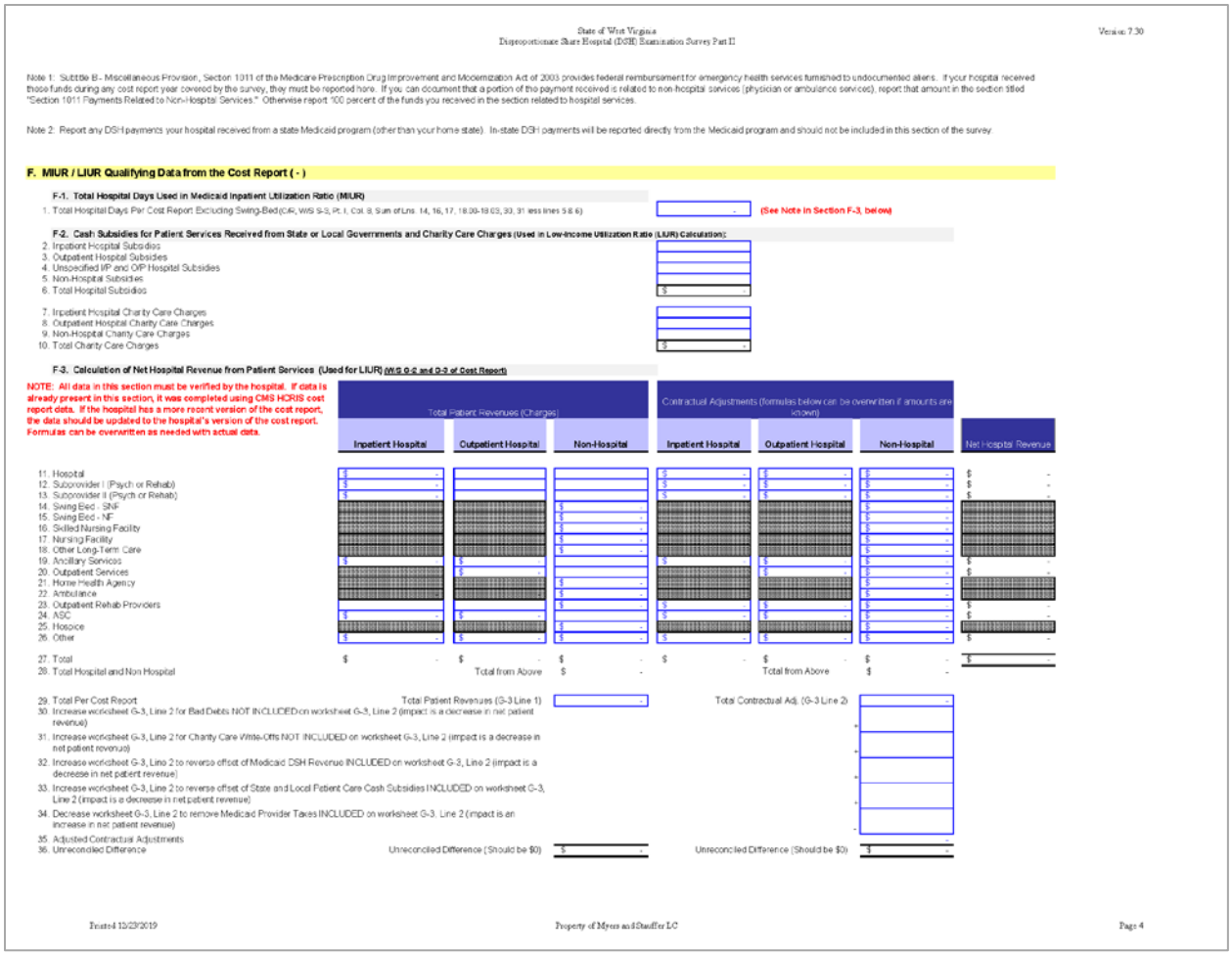
E. Disclosure of Medicaid / Uninsured Payments Received: (-)

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 (k) on Exhibit B, less physician and non-hospital portion of payments)	$-	$-	$-
12. Uninsured Cash Basis Patient Payments as a Percentage of Total Cash Basis Patient Payments:	0.00%	0.00%	0.00%

13. **Did your hospital receive any Medicaid managed care payments not paid at the claim level?**
Should include all non-claim-specific payments such as lump sum payments for full Medicaid pricing, supplementals, quality payments, bonus payments, capitation payments received by the provider (not by the MCO), or other incentive payments.
14. Total Medicaid managed care non-claims payments (see question 13 above) received applicable to hospital services
15. Total Medicaid managed care non-claims payments (see question 13 above) received applicable to non-hospital services
16. Total Medicaid managed care non-claims payments (see question 13 above) received $-

Printed 12/23/2019 Property of Myers and Stauffer LC Page 3



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

Version 7.30

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 those 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.

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 (CAP, WS S-3, Pt. I, Col. 8, Sum of Lns. 14, 16, 17, 18.00-18.03, 30, 31 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. Non-Hospital Subsidies
6. Total Hospital Subsidies

7. Inpatient Hospital Charity Care Charges
8. Outpatient Hospital Charity Care Charges
9. Non-Hospital Charity Care Charges
10. Total Charity Care Charges

F-3. Calculation of Net Hospital Revenue from Patient Services (Used for LIUR) (WS 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
11. Hospital	$ -			$ -	$ -	$ -	$ -
12. Subprovider I (Psych or Rehab)	$ -			$ -	$ -	$ -	$ -
13. Subprovider II (Psych or Rehab)	$ -			$ -	$ -	$ -	$ -
14. Swing Bed - SNF			$ -			$ -	
15. Swing Bed - NF			$ -			$ -	
16. Skilled Nursing Facility			$ -			$ -	
17. Nursing Facility			$ -			$ -	
18. Other Long-Term Care			$ -			$ -	
19. Ancillary Services	$ -	$ -		$ -	$ -	$ -	$ -
20. Outpatient Services		$ -			$ -	$ -	$ -
21. Home Health Agency			$ -			$ -	
22. Ambulance			$ -			$ -	
23. Outpatient Rehab Providers			$ -	$ -	$ -	$ -	$ -
24. ASC	$ -	$ -		$ -	$ -	$ -	$ -
25. Hospice			$ -			$ -	
26. Other	$ -	$ -	$ -	$ -	$ -	$ -	$ -
27. Total	$ -	$ -	$ -	$ -	$ -	$ -	$ -
28. Total Hospital and Non Hospital		Total from Above	$ -		Total from Above	$ -	

29. Total Per Cost Report	Total Patient Revenues (G-3 Line 1)	-	Total Contractual Adj. (G-3 Line 2)
30. 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)			+
31. 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)			+
32. 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)			+
33. 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)			+
34. 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)			-
35. Adjusted Contractual Adjustments			-
36. Unreconciled Difference	Unreconciled Difference (Should be $0)	$ -	Unreconciled Difference (Should be $0) $ -

Printed 12/23/2019

Property of Myers and Stauffer LC

Page 4

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

Version 7.30

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.

Routine Cost Centers (list below):

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 Days and I/P Ancillary Charges	I/P Routine Charges and O/P Ancillary Charges	Total Charges	Medicaid Per Diem / Cost or Other Ratios
		Cost Report Worksheet B, Part I, Col. 29	*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 26*	*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*	*Inpatient Routine Charges - Cost Report Worksheet C, Pt. I, Col. 8 (informational only unless used in Section L charges allocation)*		*Calculated Per Diem*
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 Routine	$ -	$ -	$ -	$ -	$ -	$ -	-	$ -		
19	Weighted Average										$ -

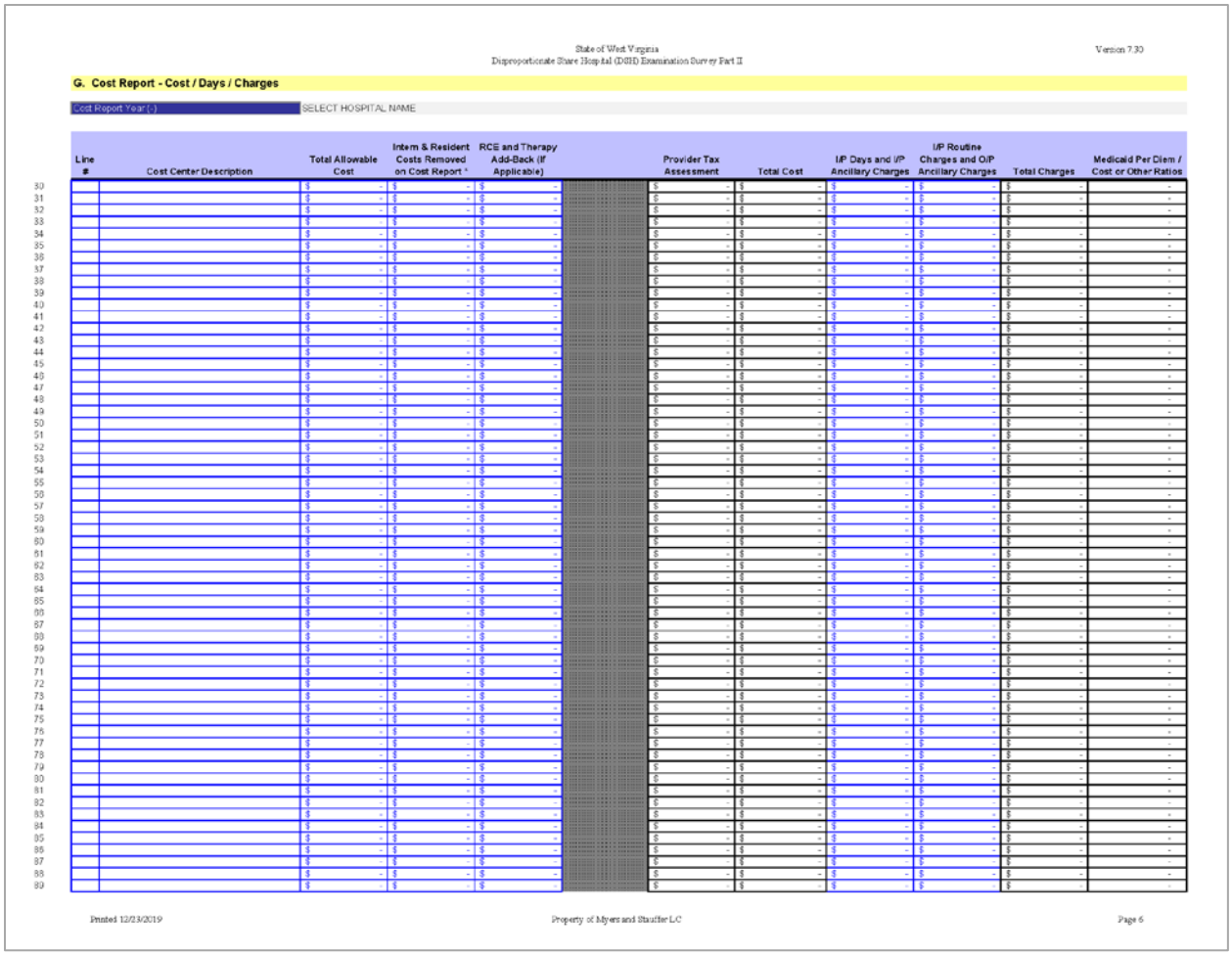
Line #	Observation Data (Non-Distinct)	*Hospital Observation Days - Cost Report W/S S-3, Pt. I, Line 26, Col. 8*	*Subprovider I Observation Days - Cost Report W/S S-3, Pt. I, Line 26.01, Col. 8*	*Subprovider II Observation Days - Cost Report W/S S-3, Pt. I, Line 26.02, Col. 8*		*Calculated (Per Diems 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*
20	09200 Observation (Non-Distinct)	-	-	-		$ -	$ -	$ -	$ -	-

Line #	Ancillary Cost Centers (from W/S C excluding Observation) (list below):	*Cost Report Worksheet B, Part I, Col. 29*	*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*
21		$ -	$ -	$ -		$ -	$ -	$ -	$ -	$ -	-
22		$ -	$ -	$ -		$ -	$ -	$ -	$ -	$ -	-
23		$ -	$ -	$ -		$ -	$ -	$ -	$ -	$ -	-
24		$ -	$ -	$ -		$ -	$ -	$ -	$ -	$ -	-
25		$ -	$ -	$ -		$ -	$ -	$ -	$ -	$ -	-
26		$ -	$ -	$ -		$ -	$ -	$ -	$ -	$ -	-
27		$ -	$ -	$ -		$ -	$ -	$ -	$ -	$ -	-
28		$ -	$ -	$ -		$ -	$ -	$ -	$ -	$ -	-
29		$ -	$ -	$ -		$ -	$ -	$ -	$ -	$ -	-

Printed 12/23/2019

Property of Myers and Stauffer LC

Page 5



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

Version 7.30

G. Cost Report - Cost / Days / Charges

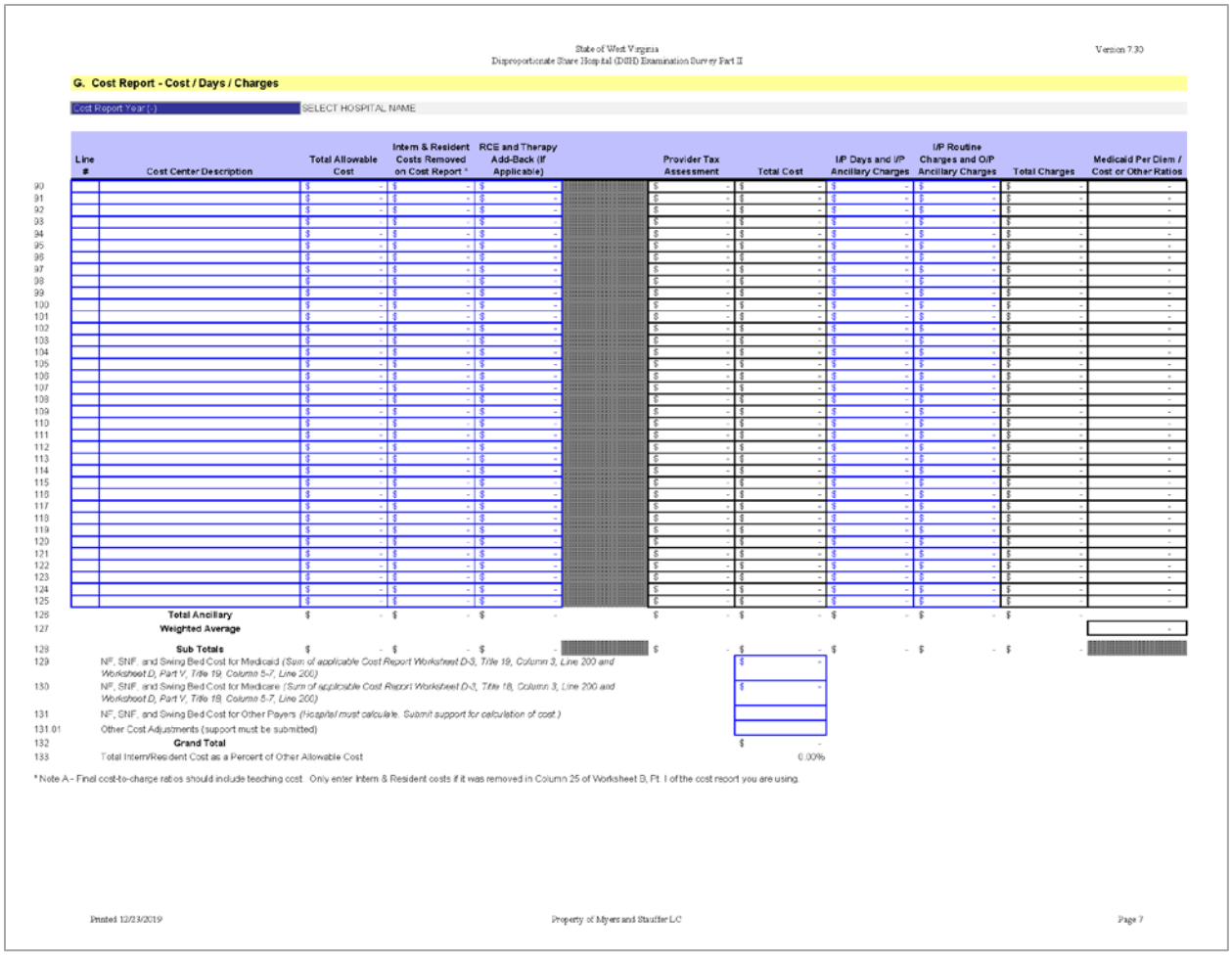
Cost Report Year (*) | SELECT HOSPITAL NAME

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 Days and I/P Ancillary Charges	I/P Routine Charges and O/P Ancillary Charges	Total Charges	Medicaid Per Diem / Cost or Other Ratios
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		$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
85		$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
86		$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
87		$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
88		$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
89		$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	-

Printed 12/23/2019

Property of Myers and Stauffer LC

Page 6



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

Version 7.30

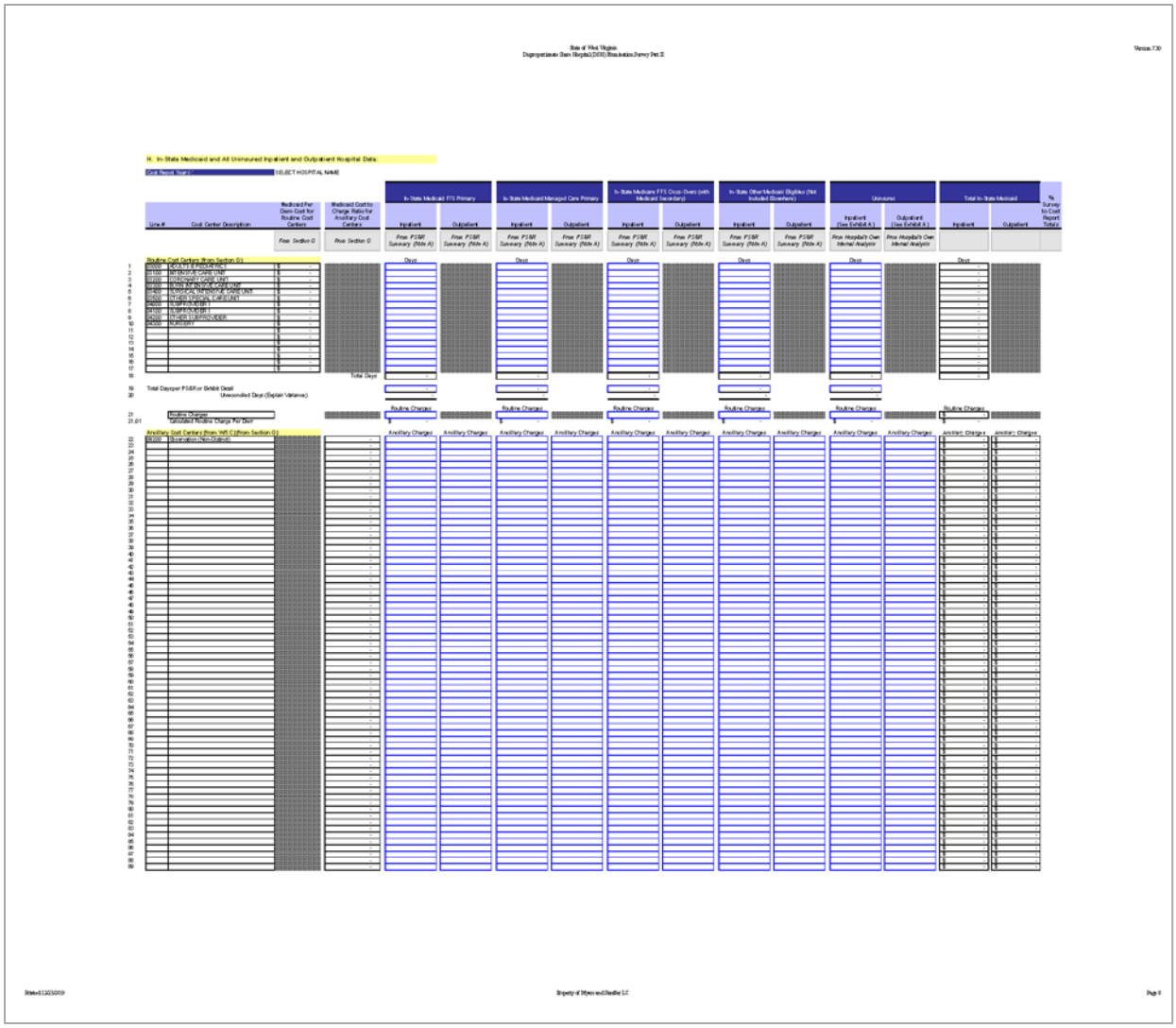
G. Cost Report - Cost / Days / Charges

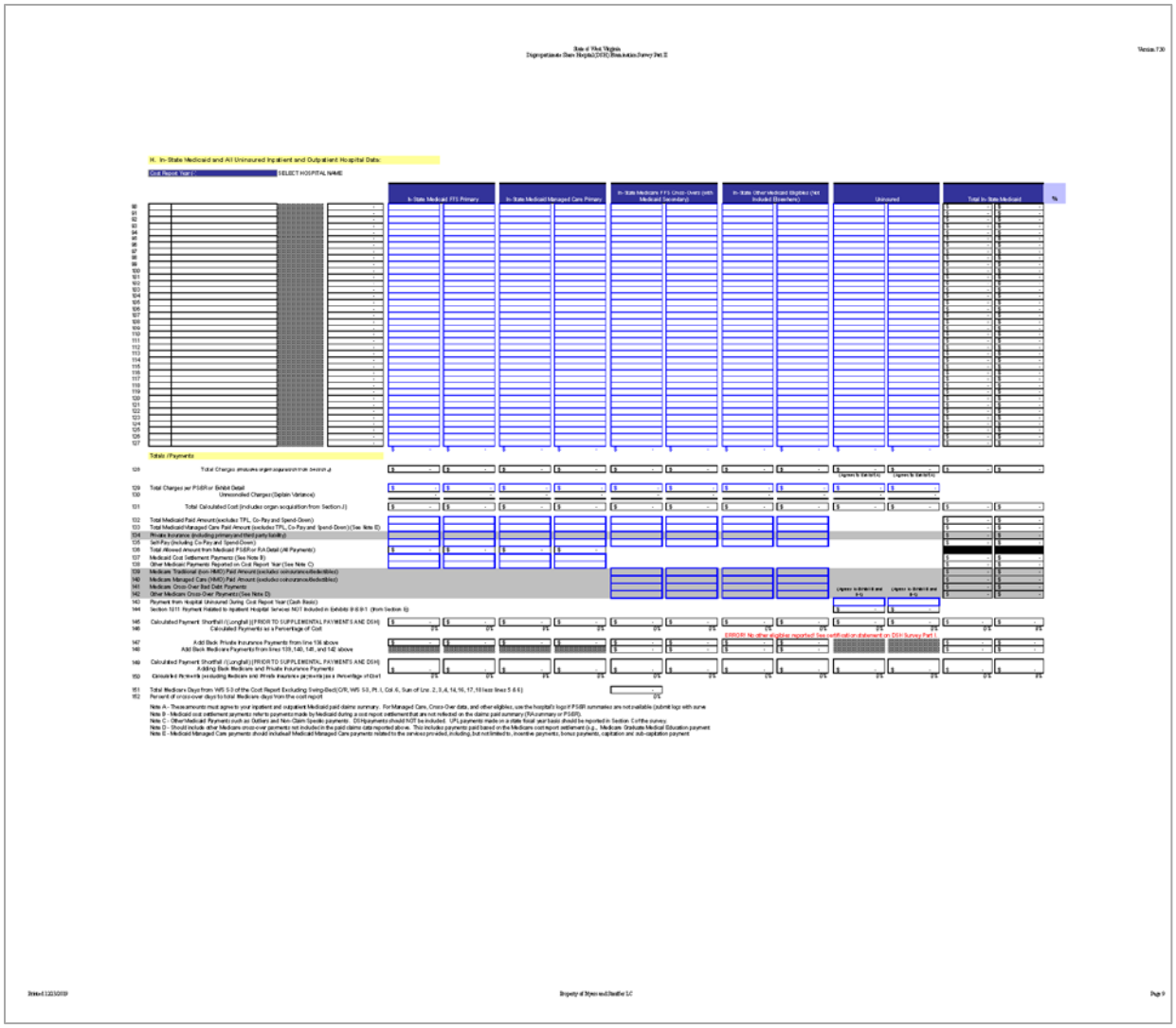
Cost Report Year (*) | SELECT HOSPITAL NAME

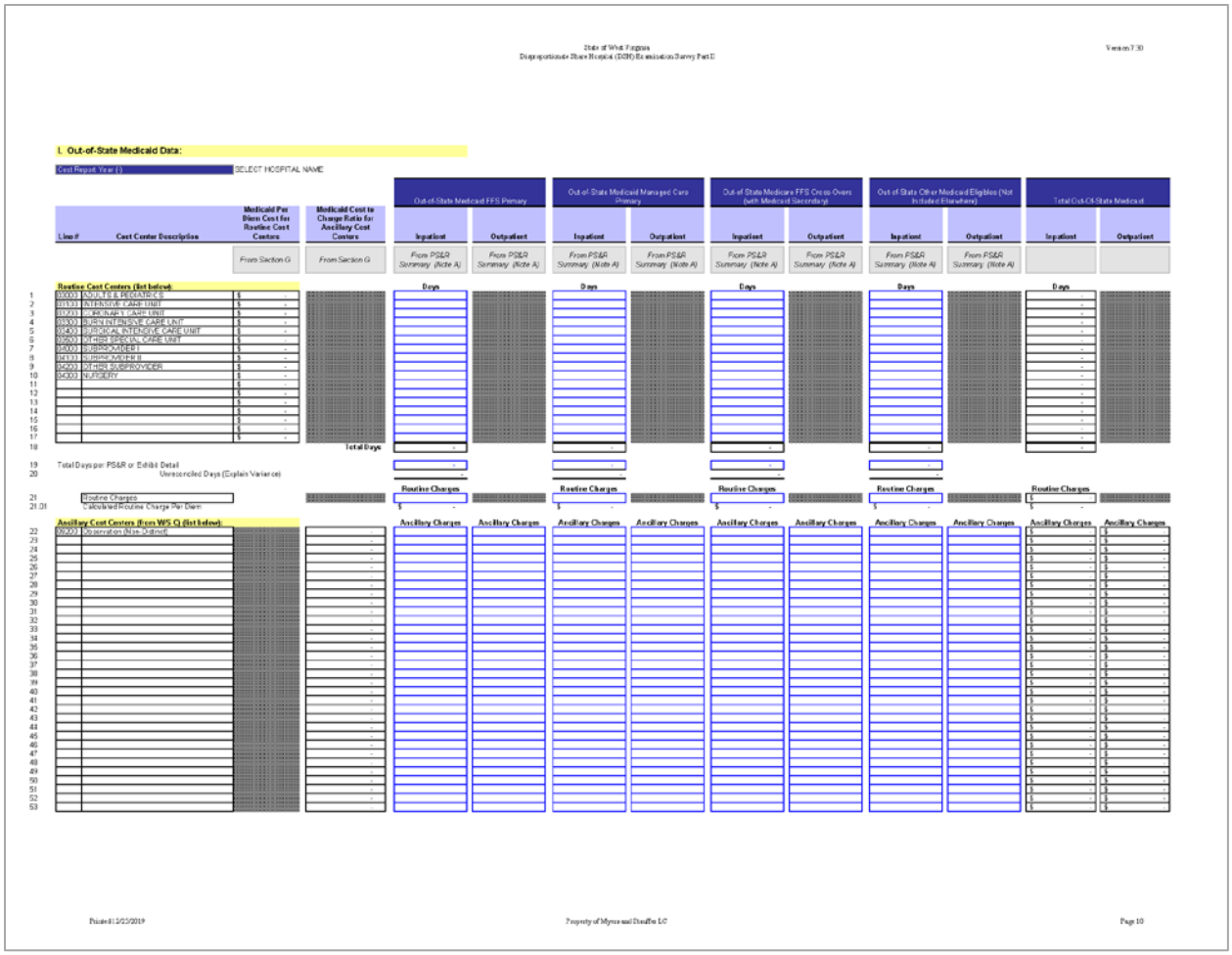
Line #	Cost Center Description	Total Allowable Cost	Intern & Resident Costs Removed on Cost Report *	RCE and Therapy Add-Back (If Applicable)		Provider Tax Assessment	Total Cost	I/P Days and I/P Ancillary Charges	I/P Routine Charges and O/P Ancillary Charges	Total Charges	Medicaid Per Diem / Cost or Other Ratios
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	**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)*						$ -				
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)*						$ -				
131	NF, SNF, and Swing Bed Cost for Other Payers *(Hospital must calculate. Submit support for calculation of cost.)*										
131.01	Other Cost Adjustments (support must be submitted)										
132	**Grand Total**						$ -				
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.

Printed 12/23/2019 | Property of Myers and Stauffer LC | Page 7







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

Version 7.30

I. Out-of-State Medicaid Data:

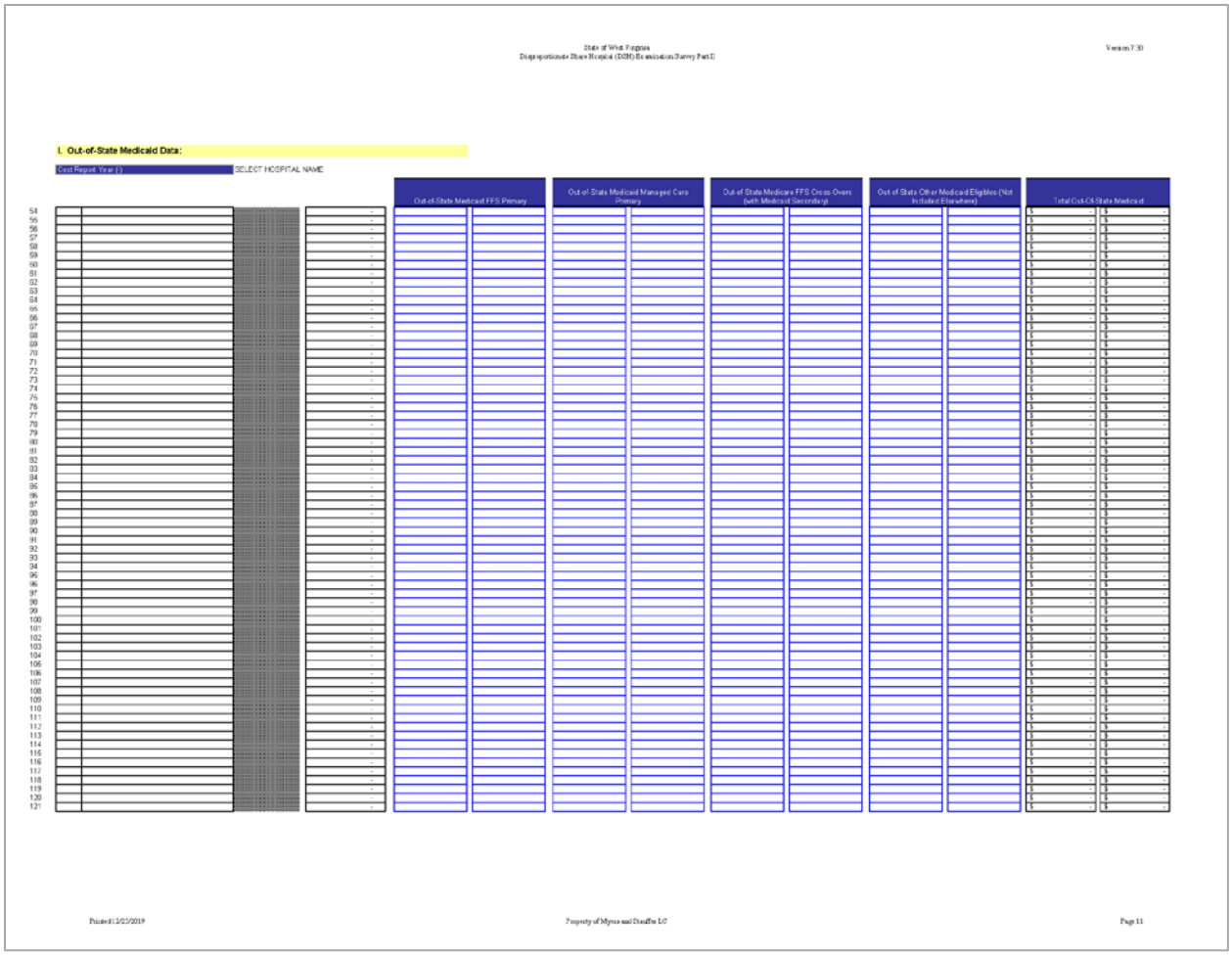
Cost Report Year ( ) SELECT HOSPITAL NAME

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	0000 ADULTS & PEDIATRICS	$ -											
2	0110 INTensive Care Unit	$ -											
3	0120 CORONARY CARE UNIT	$ -											
4	0200 BURN INTENSIVE CARE UNIT	$ -											
5	0400 SURGICAL INTENSIVE CARE UNIT	$ -											
6	0500 OTHER SPECIAL CARE UNIT	$ -											
7	0600 SUBPROVIDER I	$ -											
8	0610 SUBPROVIDER II	$ -											
9	0700 OTHER SUBPROVIDER	$ -											
10	0800 NURSERY	$ -											
11		$ -											
12		$ -											
13		$ -											
14		$ -											
15		$ -											
16		$ -											
17		$ -											
18			Total Days	-		-		-		-		-	
19	Total Days per PS&R or Exhibit Detail			-		-		-		-			
20	Unreconciled Days (Explain Variance)			-		-		-		-			
21	Routine Charges			Routine Charges		Routine Charges		Routine Charges		Routine Charges		Routine Charges	
21.01	Calculated Routine Charge Per Diem			$ -		$ -		$ -		$ -		$ -	
	Ancillary Cost Centers (from WS C) (list below):			Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges
22	0920 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			-	-	-	-	-	-	-	-	-	$ -	$ -

Printed 12/23/2019

Property of Myers and Stauffer LC

Page 10



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

Version 7.30

I. Out-of-State Medicaid Data:

Cost Report Year ( )

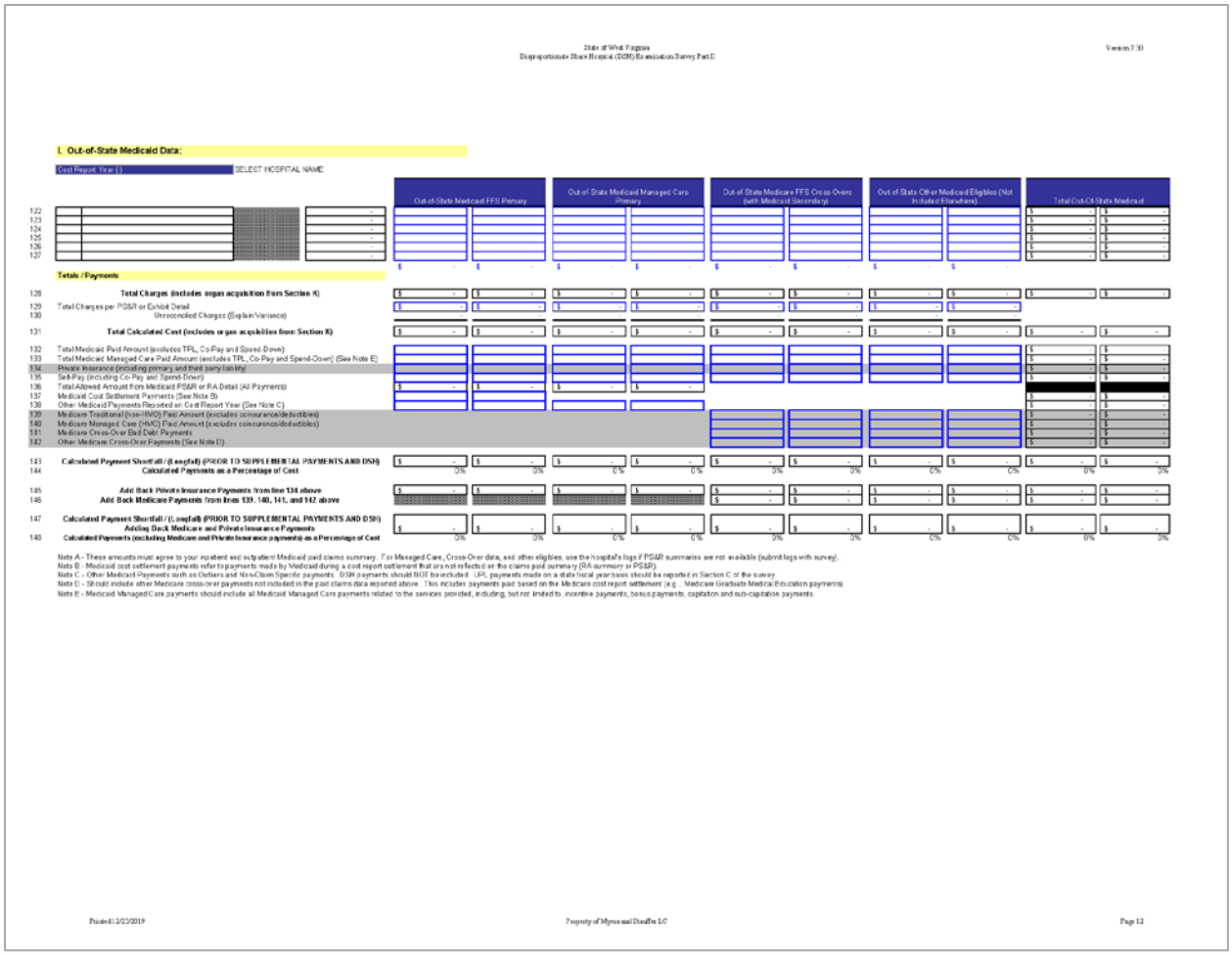
SELECT HOSPITAL NAME

				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	
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			-									$ -	$ -
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			-									$ -	$ -

Printed 1/23/2019

Property of Myers and Stauffer LC

Page 11



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

Version 7.30

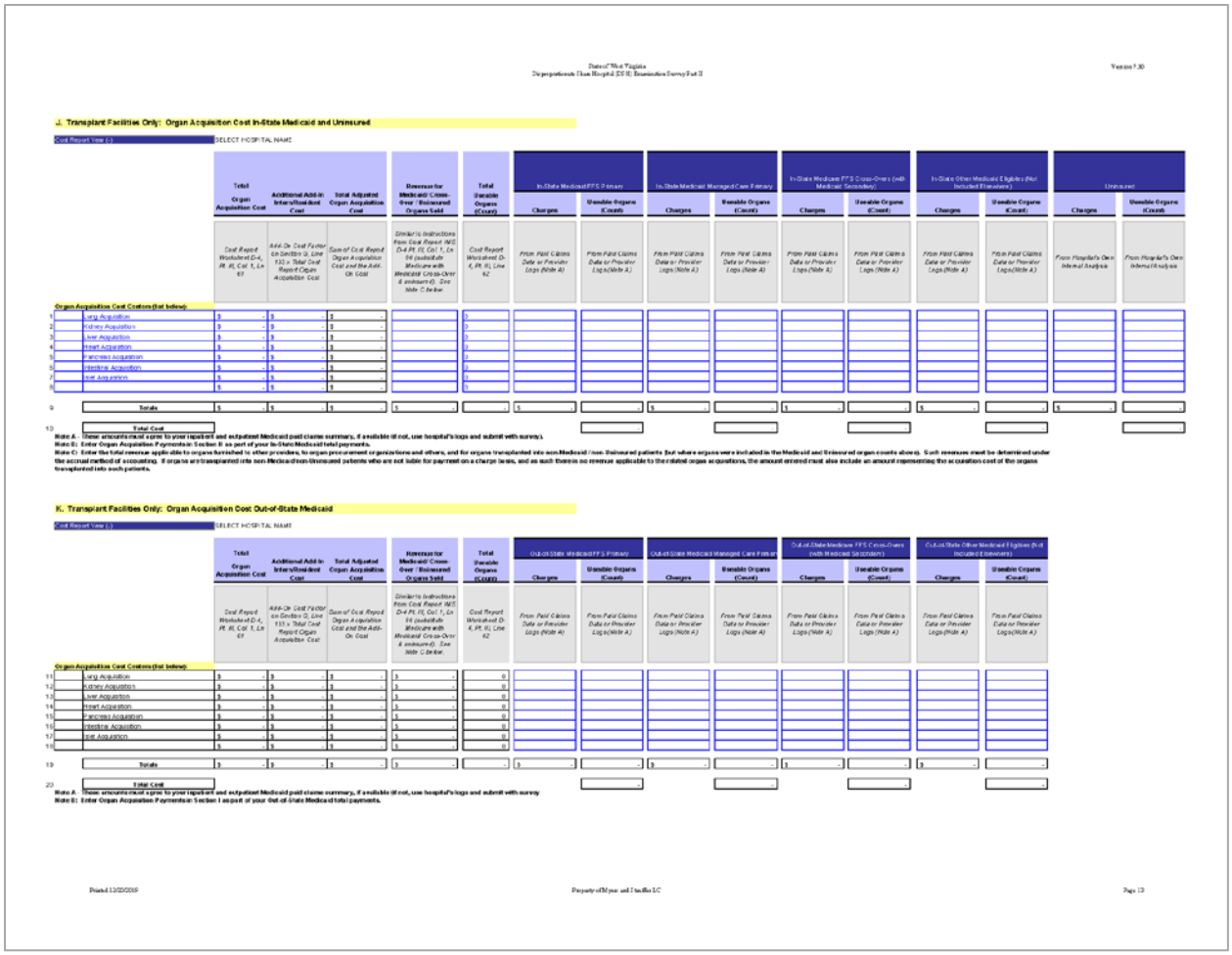
I. Out-of-State Medicaid Data:

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	
122										$ -	$ -
123										$ -	$ -
124										$ -	$ -
125										$ -	$ -
126										$ -	$ -
127										$ -	$ -
	Totals / Payments	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -		
128	**Total Charges (includes organ acquisition from Section K)**	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
129	Total Charges per PS&R or Exhibit Detail	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -		
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	Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down) (See Note E)									$ -	$ -
134	Private Insurance (including primary and third party liability)									$ -	$ -
135	Self-Pay (including Co-Pay and Spend-Down)									$ -	$ -
136	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)	$ -	$ -	$ -	$ -						
137	Medicaid Cost Settlement Payments (See Note B)									$ -	$ -
138	Other Medicaid Payments Reported on Cost Report Year (See Note C)									$ -	$ -
139	Medicare Traditional (non-HMO) Paid Amount (excludes coinsurance/deductibles)									$ -	$ -
140	Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)									$ -	$ -
141	Medicare Cross-Over Bad Debt Payments									$ -	$ -
142	Other Medicare Cross-Over Payments (See Note D)									$ -	$ -
143	**Calculated Payment Shortfall / (Longfall) (PRIOR TO SUPPLEMENTAL PAYMENTS AND DSH)**	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
144	**Calculated Payments as a Percentage of Cost**	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
145	**Add Back Private Insurance Payments from line 134 above**	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
146	**Add Back Medicare Payments from lines 139, 140, 141, and 142 above**	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
147	**Calculated Payment Shortfall / (Longfall) (PRIOR TO SUPPLEMENTAL PAYMENTS AND DSH) Adding Back Medicare and Private Insurance Payments**	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
148	**Calculated Payments (excluding Medicare and Private Insurance payments) as a Percentage of Cost**	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, Cross-Over data, and other eligibles, 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).
Note E - Medicaid Managed Care payments should include all Medicaid Managed Care payments related to the services provided, including, but not limited to, incentive payments, bonus payments, capitation and sub-capitation payments.

Printed 12/23/2019 | Property of Myers and Stauffer LC | Page 12



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

Version 9.30

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

Cost Report Year (c) | 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 Q, Line 113 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 MS-DH Pt. III, Col. 1, Ln 94 (subtotal for 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										
2	Kidney Acquisition	$ -	$ -	$ -		0										
3	Liver Acquisition	$ -	$ -	$ -		0										
4	Heart Acquisition	$ -	$ -	$ -		0										
5	Pancreas Acquisition	$ -	$ -	$ -		0										
6	Intestine Acquisition	$ -	$ -	$ -		0										
7	Islet Acquisition	$ -	$ -	$ -		0										
8		$ -	$ -	$ -		0										
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 R 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 initiated 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 (c) | 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 Primary		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 Q, Line 113 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 MS-DH Pt. III, Col. 1, Ln 94 (subtotal for 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	Intestine 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.

Printed 11/20/2019 | Property of Myers and Stauffer LC | Page 13

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 examination 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 such as Nursing Facility*

Appendix G: Sample Training Materials

Sample DSH Update Training

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

DISPROPORTIONATE SHARE HOSPITAL (DSH) PAYMENT EXAMINATION UPDATE DSH YEAR 2016

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

OVERVIEW

- DSH Examination Policy
- DSH Year 2016 Examination Timeline
- DSH Year 2016 Examination Impact
- Paid Claims Data Review
- Review of DSH Year 2016 Survey and Exhibits
- 2016 Clarifications / Changes
- Recap of Prior Year Examinations (2015)
- Myers and Stauffer DSH FAQ
- Survey Submission – DSH Web Portal

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

RELEVANT DSH POLICY

- DSH Implemented under Section 1923 of the Social Security Act (42 U.S. Code, Section 1396r-4)
- Audit/Reporting implemented in FR Vol. 73, No. 245, Friday, Dec. 19, 2008, Final Rule
- Medicaid Reporting Requirements
  42 CFR 447.299 (c)
- Independent Certified Audit of State DSH Payment Adjustments
  42 CFR 455.300 Purpose
  42 CFR 455.301 Definitions
  42 CFR 455.304 Conditions for FFP
- February, 2010 CMS FAQ titled, *"Additional Information on the DSH Reporting and Audit Requirements"*

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

RELEVANT DSH POLICY (CONT.)

- Allotment Reductions and Additional Reporting Requirements implemented in FR Vol. 78, No. 181, September 18, 2013, Final Rule
- CMCS Informational Bulletin Dated December 27, 2013 delaying implementation of Medicaid DSH Allotment reductions 2 years.
- April 1, 2014 – P.L. 113-93 (Protecting Access to Medicare Act) delays implementation of Medicaid DSH Allotment reductions 1 additional year.
- Additional Information of the DSH Reporting and Audit Requirements – Part 2, clarification published April 7, 2014.
- Audit/Reporting implemented in FR Vol. 79, No. 232, Wednesday, Dec. 03, 2014, Final Rule

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

RELEVANT DSH POLICY (CONT.)

- "Medicare Access and CHIP Reauthorization Act" - Public Law, April 16, 2015, Sec. 412 Delay of Reduction to Medicaid DSH Allotments; delayed DSH reductions until FY 2018
- Treatment of Third Party Payers in Calculating Uncompensated Care Costs, April 3, 2017 FR Vol. 82, No. 62, Final Rule
- State DSH Hospital Allotment Reductions, July 28, 2017 FR Vol. 82, No. 144, Proposed Rule
- Bi-partisan Budget Act of 2018, enacted on February 9, 2018 delayed DSH reductions until FY 2020
- December 31, 2018 Additional Information on the DSH Reporting and Audit Requirements

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

NATIONWIDE DSH LITIGATION

- On December 31, 2018, CMS issued additional guidance regarding FAQs 33 and 34.
- Myers and Stauffer will conduct the DSH examination as we have in years past and continue to collect all payment data including Medicare and private insurance payments at the state's request.
- **It is imperative that hospitals continue to provide all requested data, and that each hospital makes their best effort to break out Exhibit C payments by payer type. This will ensure that UCCs can be calculated accurately regardless of the results of ongoing litigation.**

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

1

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

DSH YEAR 2016 EXAMINATION TIMELINE

- Surveys mailed February 21, 2019
- Surveys returned by March 21, 2019
- March – May: desk reviews
- May – June: on-site/expanded reviews
- Draft report to the state by September 30, 2019
- Final report to CMS by December 31, 2019

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

DSH YEAR 2016 EXAMINATION IMPACT

- **Per 42 CFR 455.304,** 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.
- The current DSH year 2016 examination report is the sixth year that may result in DSH payment recoupments.

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

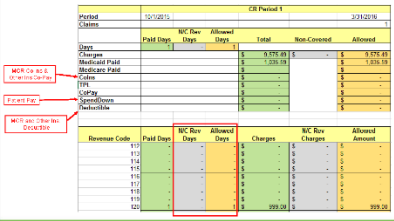
PAID CLAIMS DATA UPDATE FOR 2016

- Medicaid fee-for-service paid claims data
  - Sent to hospitals with the survey.
  - Reported based on cost report year (using discharge date).
    - This is the last year hospitals not on a 9/30 year end will be required to submit a partial prior year DSH Survey Part II.
  - Excludes non-Title 19 services (i.e. CHIP).

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

MEDICAID FEE-FOR-SERVICE PAID CLAIMS DATA



DEDICATED TO GOVERNMENT HEALTH PROGRAMS

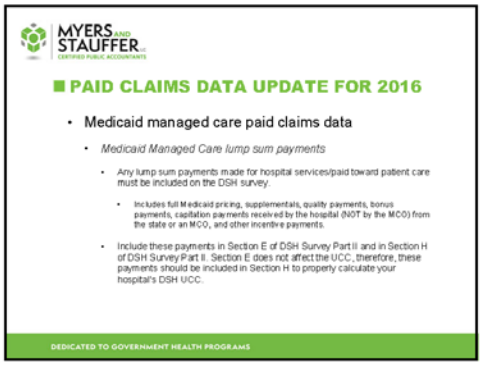
MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

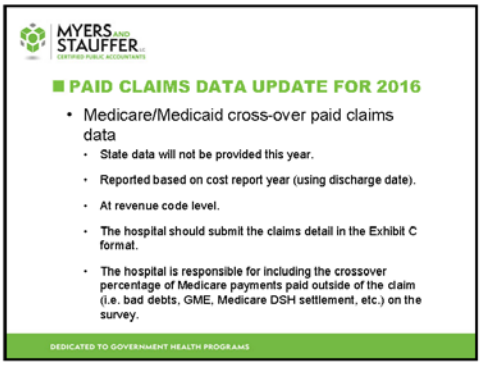
PAID CLAIMS DATA UPDATE FOR 2016

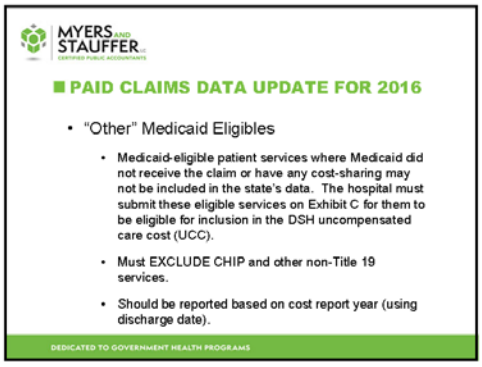
- Medicaid managed care paid claims data is not available
  - If the hospital cannot obtain a paid claims listing from the MCO, the hospital should send in a detailed listing in Exhibit C format. Physician fee professional charges should be excluded and a portion of the payment should also be excluded if the hospital receives a bundled payment.
  - Must EXCLUDE CHIP and other non-Title 19 services.
  - Should be reported based on cost report year (using discharge date).

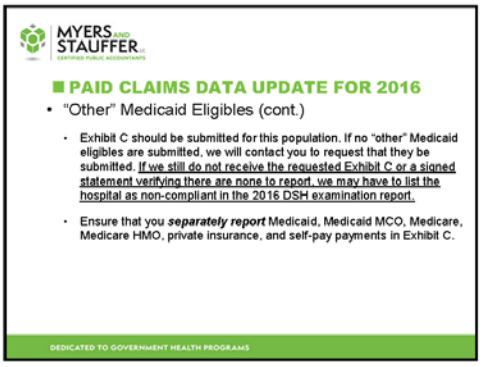
DEDICATED TO GOVERNMENT HEALTH PROGRAMS

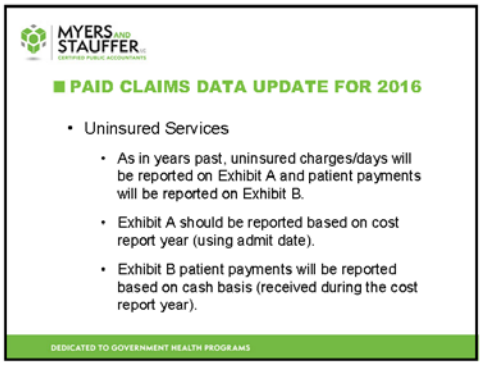
2

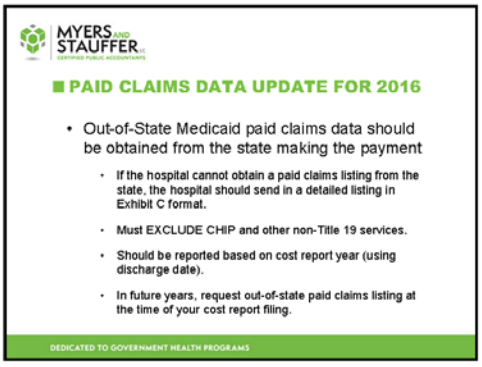

MYERS AND STAUFFER
PAID CLAIMS DATA UPDATE FOR 2016
Medicaid managed care paid claims data
Medicaid Managed Care lump sum payments
Any lump sum payments made for hospital services/paid toward patient care must be included on the DSH survey.
Includes full Medicaid pricing, supplementals, quality payments, bonus payments, capitation payments received by the hospital (NOT by the MCO) from the state or an MCO, and other incentive payments.
Include these payments in Section E of DSH Survey Part II and in Section H of DSH Survey Part II. Section E does not affect the UCC, therefore, these payments should be included in Section H to properly calculate your hospital's DSH UCC.
DEDICATED TO GOVERNMENT HEALTH PROGRAMS


MYERS AND STAUFFER
PAID CLAIMS DATA UPDATE FOR 2016
Medicare/Medicaid cross-over paid claims data
State data will not be provided this year.
Reported based on cost report year (using discharge date).
At revenue code level.
The hospital should submit the claims detail in the Exhibit C format.
The hospital is responsible for including the crossover percentage of Medicare payments paid outside of the claim (i.e. bad debts, GME, Medicare DSH settlement, etc.) on the survey.
DEDICATED TO GOVERNMENT HEALTH PROGRAMS


MYERS AND STAUFFER
PAID CLAIMS DATA UPDATE FOR 2016
"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).
Must EXCLUDE CHIP and other non-Title 19 services.
Should be reported based on cost report year (using discharge date).
DEDICATED TO GOVERNMENT HEALTH PROGRAMS


MYERS AND STAUFFER
PAID CLAIMS DATA UPDATE FOR 2016
"Other" Medicaid Eligibles (cont.)
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 or a signed statement verifying there are none to report, we may have to list the hospital as non-compliant in the 2016 DSH examination report.
Ensure that you separately report Medicaid, Medicaid MCO, Medicare, Medicare HMO, private insurance, and self-pay payments in Exhibit C.
DEDICATED TO GOVERNMENT HEALTH PROGRAMS


MYERS AND STAUFFER
PAID CLAIMS DATA UPDATE FOR 2016
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 admit date).
Exhibit B patient payments will be reported based on cash basis (received during the cost report year).
DEDICATED TO GOVERNMENT HEALTH PROGRAMS


MYERS AND STAUFFER
PAID CLAIMS DATA UPDATE FOR 2016
Out-of-State Medicaid paid claims data should be obtained from the state making the payment
If the hospital cannot obtain a paid claims listing from the state, the hospital should send in a detailed listing in Exhibit C format.
Must EXCLUDE CHIP and other non-Title 19 services.
Should be reported based on cost report year (using discharge date).
In future years, request out-of-state paid claims listing at the time of your cost report filing.
DEDICATED TO GOVERNMENT HEALTH PROGRAMS

3

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

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

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

DSH EXAMINATION SURVEYS

General Instruction – Survey Files

- Do not complete a DSH Survey Part II for a cost report year already submitted in a previous DSH exam year.
  - Example: Hospital A provided a survey for their year ending 12/31/15 with the DSH examination of SFY 2015 in the prior year. In the DSH year 2016 exam, Hospital A would only need to submit a survey for their year ending 12/31/16.
- 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 is not clear, please contact Myers and Stauffer.

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

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.

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

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.

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

DSH SURVEY PART I – DSH YEAR DATA

Section C

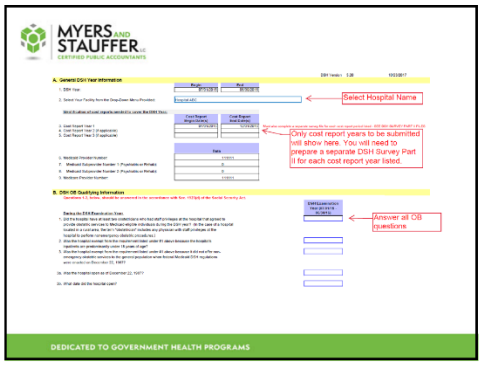
- Report any Medicaid supplemental payments, including UPL and Non-Claim Specific payments, for the state fiscal year. Do NOT include DSH payments.

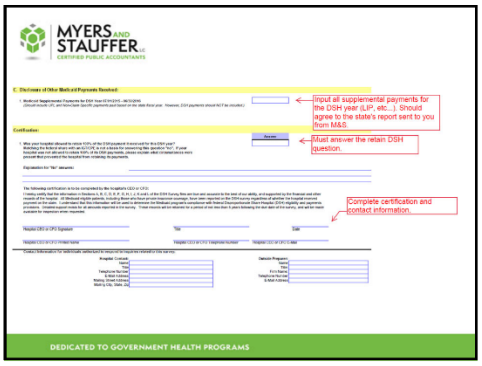
Certification

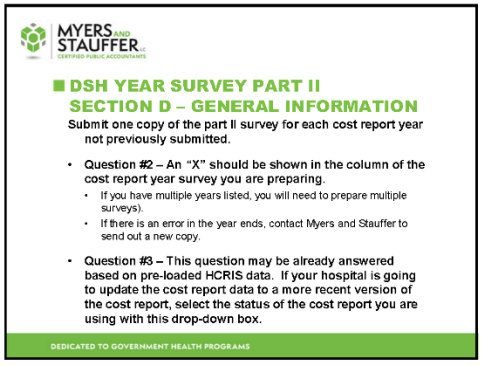
- Answer the "Retain DSH" question but please note that IGTs and CPEs are not a basis for answering the question "No".
- Enter contact information.
- Have CEO or CFO sign this section after completion of Part II of the survey.

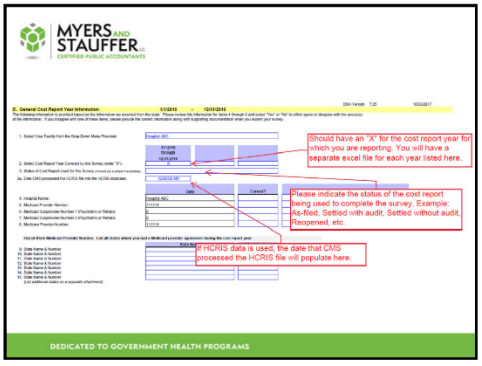
DEDICATED TO GOVERNMENT HEALTH PROGRAMS

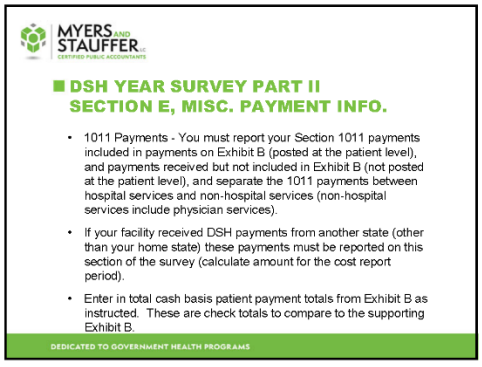
4

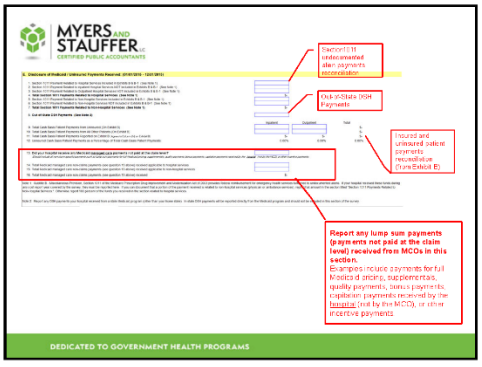

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS
Select Hospital Name
Only cost report years to be submitted will show here. You will need to prepare a separate DSH Survey Part II for each cost report year listed.
Answer all OB questions
DEDICATED TO GOVERNMENT HEALTH PROGRAMS


MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS
Input all supplemental payments for the DSH year (UIP, etc...). Should agree to the state's report sent to you from M&S.
Must answer the retain DSH question.
Complete certification and contact information.
DEDICATED TO GOVERNMENT HEALTH PROGRAMS


MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS
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.
DEDICATED TO GOVERNMENT HEALTH PROGRAMS


MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS
Should have an "X" for the cost report year for which you are reporting. You will have a separate excel file for each year listed here.
Please indicate the status of the cost report being used to complete the survey. Example: As-filed, Settled with audit, Settled without audit, Reopened, etc.
If HCRIS data is used, the date that CMS processed the HCRIS file will populate here.
DEDICATED TO GOVERNMENT HEALTH PROGRAMS


MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS
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.
DEDICATED TO GOVERNMENT HEALTH PROGRAMS


MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS
Section 1011 Undocumented plan payments reconciliation
Out-of-State DSH Payments
Insured and Uninsured patient payments reconciliation (Form Exhibit B)
Report any lump sum payments (payments net paid at the state level) received from MCOs in this section.
Examples include payments for full Medicaid pricing, supplemental, quality payments, bonus payments, capitation payments received by the hospital (not by the MCO), or other incentive payments.
DEDICATED TO GOVERNMENT HEALTH PROGRAMS

5

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

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. If any subsidies are directed toward non-hospital services, record the subsidies in the non-hospital cell.
- 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 LC
CERTIFIED PUBLIC ACCOUNTANTS

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.

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

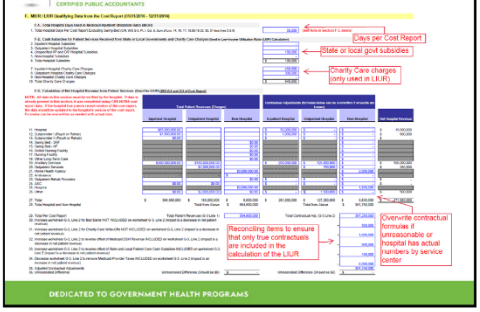
DSH YEAR SURVEY PART II SECTION F, MIUR/LIUR

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 30 and 31 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 32 and 33 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 34 so it can be properly excluded in calculating net patient service revenue.

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS



DEDICATED TO GOVERNMENT HEALTH PROGRAMS

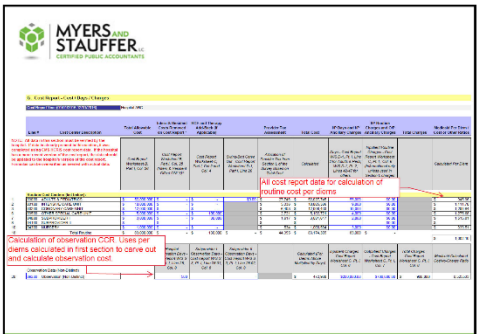
MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

DSH YEAR SURVEY PART II SECTION G, COST REPORT DATA

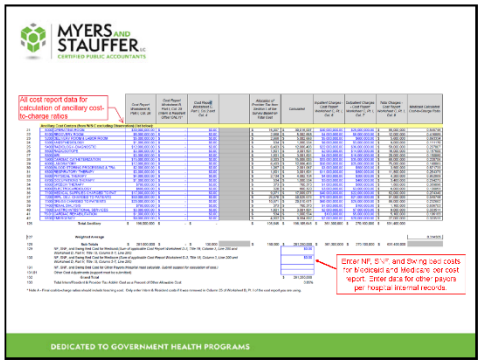
- Utilized to compute the per diems and cost-to-charge ratios used to calculate uncompensated care costs.
  - Pre-populated with hospital-specific HCRIS data.
  - Hospital should update the pre-populated HCRIS costs coming from B Part I to agree with the most recent version of the cost report. RCE adjustments may need to be updated also.
  - All other pre-populated HCRIS data should be verified to the most recent version of the cost report by the hospital. Changes should be made if HCRIS values don't agree to the cost report.
  - NF, SNF, and Swing Bed Cost for Medicaid, Medicare, and Other payers will be excluded from Total Hospital Cost.

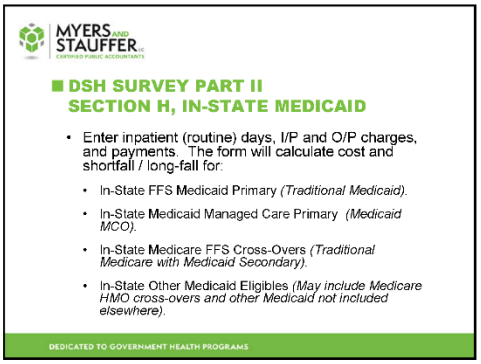
DEDICATED TO GOVERNMENT HEALTH PROGRAMS

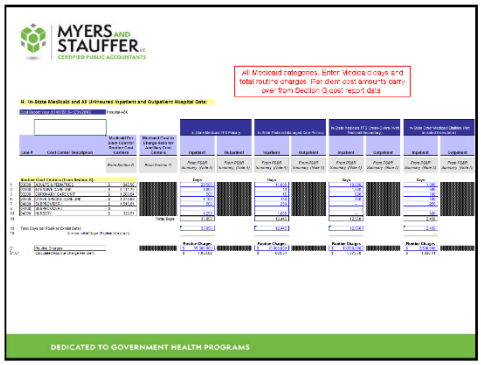
MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

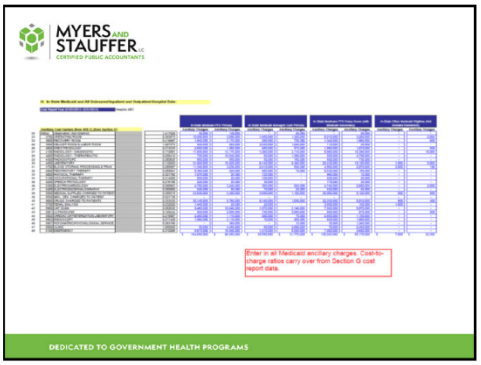


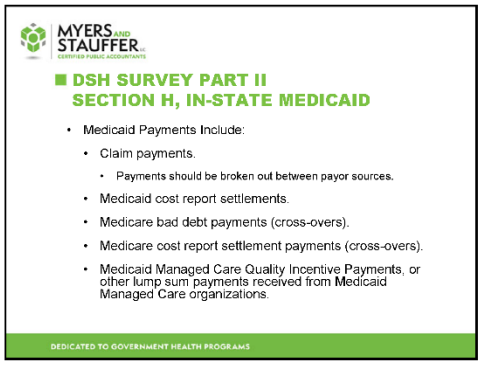
DEDICATED TO GOVERNMENT HEALTH PROGRAMS

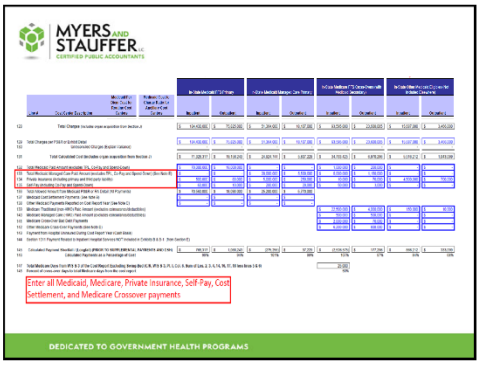

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS
All cost report data for calculation of ancillary cost-to-charge ratios
Enter NF, SNF, and swing bed costs for Medicaid and Medicare per cost report. Enter data for other payors per hospital internal records.
DEDICATED TO GOVERNMENT HEALTH PROGRAMS


MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS
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 Medicaid Secondary).
In-State Other Medicaid Eligibles (May include Medicare HMO cross-overs and other Medicaid not included elsewhere).
DEDICATED TO GOVERNMENT HEALTH PROGRAMS


MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS
All Medicaid categories. Enter 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
CERTIFIED PUBLIC ACCOUNTANTS
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
CERTIFIED PUBLIC ACCOUNTANTS
DSH SURVEY PART II
SECTION H, IN-STATE MEDICAID
Medicaid Payments Include:
Claim payments.
Payments should be broken out between payor sources.
Medicaid cost report settlements.
Medicare bad debt payments (cross-overs).
Medicare cost report settlement payments (cross-overs).
Medicaid Managed Care Quality Incentive Payments, or other lump sum payments received from Medicaid Managed Care organizations.
DEDICATED TO GOVERNMENT HEALTH PROGRAMS


MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS
Enter all Medicaid, Medicare, Private Insurance, Self-Pay, Cost Settlement, and Medicare Crossover payments
DEDICATED TO GOVERNMENT HEALTH PROGRAMS

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

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.

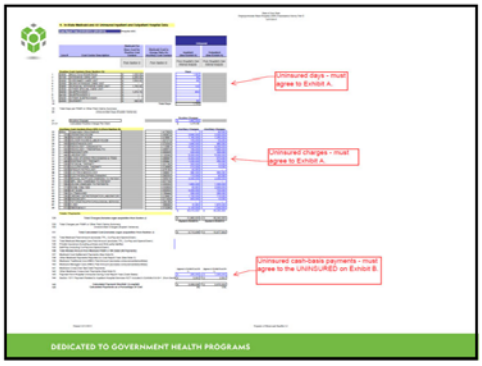
DEDICATED TO GOVERNMENT HEALTH PROGRAMS

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

DSH SURVEY PART II SECTION H, UNINSURED

- State-only claims with no Medicare or private insurance liability can be included in Exhibit A.
  - Exception: State-only indigent care programs delivered by a private Managed Care Organization (MCO) should be submitted on Exhibit C to ensure proper reporting of payments received from the MCO. Cost and payments should still be included in uninsured columns of DSH Survey Part II.
  - See Additional Information of the DSH Reporting and Audit Requirements – Part 2, clarification published April 7, 2015, item # 12.

DEDICATED TO GOVERNMENT HEALTH PROGRAMS



DEDICATED TO GOVERNMENT HEALTH PROGRAMS

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

DSH SURVEY PART II SECTION H, UNINSURED

- If BOTH of the following conditions are met, a hospital is NOT required to submit any uninsured data on the survey nor Exhibits A and B:
  1. The hospital Medicaid shortfall is greater than the hospital's total Medicaid DSH payments for the year.
     - The shortfall is equal to all Medicaid (FFS, MCO, cross-over, In-State, Out-of-State) cost less all applicable payments in the survey and non-claim payments such a UPL, GME, outlier, and supplemental payments.
  2. The hospital provides a certification that it incurred additional uncompensated care costs serving uninsured individuals.

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

DSH SURVEY PART II SECTION H, UNINSURED

NOTE: It is important to remember that if you are not required to submit uninsured data that it may still be to the advantage of the hospital to submit it.

1. Your hospital's total UCC may be used to redistribute overpayments from other hospitals (to your hospital).
2. Your hospital's total UCC may be used to establish future DSH payments.
3. CMS DSH allotment reductions may be partially based on states targeting DSH payments to hospitals with high uninsured and Medicaid populations.

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

2016 CLARIFICATIONS

- *DSH Allotments*
  - Allotment reduction has been delayed even further until federal fiscal year 2020, through the Medicare Access and CHIP Reauthorization Act of 2016. The bill maintains a $4 billion reduction for 2020.
  - State DSH Hospital Allotment Reductions, July 28, 2017 FR Vol. 82, No. 144, Proposed Rule

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

8

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.
    - The errors occur when the cost report groupings differ from the grouping methodology used to complete the DSH survey.
  - Calculated payments as a percentage of cost by payor (at bottom).
    - Review percentage for reasonableness.

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

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

- Additional Edits
  - On Section H and I, in the cross-over columns, there will be an edit above the days section that will pop up if you enter more cross-over days on the DSH survey than are included in Medicare days on W/S S-3 of the cost report per HCRIS data.
    - Please review your data if this occurs and correct the issue prior to filing the survey.

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

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

- Additional Edits
  - On Section H, in column AY, there is a % Survey to Cost Report Totals column. The percentages listed in this column are calculating total in-state and out-of-state days and charges divided by total cost report days and charges by cost center, and in total.
    - Please review your data if this occurs and correct the issue prior to filing the survey.

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

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.

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

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.

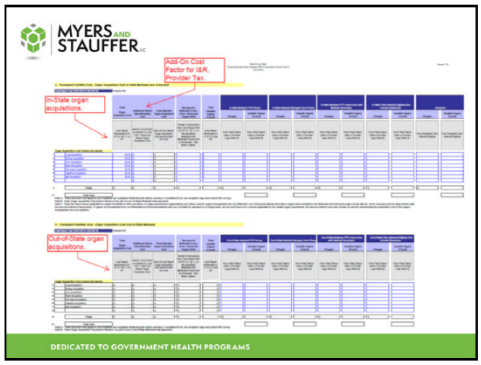
DEDICATED TO GOVERNMENT HEALTH PROGRAMS

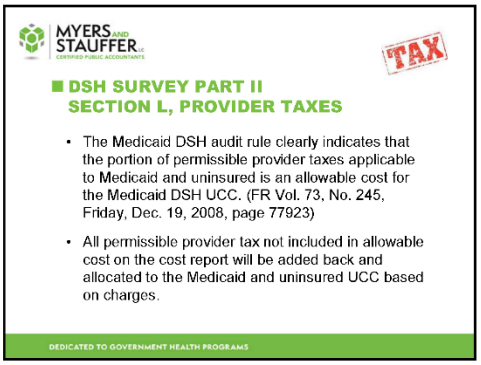
DSH SURVEY PART II - SECTIONS J & K, ORGAN ACQUISITION

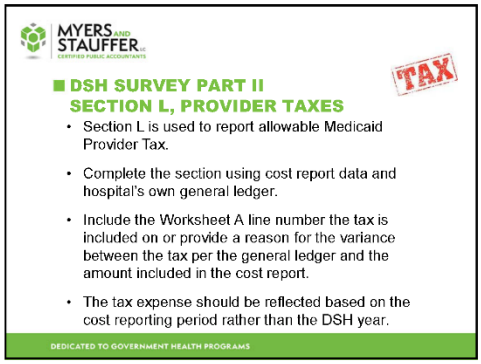
- All organ acquisition charges should be reported in Sections J & K of the survey and should be EXCLUDED from Section H & I of the survey. (days should also be excluded from H & I)
- Medicaid and uninsured charges/days included in the cost report D-4 series as part of the total organ acquisition charges/days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

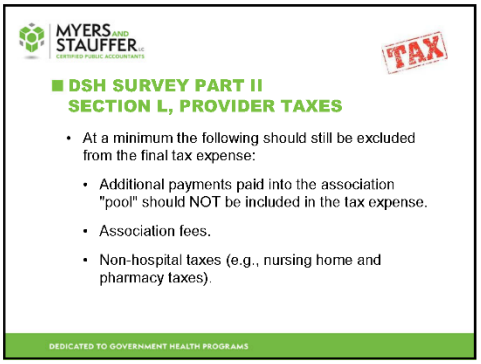
DEDICATED TO GOVERNMENT HEALTH PROGRAMS

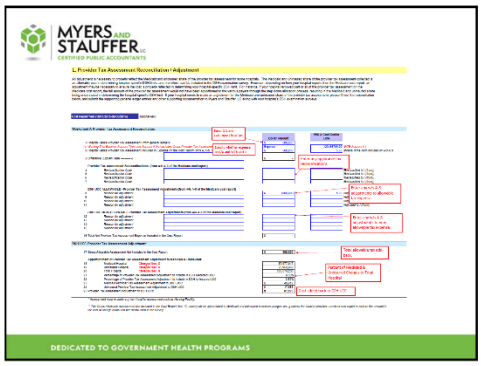
9

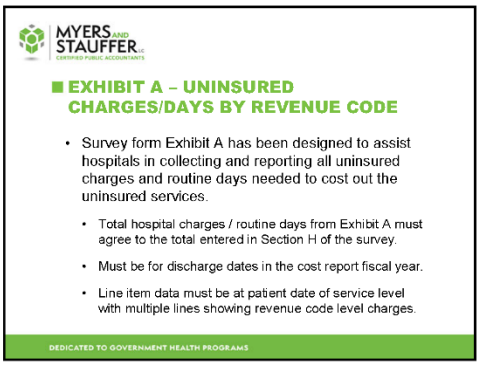

MYERS AND STAUFFER
Add-On Cost Factor for I&R, Provider Tax
In-State organ acquisitions
Out-of-State organ acquisitions
DEDICATED TO GOVERNMENT HEALTH PROGRAMS


MYERS AND STAUFFER
CERTIFIED PUBLIC ACCOUNTANTS
TAX
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)
• 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 based on charges.
DEDICATED TO GOVERNMENT HEALTH PROGRAMS


MYERS AND STAUFFER
CERTIFIED PUBLIC ACCOUNTANTS
TAX
DSH SURVEY PART II
SECTION L, PROVIDER TAXES
• Section L is used to report allowable Medicaid Provider Tax.
• Complete the section using cost report data and hospital's own general ledger.
• Include the Worksheet A line number the tax is included on or provide a reason for the variance between the tax per the general ledger and the amount included in the cost report.
• The tax expense should be reflected based on the cost reporting period rather than the DSH year.
DEDICATED TO GOVERNMENT HEALTH PROGRAMS


MYERS AND STAUFFER
CERTIFIED PUBLIC ACCOUNTANTS
TAX
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).
DEDICATED TO GOVERNMENT HEALTH PROGRAMS


MYERS AND STAUFFER
CERTIFIED PUBLIC ACCOUNTANTS
DEDICATED TO GOVERNMENT HEALTH PROGRAMS


MYERS AND STAUFFER
CERTIFIED PUBLIC ACCOUNTANTS
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 discharge dates 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.
DEDICATED TO GOVERNMENT HEALTH PROGRAMS

10

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

EXHIBIT A - UNINSURED

- Exhibit A:
  - Include *Primary Payor Plan*, *Secondary Payor Plan*, *Provider #*, *PCN*, *Name*, *Admit*, *Discharge*, *Service Indicator*, *Revenue Code*, *Total Charges*, *Days*, *Patient Payments*, *Private Insurance Payments*, and *Claim Status* fields.
    - A complete list (key) of payor plans is required to be submitted separately with the survey.

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

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).
- Data not submitted in the correct format may be returned to the hospital with a letter to request revisions to get the data into the prescribed Exhibit A format.

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

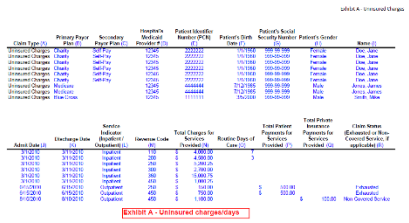


Exhibit A - Uninsured charges/days

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

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 LC
CERTIFIED PUBLIC ACCOUNTANTS

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 2016 cost report year that relates to a service provided in the 2006 cost report year, must be used to reduce uninsured cost for the 2016 cost report year.

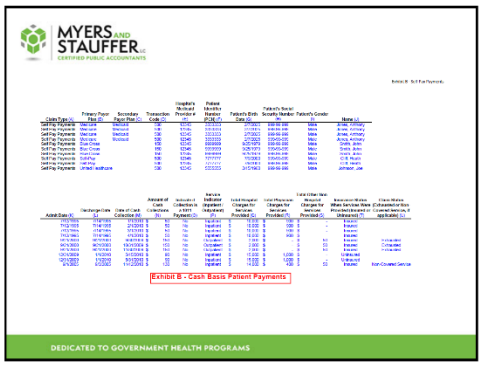
DEDICATED TO GOVERNMENT HEALTH PROGRAMS

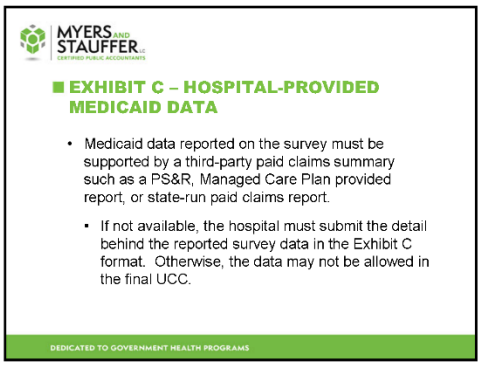
MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

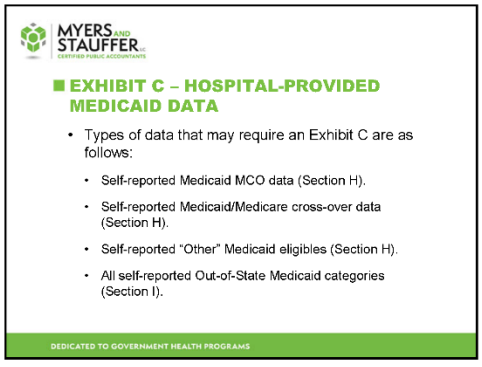
EXHIBIT B – ALL PATIENT PAYMENTS (SELF-PAY) ON A CASH BASIS

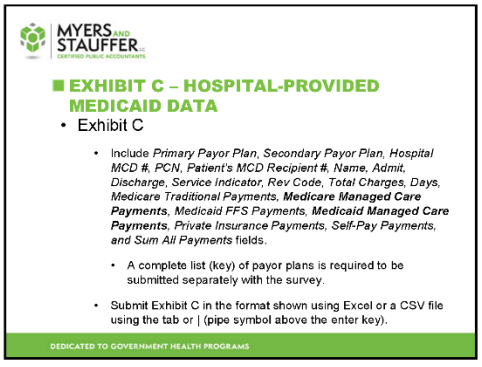
- Exhibit B
  - Include *Primary Payor Plan*, *Secondary Payor Plan*, *Payment Transaction Code*, *Provider #*, *PCN*, *Name*, *Admit*, *Discharge*, *Date of Collection*, *Amount of Collection*, *1011 Indicator*, *Service Indicator*, *Hospital Charges*, *Physician Charges*, *Non-Hospital Charges*, *Insurance Status*, *Claim Status* and *Calculated Collection* 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).
- Data not submitted in the correct format may be returned to the hospital with a letter to request revisions to get the data into the prescribed Exhibit B format.

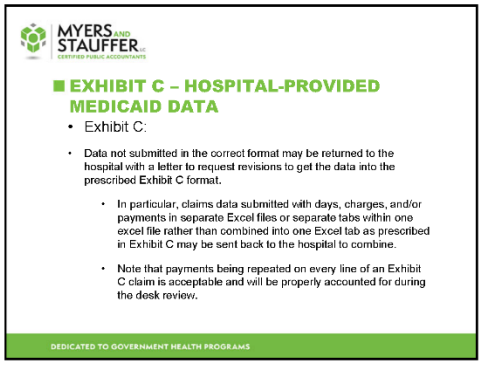
DEDICATED TO GOVERNMENT HEALTH PROGRAMS

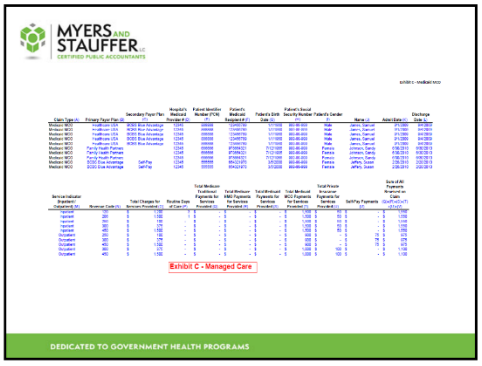

MYERS AND STAUFFER
Exhibit B - Cash Basis Patient Payments
DEDICATED TO GOVERNMENT HEALTH PROGRAMS


MYERS AND STAUFFER
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.
DEDICATED TO GOVERNMENT HEALTH PROGRAMS


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).
• All self-reported Out-of-State Medicaid categories (Section I).
DEDICATED TO GOVERNMENT HEALTH PROGRAMS


MYERS AND STAUFFER
EXHIBIT C – HOSPITAL-PROVIDED MEDICAID DATA
• Exhibit C
• Include *Primary Payor Plan, Secondary Payor Plan, Hospital MCD #, PCN, Patient's MCD Recipient #, Name, Admit, Discharge, Service Indicator, Rev Code, Total Charges, Days, Medicare Traditional Payments, **Medicare Managed Care Payments**, Medicaid FFS Payments, **Medicaid Managed Care Payments**, Private Insurance Payments, Self-Pay Payments, and Sum All Payments* 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).
DEDICATED TO GOVERNMENT HEALTH PROGRAMS


MYERS AND STAUFFER
EXHIBIT C – HOSPITAL-PROVIDED MEDICAID DATA
• Exhibit C:
• Data not submitted in the correct format may be returned to the hospital with a letter to request revisions to get the data into the prescribed Exhibit C format.
• In particular, claims data submitted with days, charges, and/or payments in separate Excel files or separate tabs within one excel file rather than combined into one Excel tab as prescribed in Exhibit C may be sent back to the hospital to combine.
• Note that payments being repeated on every line of an Exhibit C claim is acceptable and will be properly accounted for during the desk review.
DEDICATED TO GOVERNMENT HEALTH PROGRAMS


MYERS AND STAUFFER
Exhibit C - Managed Care
DEDICATED TO GOVERNMENT HEALTH PROGRAMS

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 examination.
- Includes Myers and Stauffer address and phone numbers.

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

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.

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

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.

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

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, 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.

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

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

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

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.

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

13

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

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).
20. Documentation supporting Medicaid Managed Care Quality Inventive Payments, or any other Medicaid Managed Care lump sum payments.

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

2016 CLARIFICATIONS / CHANGES

- The 2008 DSH rule requires that a hospital's DSH uncompensated care cost include all Other Medicaid Eligibles.
- The 2008 DSH rule specifically states that the UCC calculation must include "regular Medicaid payments, Medicaid managed care organization payments, supplemental/enhanced Medicaid payments, uninsured revenues, and 1011 payments." *FR Vol. 73, No. 245, Friday, Dec. 19, 2008, Final Rule, 77904*
- Seattle Children's and Texas Children's Hospitals have sued to stop recoupments of their DSH overpayments that have resulted from the inclusion of these private insurance claims in their DSH UCC. On December 29, 2014, a federal court ordered an injunction against Washington and Texas state Medicaid agencies and CMS preventing the state and/or CMS from recouping the overpayments as included in the DSH examination report. On December 31, 2018, CMS removed FAQs #33 and 34, meaning that private insurance and Medicare payments should not offset cost for periods prior to June 2, 2017.

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

2016 CLARIFICATIONS / CHANGES

- Myers and Stauffer, or any other independent CPA firm, must calculate a hospital's uncompensated care cost for the 2016 DSH examinations without offsetting private insurance and Medicare payments.
- CMS still plans to enforce the 2017 rule, pending their appeal of the Texas court case. As a result, we are still collecting data related to private insurance and Medicare payments, but will not include them in our final report for the 2016 DSH examination.
- However, we do recommend that you submit your Other Medicaid Eligibles exactly as requested in Exhibit C. Specifically, ensure that you **separately identify** each claims' Medicaid FFS, Medicaid Managed Care, Medicare Traditional, Medicare Managed Care, Private Insurance and Self-Pay payments into their individual columns as laid out in the Exhibit A-C template that was provided.

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

PRIOR YEAR DSH EXAMINATION (2015)

Common Issues Noted During Examination

- **Hospitals had duplicate patient claims in the uninsured, cross-over, and state's Medicaid FFS data.**
- **Patient payor classes that were not updated. (ex. a patient was listed as self-pay and it was determined that they later were Medicaid eligible and paid by Medicaid yet the patient was still claimed as uninsured).**
- **Incorrectly reporting elective (cosmetic surgeries) services and non-Medicaid untimely filings as uninsured patient claims.**

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

PRIOR YEAR DSH EXAMINATION (2015)

Common Issues Noted During Examination

- **Charges and days reported on survey exceeded total charges and days reported on the cost report (by cost center).**
- **Provider's revenue code crosswalk or grouping schedule did not correspond to how the Exhibits were grouped on the survey or agree with cost report groupings.**
- **Inclusion of patients in the uninsured charges listing (Exhibit A) that are concurrently listed as insured in the payments listing (Exhibit B).**
- **Patients listed as both insured and uninsured in Exhibit B for the same dates of service.**

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

14

PRIOR YEAR DSH EXAMINATION (2015)

Common Issues Noted During Examination

- Patient-level documentation on uninsured Exhibit A and uninsured patient payments from Exhibit B did not agree to totals on the survey.
- Under the December 3, 2014 final DSH rule, hospitals reported "Exhausted" / "Insurance Non-Covered" on Exhibit A (Uninsured) but did not report the payments on Exhibit B.

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

PRIOR YEAR DSH EXAMINATION (2015)

Common Issues Noted During Examination

- "Exhausted" / "Insurance Non-Covered" reported in uninsured incorrectly included the following:
  - Services partially exhausted.
  - Denied due to timely filing.
  - Denied for medical necessity.
  - Denials for pre-certification.

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

PRIOR YEAR DSH EXAMINATION (2015)

Common Issues Noted During Examination

- Exhibit B – Patient payments did not always include all patient payments – some hospitals incorrectly limited their data to uninsured patient payments.
- Some hospitals did not include their charity care patients in the uninsured even though they had no third party coverage.

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

PRIOR YEAR DSH EXAMINATION (2015)

Common Issues Noted During Examination

- Medicare cross-over payments did not include all Medicare payments (outlier, cost report settlements, lump-sum/pass-through, payments received after year end, etc.).
- Only uninsured payments are to be on cash basis – all other payor payments must include all payments made for the dates of service as of the examination date.

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

PRIOR YEAR DSH EXAMINATION (2015)

Common Issues Noted During Examination

- Liability insurance claims were incorrectly included in uninsured even when the insurance (e.g., auto policy) made a payment on the claim.
- Hospitals did not report their charity care in the LIUR section of the survey or did not include a break-down of inpatient and outpatient charity.

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

FAQ

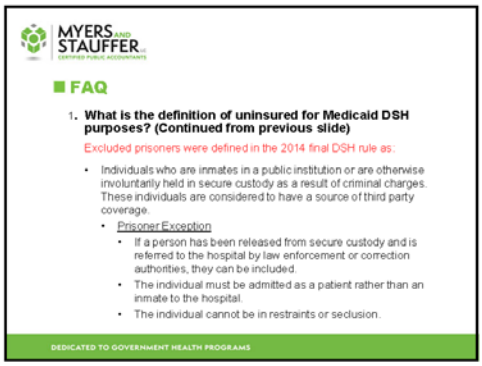
1. **What is the definition of uninsured for Medicaid DSH purposes?**

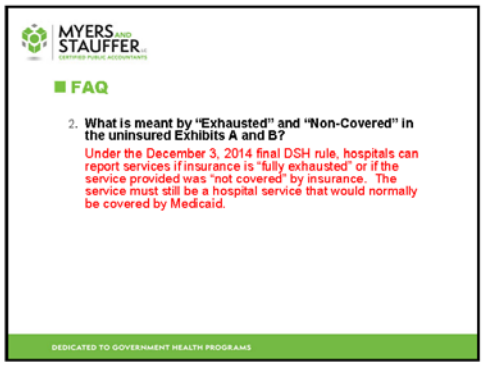
   Uninsured patients are individuals with no source of third party health care coverage (insurance) for the specific inpatient or outpatient hospital service provided. Prisoners must be excluded.

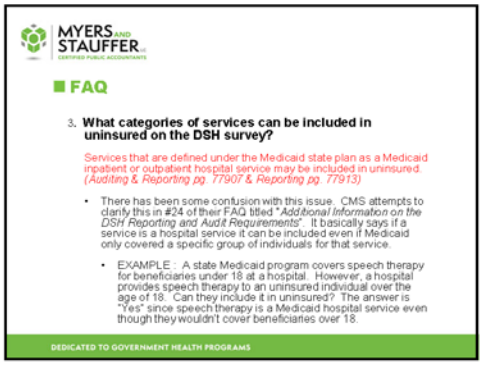
   - On December 3, 2014, CMS finalized the proposed rule published on January 18, 2012 Federal Register to clarify the definition of uninsured and prisoners.
   - Under this final DSH rule, the DSH examination looks at whether a patient is uninsured using a "service-specific" approach.
   - Based on the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

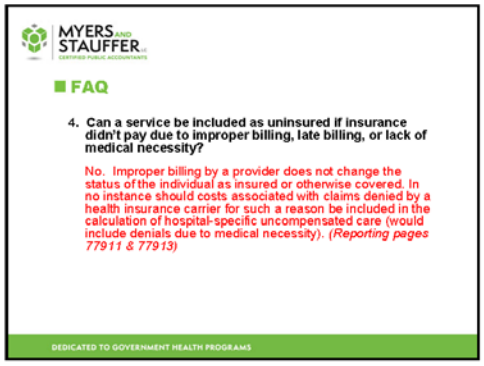
DEDICATED TO GOVERNMENT HEALTH PROGRAMS

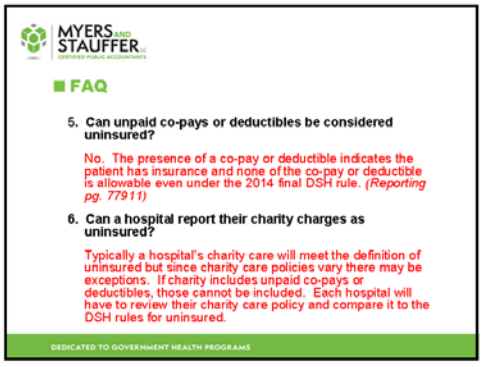
15

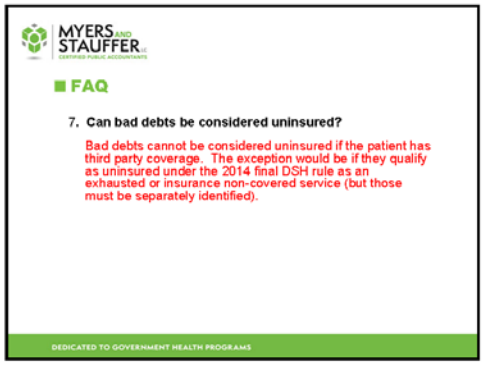

MYERS AND STAUFFER
FAQ
1. What is the definition of uninsured for Medicaid DSH purposes? (Continued from previous slide)
Excluded prisoners were defined in the 2014 final DSH rule as:
• Individuals who are inmates in a public institution or are otherwise involuntarily held in secure custody as a result 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.
DEDICATED TO GOVERNMENT HEALTH PROGRAMS


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.
DEDICATED TO GOVERNMENT HEALTH PROGRAMS

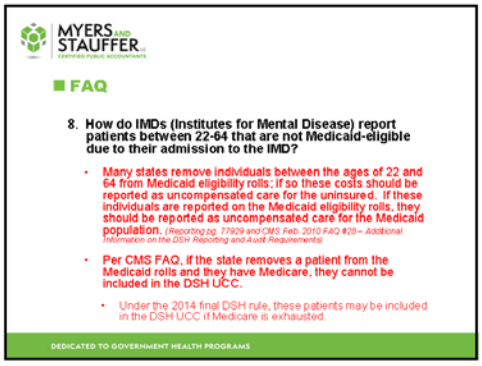

MYERS AND STAUFFER
FAQ
3. What categories of services can be included in uninsured on the DSH survey?
Services that are defined under the Medicaid state plan as a Medicaid inpatient or outpatient hospital service may be included in uninsured. (Auditing & Reporting pg. 77907 & Reporting pg. 77913)
• There 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.
DEDICATED TO GOVERNMENT HEALTH PROGRAMS

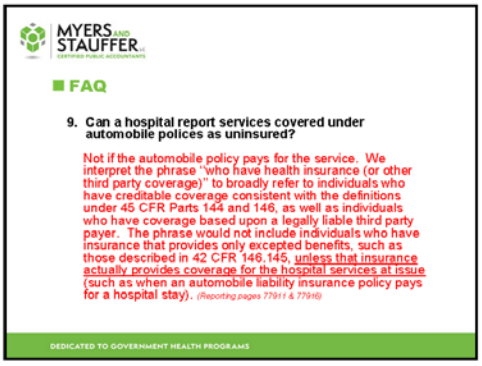

MYERS AND STAUFFER
FAQ
4. Can a service be included as uninsured if insurance didn't pay due to improper billing, late billing, or lack of medical necessity?
No. Improper billing by a provider does not change the status of the individual as insured or otherwise covered. In no instance should costs associated 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)
DEDICATED TO GOVERNMENT HEALTH PROGRAMS

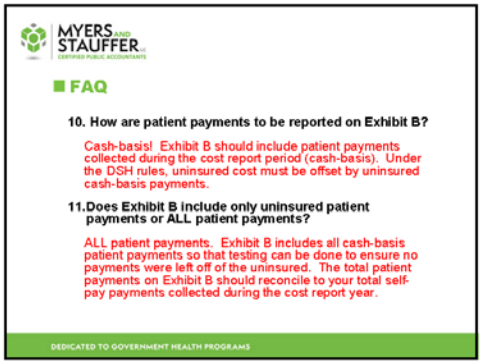

MYERS AND STAUFFER
FAQ
5. Can unpaid co-pays or deductibles be considered uninsured?
No. The presence of a co-pay or deductible indicates the patient has insurance and none of the co-pay or deductible is allowable even under the 2014 final DSH rule. (Reporting pg. 77911)
6. Can a hospital report their 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.
DEDICATED TO GOVERNMENT HEALTH PROGRAMS

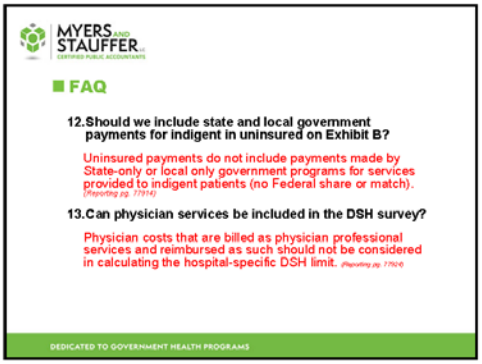

MYERS AND STAUFFER
FAQ
7. Can bad debts be considered uninsured?
Bad debts cannot be considered uninsured if the patient has third party coverage. The exception would be if they qualify as uninsured under the 2014 final DSH rule as an exhausted or insurance non-covered service (but those must be separately identified).
DEDICATED TO GOVERNMENT HEALTH PROGRAMS

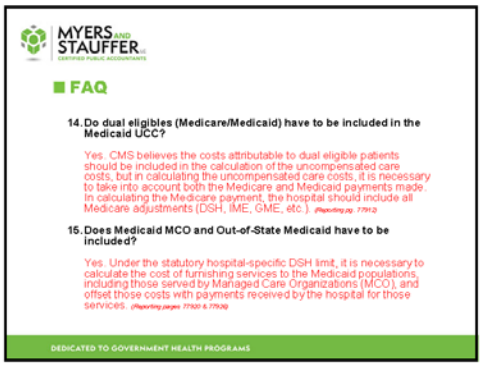
16

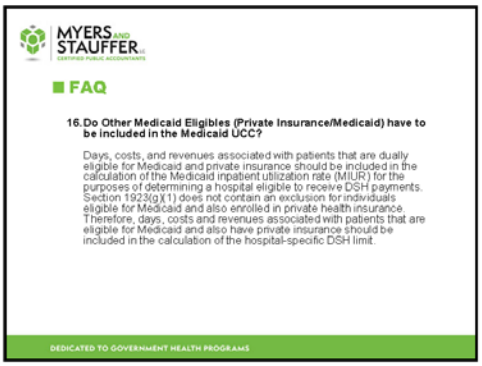

MYERS AND STAUFFER
FAQ
8. How do IMDs (Institutes for Mental Disease) report patients between 22-64 that are not Medicaid-eligible due to their admission to the IMD?
Many states remove individuals between the ages of 22 and 64 from Medicaid eligibility rolls; if so these costs should be reported as uncompensated 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.
DEDICATED TO GOVERNMENT HEALTH PROGRAMS


MYERS AND STAUFFER
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)
DEDICATED TO GOVERNMENT HEALTH PROGRAMS


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. 77912)
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 & 77939)
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.
DEDICATED TO GOVERNMENT HEALTH PROGRAMS

17

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

OTHER INFORMATION

Please use the DSH Part I Survey Submission Checklist when preparing to submit your surveys and supporting documentation.

Upload survey and other data to:
https://dsh.mslc.com

Submit questions to:
(800) 374-6858
MIDSH@mslc.com

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

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

WEB PORTAL

Website: https://dsh.mslc.com

- Contact MIDSH@mslc.com to request registration form or update contact information.
- Must provide valid IP address to be set up to send/receive data.
- Consultants are not permitted to receive files from M&S via email. If you wish for consultants to have access to your data/results, you must include them on your web portal form, submit a separate form for authorization (provided by M&S), or supply the files yourself.

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

WEB PORTAL

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

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

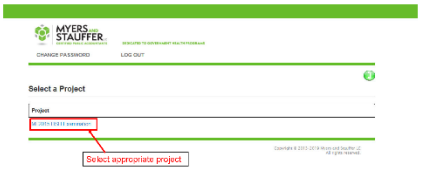
MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

WEB PORTAL

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

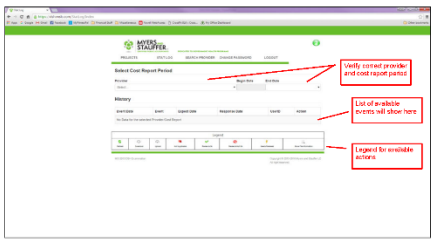
DEDICATED TO GOVERNMENT HEALTH PROGRAMS

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS



DEDICATED TO GOVERNMENT HEALTH PROGRAMS

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS



DEDICATED TO GOVERNMENT HEALTH PROGRAMS

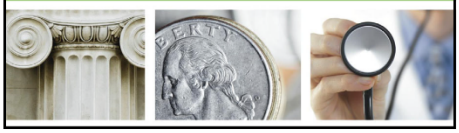
DSH Examination Training – SFY 2014

MYERS AND STAUFFER

DISPROPORTIONATE SHARE HOSPITAL (DSH) PAYMENT EXAMINATION

South Carolina State Fiscal Year 2014

DEDICATED TO GOVERNMENT HEALTH PROGRAMS



MYERS AND STAUFFER

CONTACT INFORMATION

John D. Kraft, CPA, CHFP - Member
JKraft@mslc.com

Diane Kovar, CPA – Senior Manager
dkovar@mslc.com 410.581.4544

Jeff Roumm – Manager
jroumm@mslc.com 410.581.4566

Myers and Stauffer LC
400 Redland Court, Suite 300
Owings Mills, MD 21117
800-505-1698

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

MYERS AND STAUFFER

TRAINING OVERVIEW

- New DSH Developments
- Common Examination Issues
- Review of DSH Survey Forms
- New Web Portal Intro

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

MYERS AND STAUFFER

DSH PAYMENTS REFRESHER

- DSH implemented under Section 1923 of the Social Security Act (42 U.S. Code, Section 1396r-4)
- Medicaid DSH payments are intended to cover ONLY the uncompensated care costs for Medicaid and uninsured (for hospitals that qualify)
- SPRY 2011 was the first year for paybacks/redistributions

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

MYERS AND STAUFFER

NEW 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.

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

MYERS AND STAUFFER

NEW 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 dic 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.

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

1

MYERS AND STAUFFER

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.
  - The proposed rule has been finalized (December 2014), Myers and Stauffer will continue to utilize those definitions as they have been since the 2009 DSH examinations.

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

MYERS AND STAUFFER

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.

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

MYERS AND STAUFFER

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)

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

MYERS AND STAUFFER

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 considered 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 of services.

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

MYERS AND STAUFFER

NEW DSH DEVELOPMENTS

- 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)

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

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).

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

2

MYERS AND STAUFFER

NEW DSH DEVELOPMENTS

- **CMS audits of the DSH audits continue**
  - No formal results have yet been issued
  - 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

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

MYERS AND STAUFFER

MSLC DSH PROCEDURES

- Continue using 2 Surveys to collect DSH Year Data
  - Allows for transparency of the process
  - Providers can see how their data impacts the DSH calculation
- Using NEW Web Portal for submission (to be discussed later)

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

MYERS AND STAUFFER

DSH YEAR 2014 EXAMINATION TIMELINE - TENTATIVE

- March: State MMIS FFS (aka MARS) data reviewed, summarized and distributed
- April: Hospital Data due to MSLC
- May-July: Desk review examinations
- August-October: Expanded Reviews
- November: Draft report due to the state
- December 15: Final report due to State

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

MYERS AND STAUFFER

2013 EXAMINATION RESULTS

- Hospitals paid in excess of Federal DSH limits: 5 out of 63 (7.9%).
- Compliance with documentation requests was generally good
- Fewer findings in 2013 than previous years

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

MYERS AND STAUFFER

COMMON 2013 EXAMINATION ISSUES

- Five hospitals could not submit revenue code detail for Medicaid and/or uninsured data. Days and charges had to be allocated based on Medicare cost report totals or submitted totals. Certain screening procedures designed to identify non-covered services could not be completed.
- Fourteen 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 Medicare cost report totals or submitted totals.

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

MYERS AND STAUFFER

COMMON 2013 EXAMINATION ISSUES

- Four hospitals did not submit Medicaid and/or uninsured patient days by revenue code. As such, claims with multiple routine revenue codes listed were allocated based on days from the Medicare cost report worksheet S-3.
- Three hospitals failed to submit accounts with commercial insurance and/or Medicare managed care as the primary payer and Medicaid (FFS and/or MCO) as the secondary payer. As these populations often generate profits, uncompensated care cost may be overstated due to their exclusion.

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

3

MYERS AND STAUFFER

PAID CLAIMS DATA UPDATE FOR 2014

- Medicaid fee-for-service paid claims data
  - MSLC will send to providers to map and enter into Survey Part II Section H once available. If a hospital is ready to submit its survey before MSLC sends the MMIS FFS claims data or if MMIS FFS data is not ready prior to the due date, please submit survey as is and MSLC will map the FFS claims data using the hospital submitted crosswalk.
  - Reported based on cost report year (using discharge date).
  - At revenue code level.

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

MYERS AND STAUFFER

PAID CLAIMS DATA UPDATE FOR 2014

- Medicare FFS/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 discharge date).

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

MYERS AND STAUFFER

PAID CLAIMS DATA UPDATE FOR 2014

- 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 discharge date).

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

MYERS AND STAUFFER

PAID CLAIMS DATA UPDATE FOR 2014

- 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 discharge date).

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

MYERS AND STAUFFER

PAID CLAIMS DATA UPDATE FOR 2014

- "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).

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

MYERS AND STAUFFER

PAID CLAIMS DATA UPDATE FOR 2014

- "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 2014 DSH examination report.

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

4

MYERS AND STAUFFER

PAID CLAIMS DATA UPDATE FOR 2014

- All Exhibit C Provider Submitted Data
  - Ensure that you ***separately report all*** Medicaid FFS, Medicaid MCO, Medicare FFS, Medicare HMO, private insurance and self-pay payments in Exhibit C.

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

MYERS AND STAUFFER

PAID CLAIMS DATA UPDATE FOR 2014

- 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).

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

MYERS AND STAUFFER

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

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.

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

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 12/31/2013 with the DSH audit of SFY 2013 in the prior year. In the DSH year 2014 exam, Hospital A would only need to submit a survey for their year ending 12/31/2014.
- 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.

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

MYERS AND STAUFFER

DSH EXAMINATION SURVEYS

General Instruction – HCRIS Data

- Myers and Stauffer pre-loads 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.

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

5

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

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.

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

DSH SURVEY PART I – DSH YEAR DATA

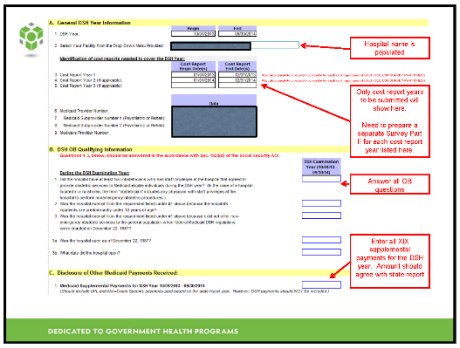
Section C

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

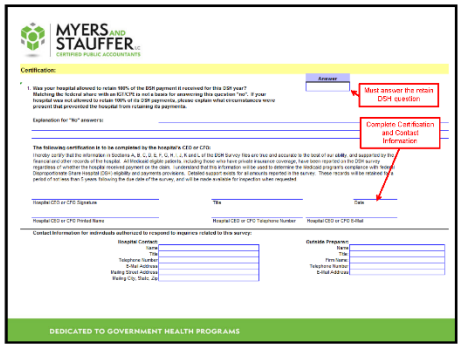
Certification

- 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.

DEDICATED TO GOVERNMENT HEALTH PROGRAMS



DEDICATED TO GOVERNMENT HEALTH PROGRAMS



DEDICATED TO GOVERNMENT HEALTH PROGRAMS

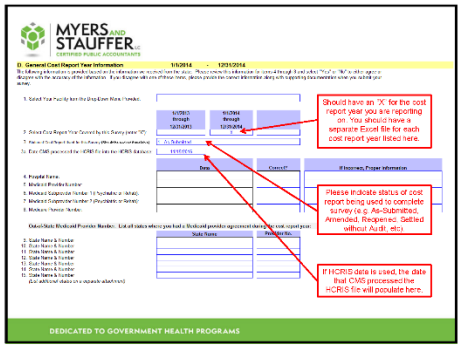
MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

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 has a more recent version of the cost report, select the status of the cost report you are using with this drop-down box and update the cost report data to the more recent cost report.**

DEDICATED TO GOVERNMENT HEALTH PROGRAMS



DEDICATED TO GOVERNMENT HEALTH PROGRAMS

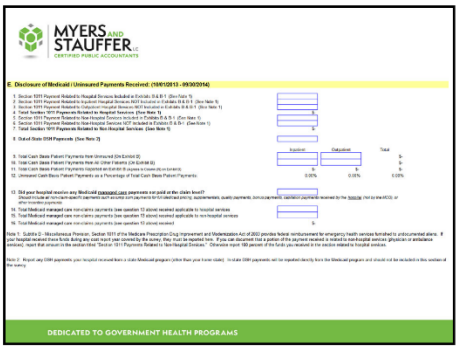
6

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

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.

DEDICATED TO GOVERNMENT HEALTH PROGRAMS



DEDICATED TO GOVERNMENT HEALTH PROGRAMS

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

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. If any subsidies are directed toward non-hospital services, record the subsidies in the non-hospital cell.
- 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 LC
CERTIFIED PUBLIC ACCOUNTANTS

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.

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

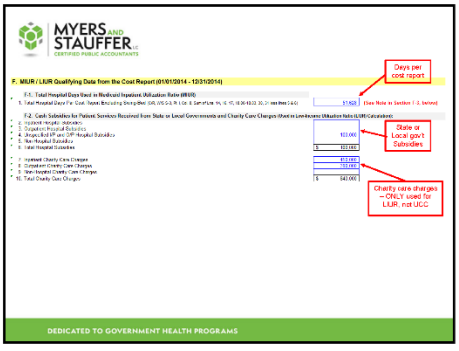
DSH YEAR SURVEY PART II
SECTION F, MIUR/LIUR

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

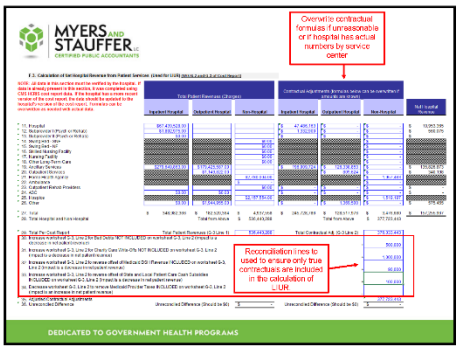
- Bad debt and charity care write-offs not included on G-3, line 2 should be entered on lines 30 and 31 so they can be properly excluded in calculating net patient service revenue utilized in the LIUR.
- Medicaid DSH payments and state and local patient care cash subsidies included on G-3, line 2 should be entered on line 32 and 33 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 34 so it can be properly excluded in calculating net patient service revenue.

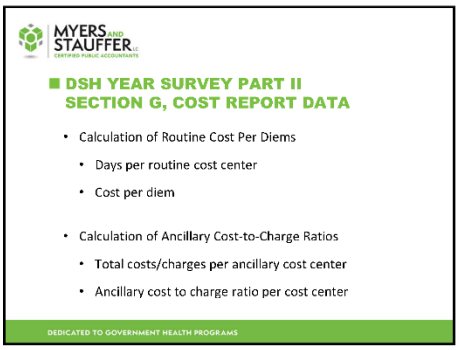
DEDICATED TO GOVERNMENT HEALTH PROGRAMS

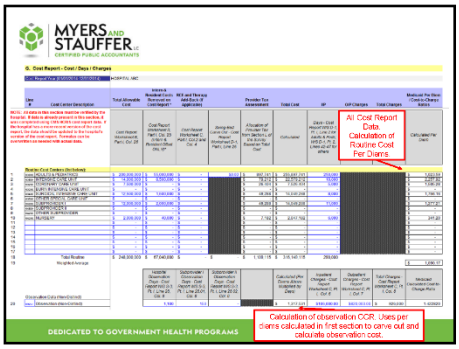
MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

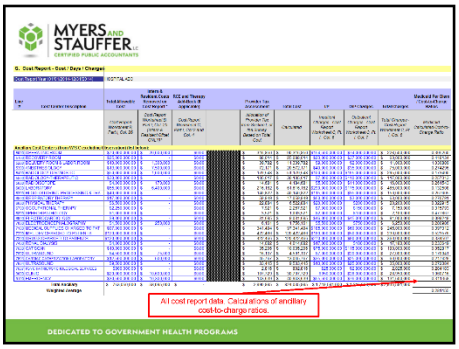


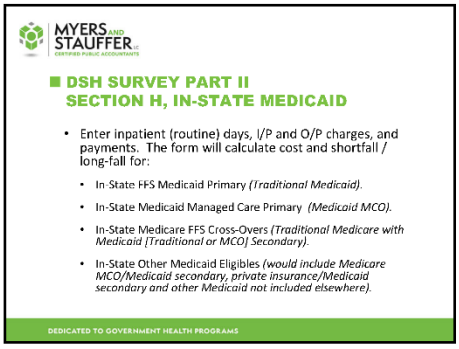
DEDICATED TO GOVERNMENT HEALTH PROGRAMS

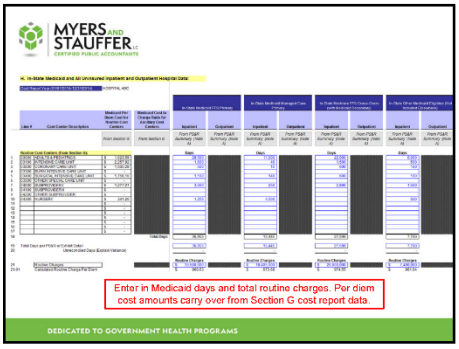

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS
Overwrite contractual formulas if unreasonable or if hospital has actual numbers by service center
Reconciliation lines to used to ensure only true contractuals are included in the calculation of LOS
DEDICATED TO GOVERNMENT HEALTH PROGRAMS


MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS
DSH YEAR SURVEY PART II
SECTION G, COST REPORT DATA
Calculation of Routine Cost Per Diems
Days per routine cost center
Cost per diem
Calculation of Ancillary Cost-to-Charge Ratios
Total costs/charges per ancillary cost center
Ancillary cost to charge ratio per cost center
DEDICATED TO GOVERNMENT HEALTH PROGRAMS

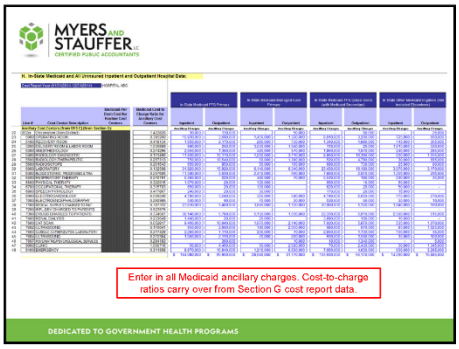

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS
All Cost Report Data. Calculation of Routine Cost Per Diems
Calculation of observation CCR. Uses per diems calculated in first section to carve out and calculate observation cost.
DEDICATED TO GOVERNMENT HEALTH PROGRAMS

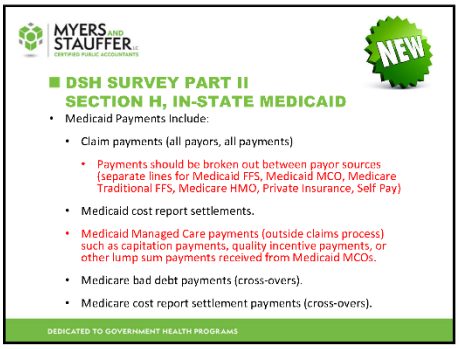

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS
All cost report data. Calculations of ancillary cost-to-charge ratios.
DEDICATED TO GOVERNMENT HEALTH PROGRAMS

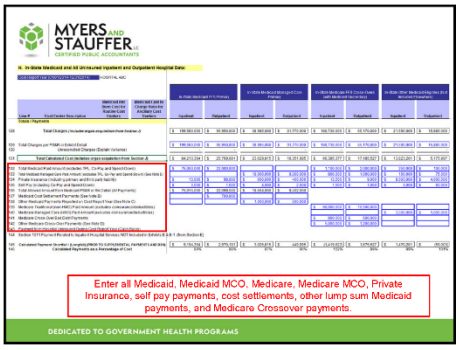

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS
DSH SURVEY PART II
SECTION H, IN-STATE MEDICAID
Enter inpatient (routine) days, I/P and O/P charges, and payments. The form will calculate cost and shortfall / long-fall for:
In-State FFS Medicaid Primary (Traditional Medicaid).
In-State Medicaid Managed Care Primary (Medicaid MCO).
In-State Medicare FFS Cross-Overs (Traditional Medicare with Medicaid [Traditional or MCO] Secondary).
In-State Other Medicaid Eligibles (would include Medicare MCO/Medicaid secondary, private insurance/Medicaid secondary and other Medicaid not included elsewhere).
DEDICATED TO GOVERNMENT HEALTH PROGRAMS

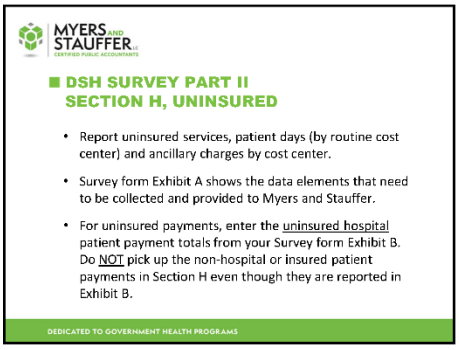

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS
Enter in Medicaid days and total routine charges. Per diem cost amounts carry over from Section G cost report data.
DEDICATED TO GOVERNMENT HEALTH PROGRAMS

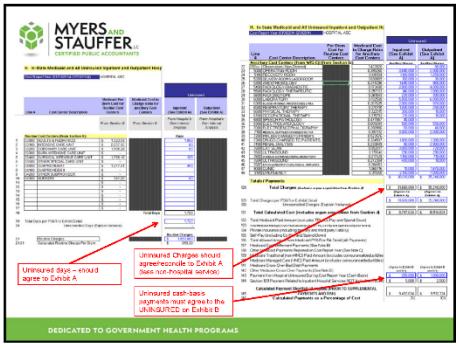
8

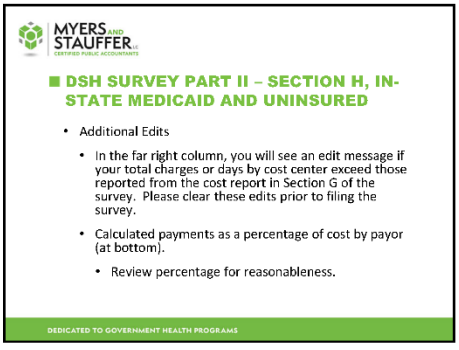

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS
Enter in all Medicaid ancillary charges. Cost-to-charge ratios carry over from Section G cost report data.
DEDICATED TO GOVERNMENT HEALTH PROGRAMS

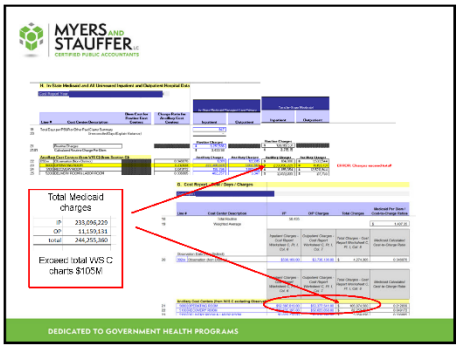

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS
NEW
DSH SURVEY PART II
SECTION H, IN-STATE MEDICAID
Medicaid Payments Include:
Claim payments (all payors, all payments)
Payments should be broken out between payor sources (separate lines for Medicaid FFS, Medicaid MCO, Medicare Traditional FFS, Medicare HMO, Private Insurance, Self Pay)
Medicaid cost report settlements.
Medicaid Managed Care payments (outside claims process) such as capitation payments, quality incentive payments, or other lump sum payments received from Medicaid MCOs.
Medicare bad debt payments (cross-overs).
Medicare cost report settlement payments (cross-overs).
DEDICATED TO GOVERNMENT HEALTH PROGRAMS

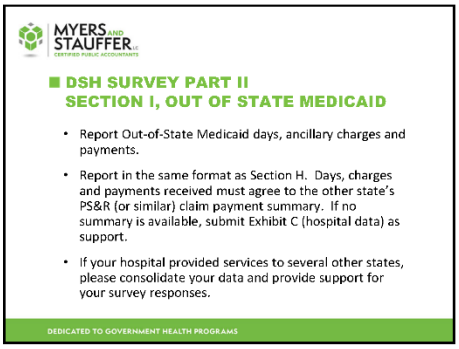

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS
Enter all Medicaid, Medicaid MCO, Medicare, Medicare MCO, Private Insurance, self pay payments, cost settlements, other lump sum Medicaid payments, and Medicare Crossover payments.
DEDICATED TO GOVERNMENT HEALTH PROGRAMS

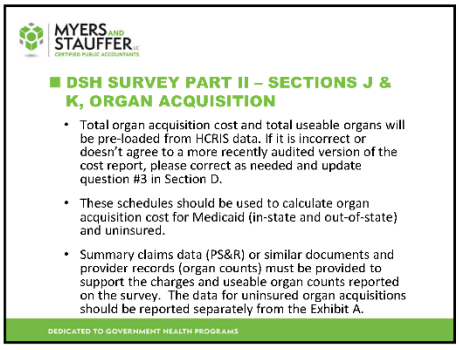

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS
DSH SURVEY PART II
SECTION H, UNINSURED
Report uninsured services, patient days (by routine cost center) and ancillary charges by cost center.
Survey form Exhibit A shows the data elements that need to be collected and provided to Myers and Stauffer.
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

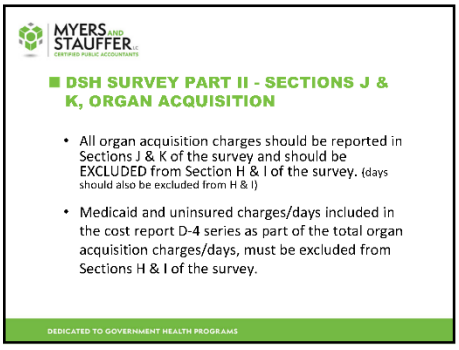

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS
Uninsured days – should agree to Exhibit A
Uninsured Charges should agree/reconcile to Exhibit A (non-hospital service)
Uninsured cash-basis payments must agree to the UNINSURED on Exhibit B
DEDICATED TO GOVERNMENT HEALTH PROGRAMS

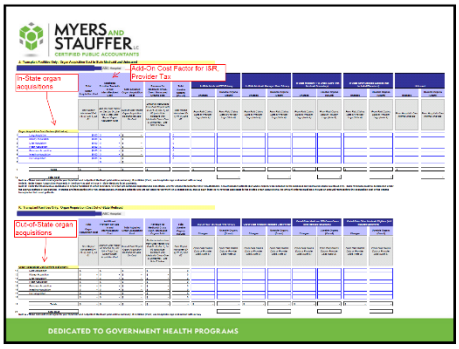

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS
DSH SURVEY PART II – SECTION H, IN-STATE MEDICAID AND UNINSURED
Additional Edits
In the far right column, you will see an edit message if your total charges or days by cost center exceed those reported from the cost report in Section G of the survey. Please clear these edits prior to filing the survey.
Calculated payments as a percentage of cost by payor (at bottom).
Review percentage for reasonableness.
DEDICATED TO GOVERNMENT HEALTH PROGRAMS

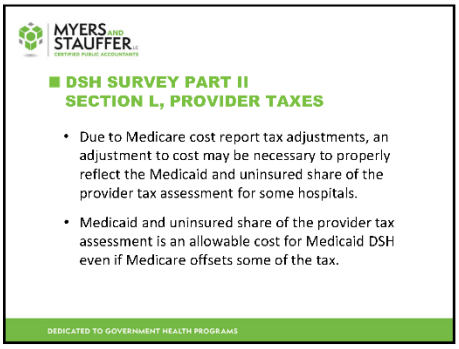

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS
Total Medicaid charges
IP 233,056,229
OP 11,199,131
Total 244,255,360
Excluded Total VVS C charrs $105M
DEDICATED TO GOVERNMENT HEALTH PROGRAMS


MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS
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.
DEDICATED TO GOVERNMENT HEALTH PROGRAMS


MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS
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.
DEDICATED TO GOVERNMENT HEALTH PROGRAMS


MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS
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.
DEDICATED TO GOVERNMENT HEALTH PROGRAMS


MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS
Add-On Cost Factor for ISR Provider Tax
In-State organ acquisitions
Out-of-State organ acquisitions
DEDICATED TO GOVERNMENT HEALTH PROGRAMS


MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS
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.
DEDICATED TO GOVERNMENT HEALTH PROGRAMS

10

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

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).

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

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

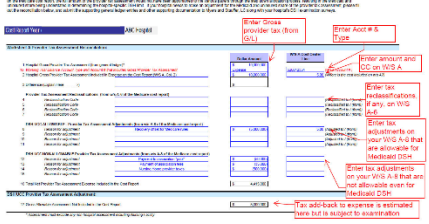
MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

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., costs).

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS



DEDICATED TO GOVERNMENT HEALTH PROGRAMS

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

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.

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

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, Private Insurance, Claim Status fields, and Medical Record #.
  - A complete list (key) of payor plans is required to be submitted separately with the survey.

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

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).

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

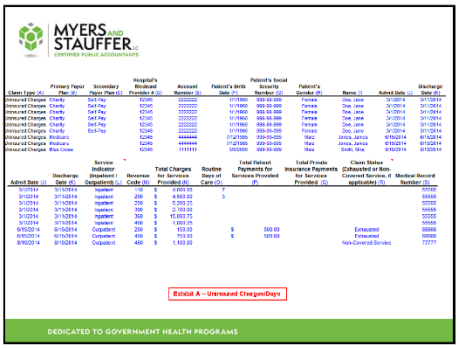


Exhibit A – Uninsured Charges/Days

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

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

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 2014 cost report year that relates to a service provided in the 2005 cost report year, must be used to reduce uninsured cost for the 2014 cost report year.

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

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).

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

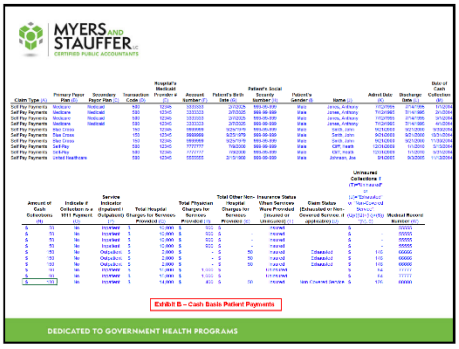


Exhibit B – Cash Basis Patient Payments

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

EXHIBIT C – HOSPITAL-PROVIDED MEDICAID DATA

- Medicaid data reported on the survey should 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.

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

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 Medicare Traditional/Medicaid 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).

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

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 Traditional Payments,* ***Medicare Managed Care Payments****, Medicaid FFS Payments,* ***Medicaid Managed Care Payments****, Private Insurance 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).

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

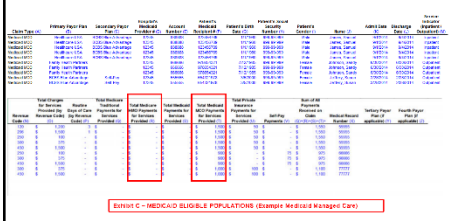


Exhibit C – MEDICAID ELIGIBLE POPULATIONS (Example Medicaid Managed Care)

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

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.

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

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.

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

MYERS AND STAUFFER

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.

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

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.

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

MYERS AND STAUFFER

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.

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

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.

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

MYERS AND STAUFFER

DSH SURVEY PART I – DSH YEAR DATA

Submission Checklist (cont.)

15. Revenue code cross-walk used to prepare cost report (i.e. revenue code to Medicare cost report cost center crosswalk).
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).

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

MYERS AND STAUFFER

DSH SURVEY PART I – DSH YEAR DATA

Submission Checklist (cont.)

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).
20. Documentation supporting any Medicaid Managed Care payments outside the normal claims process for the cost reporting period under review, including Medicaid MCO quality incentive payments, capitation payments, or any other Medicaid MCO lump sum payments.

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

14

MYERS AND STAUFFER

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

MYERS AND STAUFFER

OTHER INFORMATION

Please use the DSH Part I Survey Submission Checklist when preparing to submit your surveys and supporting documentation.

Upload survey and other data to NEW Web Portal:
https://dsh.mslc.com

Submit questions to:
(800) 505-1698
jroumm@mslc.com or dkovar@mslc.com

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

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

MYERS AND STAUFFER

WEB PORTAL

Website: https://dsh.mslc.com

- Contact jroumm@mslc.com to request registration form or update contact information.
- Must provide valid IP address to be set up to send/receive data.

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

MYERS AND STAUFFER

WEB PORTAL

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

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

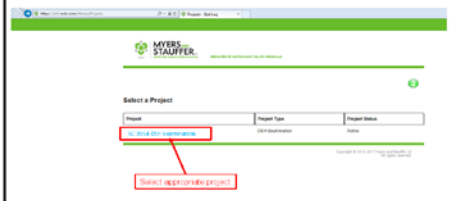
MYERS AND STAUFFER

WEB PORTAL

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

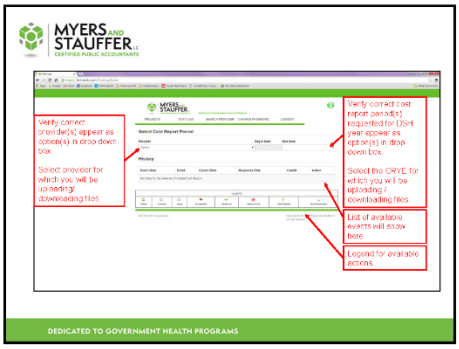
DEDICATED TO GOVERNMENT HEALTH PROGRAMS

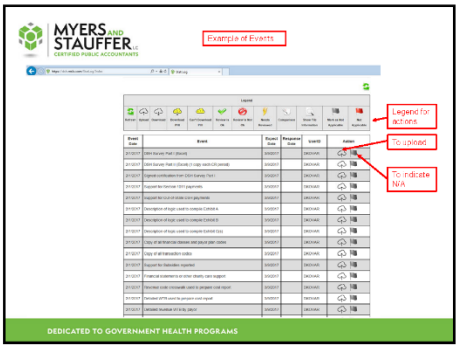
MYERS AND STAUFFER

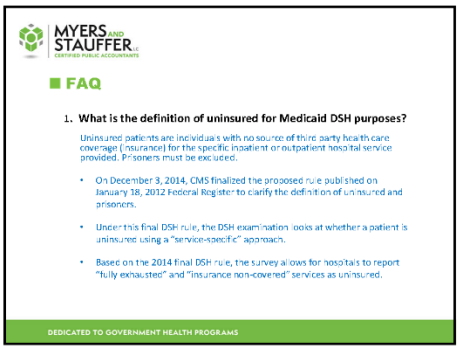


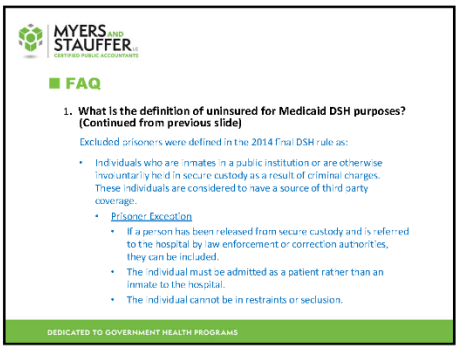
DEDICATED TO GOVERNMENT HEALTH PROGRAMS

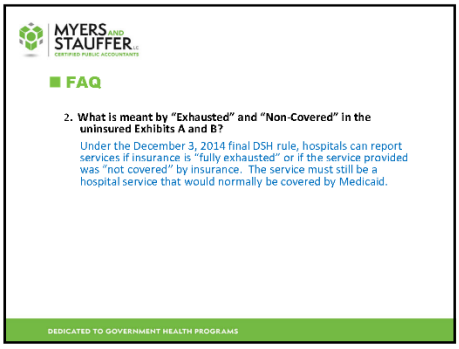
15

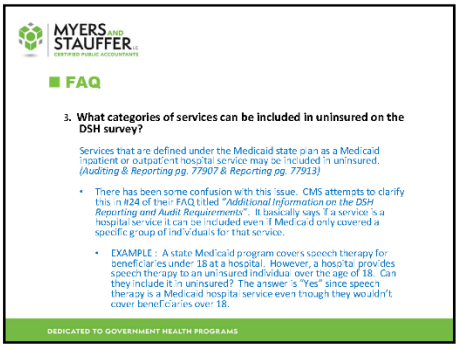

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS
Verify correct provider(s) appear as option(s) in drop down box.
Select provider for which you will be uploading/ downloading files.
Verify correct cost report period(s) requested for DSH year appear as option(s) in drop down box.
Select the CR'YE for which you will be uploading / downloading files.
List of available events will show here.
Legend for available actions.
DEDICATED TO GOVERNMENT HEALTH PROGRAMS

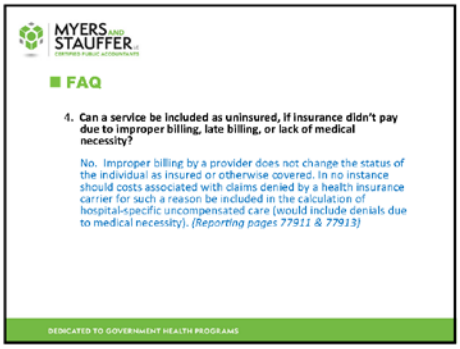

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS
Example of Events
Legend for actions
To upload
To indicate N/A
DEDICATED TO GOVERNMENT HEALTH PROGRAMS

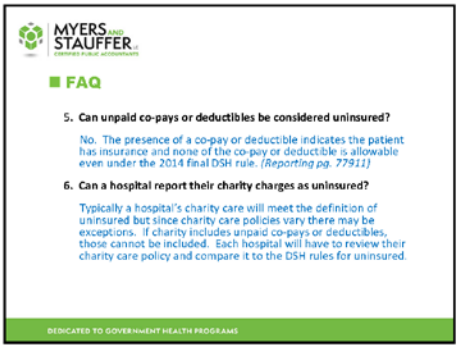

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS
FAQ
1. What is the definition of uninsured for Medicaid DSH purposes?
Uninsured patients are individuals with no source of third party health care coverage (insurance) for the specific inpatient or outpatient hospital service provided. Prisoners must 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

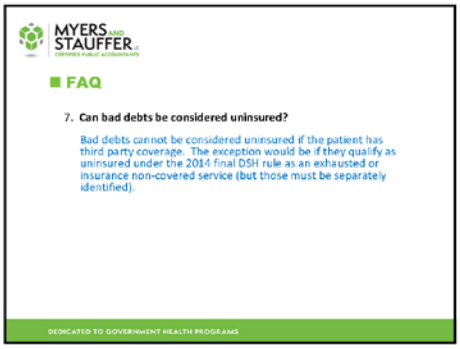

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS
FAQ
1. What is the definition of uninsured for Medicaid DSH purposes? (Continued from previous slide)
Excluded prisoners were defined in the 2014 final DSH rule as:
• Individuals who are inmates in a public institution or are otherwise involuntarily 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.
DEDICATED TO GOVERNMENT HEALTH PROGRAMS

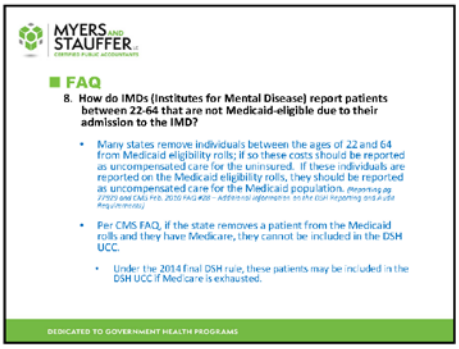

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS
FAQ
2. What is meant by "Exhausted" and "Non-Covered" in the uninsured Exhibits A and B?
Under the December 3, 2014 final DSH rule, hospitals can report services if insurance is "fully exhausted" or if the service provided was "not covered" by insurance.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

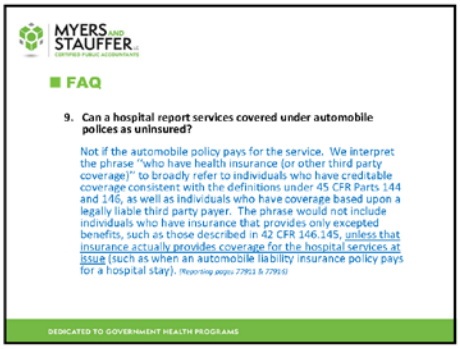

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS
FAQ
3. What categories of services can be included in uninsured on the DSH survey?
Services that are defined under the Medicaid state plan as a Medicaid inpatient or outpatient hospital service may be included in uninsured. (Auditing & Reporting pg. 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.
DEDICATED TO GOVERNMENT HEALTH PROGRAMS

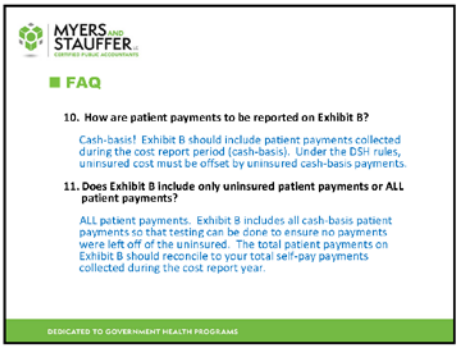

MYERS AND STAUFFER
FAQ
4. Can a service be included as uninsured, if insurance didn't pay due to improper billing, late billing, or lack of medical necessity?
No. Improper billing by a provider does not change the status of the individual as insured or otherwise covered. In no instance should costs associated 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)
DEDICATED TO GOVERNMENT HEALTH PROGRAMS


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.
DEDICATED TO GOVERNMENT HEALTH PROGRAMS


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).
DEDICATED TO GOVERNMENT HEALTH PROGRAMS


MYERS AND STAUFFER
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. 77909 and CMS Feb. 2016 FAQ #08 – 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.
DEDICATED TO GOVERNMENT HEALTH PROGRAMS


MYERS AND STAUFFER
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 77913 & 77915)
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

17

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).

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.

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

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.).

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.

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.

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

MYERS AND STAUFFER

QUESTIONS/COMMENTS?

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

MYERS AND STAUFFER

CONTACT INFORMATION

John D. Kraft, CPA, CHFP - Member
JKraft@mslc.com

Diane Kovar, CPA – Senior Manager
dkovar@mslc.com 410.581.4544

Jeff Roumm – Manager
jroumm@mslc.com 410.581.4566

Myers and Stauffer LC
400 Redland Court, Suite 300
Owings Mills, MD 21117
800-505-1698

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

MYERS AND STAUFFER

APPENDIX - WEBSITES

CMS DSH https://www.cms.gov/medicare/medicare-fee-for-service-payment/acutehospitalinpatpps/dsh.html

Final DSH Rule 12/03/2014 https://www.gpo.gov/fdsys/pkg/FR-2014-12-03/pdf/2014-28424.pdf

General DSH Audit and Reporting Protocol https://downloads.cms.gov/cmsgov/archived-downloads/MedicaidGenInfo/downloads/cms2198fcatprotocol.pdf

CMS Additional Info on DSH Reporting & Audit Requirements https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Financing-and-Reimbursement/Downloads/AdditionalInformationonDSH-Reporting.pdf

CMS Additional Info on DSH Reporting & Audit Requirements Part 2 https://www.medicaid.gov/medicaid-chip-program-information/by-topics/financing-and-reimbursement/downloads/part-2-additional-info-on-dsh-reporting-and-auditing.pdf

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

DSH Examination Training – DSH Year 2015

MYERS AND STAUFFER

DISPROPORTIONATE SHARE HOSPITAL (DSH) PAYMENT EXAMINATION

New Hampshire State DSH Year 2015

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

MYERS AND STAUFFER

CONTACT INFORMATION

John D. Kraft, CPA, CHFP - Member
Jkraft@mslc.com

Diane Kovar, CPA – Senior Manager
dkovar@mslc.com 410.581.4544

Kristie Masilek – Manager
kmasilek@mslc.com 410.581.4546

Myers and Stauffer LC
400 Redland Court, Suite 300
Owings Mills, MD 21117
800-505-1698

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

MYERS AND STAUFFER

TRAINING OVERVIEW

- **DSH Refresher**
- **Review of DSH Survey Forms**

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

MYERS AND STAUFFER

DSH REFRESHER

- DSH implemented under Section 1923 of the Social Security Act (42 U.S. Code, Section 1396r-4)
- Medicaid DSH payments are intended to cover ONLY the uncompensated care costs for Medicaid and uninsured (for hospitals that qualify)
- SPRY 2011 was the first year for paybacks/redistributions

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

MYERS AND STAUFFER

DSH REFRESHER - UNINSURED

- 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)

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

MYERS AND STAUFFER

DSH REFRESHER - UNINSURED

- 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 considered 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 of services.

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

1

MYERS AND STAUFFER

DSH REFRESHER - UNINSURED

- 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)

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

MYERS AND STAUFFER

MSLC DSH PROCEDURES

- Continue using 2 Surveys to collect DSH Year Data
  - Allows for more transparency of the process
  - Providers can see how their data impacts the DSH calculation
- Using MSLC web portal to distribute requests and receive submissions (https://dsh.mslc.com/)

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

MYERS AND STAUFFER

DSH YEAR 2015 EXAMINATION TIMELINE - TENTATIVE

- April: State MMIS FFS data reviewed, summarized and distributed . Surveys sent to providers.
- May: Hospital Data due to MSLC
- June - August: Desk review examinations
- August - September: Expanded Reviews
- September 30: Draft report due to the State
- December 31: Final report due to the State

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

MYERS AND STAUFFER

PAID CLAIMS DATA UPDATE FOR 2015

- Medicaid fee-for-service paid claims data
  - Included State FFS data summaries on the web portal with the surveys to map and enter into Survey Part II Section H.
  - Same format as last year.
  - Reported based on cost report year (using discharge date).
  - At revenue code level.
  - Detailed data is available upon request.

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

MYERS AND STAUFFER

PAID CLAIMS DATA UPDATE FOR 2015

- Medicare FFS/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 discharge date).
  - At revenue code level.

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

MYERS AND STAUFFER

PAID CLAIMS DATA UPDATE FOR 2015

- Medicaid managed care paid claims data
  - If the hospital cannot obtain a paid claims listing from the MCOs, 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 discharge date).
  - At revenue code level.

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

2

MYERS AND STAUFFER

PAID CLAIMS DATA UPDATE FOR 2015

- 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 discharge date).
  - At revenue code level.

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

MYERS AND STAUFFER

PAID CLAIMS DATA UPDATE FOR 2015

- "Other" Medicaid Eligibles
  - This population would include Medicare MCO primary/Medicaid secondary claims, private insurance primary/Medicaid secondary claims, and any other Medicaid eligible claims not included elsewhere.
  - 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 and therefore should be included in this population.
  - The hospital should send eligible services 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 discharge date).
  - At revenue code level.

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

MYERS AND STAUFFER

PAID CLAIMS DATA UPDATE FOR 2015

- All Exhibit C Provider Submitted Data
  - Ensure that you ***separately report all*** Medicaid FFS, Medicaid MCO, Medicare FFS, Medicare HMO, private insurance and self-pay payments in Exhibit C.

IMPORTANT NOTE:

The State of New Hampshire has elected not to require hospitals to submit Medicare FFS, Medicare HMO or private insurance payments at this time. This applies throughout the DSH survey requests and the following slides of this presentation.

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

MYERS AND STAUFFER

PAID CLAIMS DATA UPDATE FOR 2015

- 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).

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

MYERS AND STAUFFER

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

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.

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

3

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

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 12/31/2014 with the DSH audit of SFY 2014 in the prior year. In the DSH year 2015 exam, Hospital A would only need to submit a survey for their year ending 12/31/2015.
- 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.

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

DSH EXAMINATION SURVEYS

General Instruction – HCRIS Data

- Myers and Stauffer pre-loads certain sections of Survey 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.

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

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.

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

DSH SURVEY PART I – DSH YEAR DATA

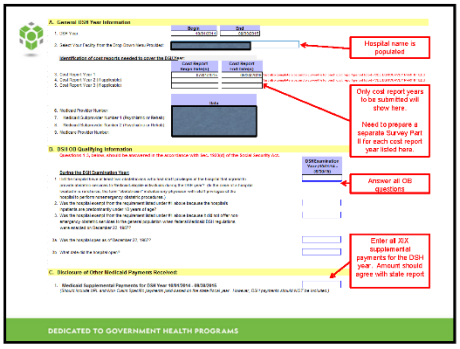
Section C

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

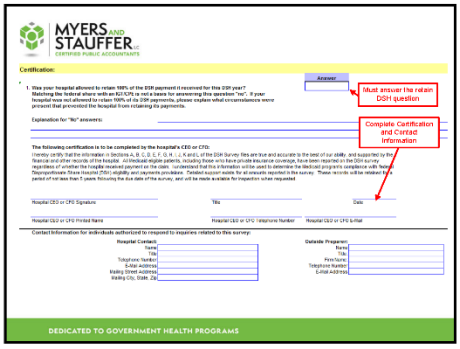
Certification

- 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.

DEDICATED TO GOVERNMENT HEALTH PROGRAMS



DEDICATED TO GOVERNMENT HEALTH PROGRAMS



DEDICATED TO GOVERNMENT HEALTH PROGRAMS

4

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

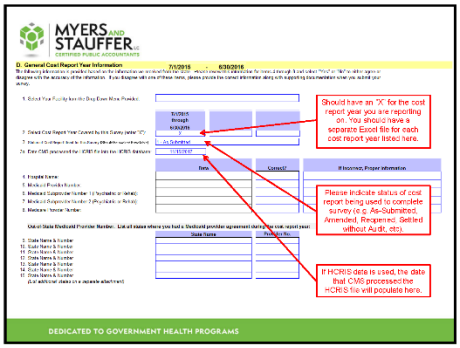
DSH YEAR SURVEY PART II SECTION D – GENERAL INFORMATION

Submit one copy of the Survey 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 has a more recent version of the cost report, select the status of the cost report you are using with this drop-down box and update the cost report data to the more recent cost report.**

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS



DEDICATED TO GOVERNMENT HEALTH PROGRAMS

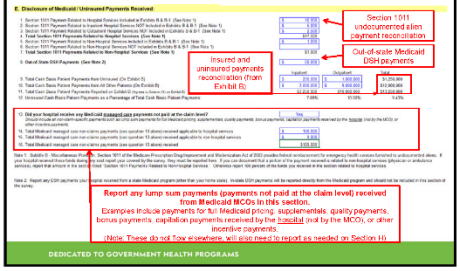
MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

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.

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS



DEDICATED TO GOVERNMENT HEALTH PROGRAMS

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

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. If any subsidies are directed toward non-hospital services, record the subsidies in the non-hospital cell.
- 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 LC
CERTIFIED PUBLIC ACCOUNTANTS

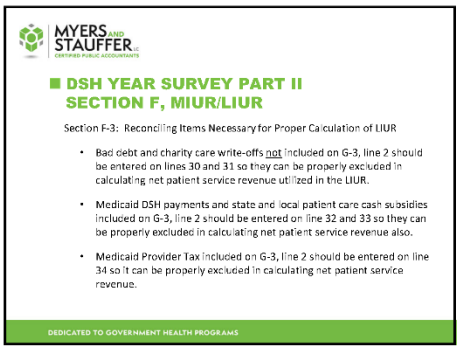
DSH YEAR SURVEY PART II SECTION F, MIUR/LIUR

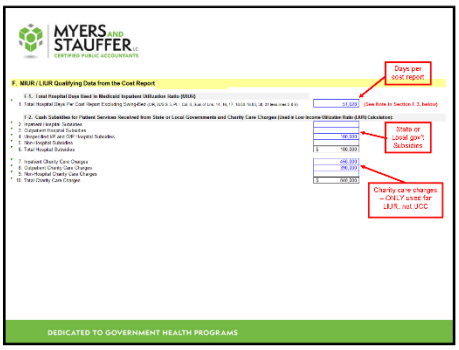
Section F-3: Report hospital revenues and contractual adjustments.

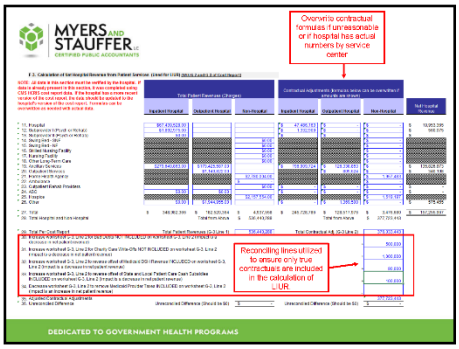
- Myers and Stauffer will pre-load CMS HCRIS cost report data into this section. If it is incorrect or doesn't agree to a more recently audited version of the cost report, please correct as needed and update question #3 in Section D.
- Totals should agree with the cost report worksheets G-2 and G-3. 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.

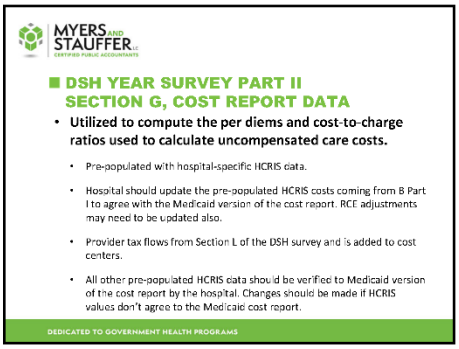
DEDICATED TO GOVERNMENT HEALTH PROGRAMS

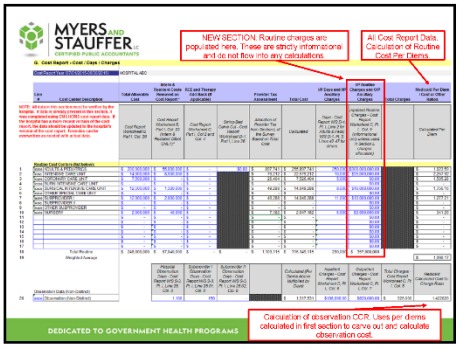
5

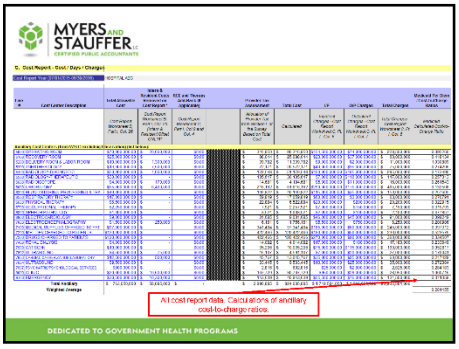

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS
DSH YEAR SURVEY PART II
SECTION F, MIUR/LIUR
Section F-3: Reconciling Items Necessary for Proper Calculation of LIUR
Bad debt and charity care write-offs not included on G-3, line 2 should be entered on lines 30 and 31 so they can be properly excluded 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 32 and 33 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 34 so it can be properly excluded in calculating net patient service revenue.
DEDICATED TO GOVERNMENT HEALTH PROGRAMS


MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS
Days per cost report
State or Local gov't Subsidies
Charity care charges – ONLY used for LIUR, not UCC
DEDICATED TO GOVERNMENT HEALTH PROGRAMS


MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS
Overwrite contractual formulas if unreasonable or if hospital has actual numbers by service center
Reconciling lines utilized to ensure only true contractuals are included in the calculation of LIUR
DEDICATED TO GOVERNMENT HEALTH PROGRAMS


MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS
DSH YEAR SURVEY PART II
SECTION G, COST REPORT DATA
Utilized to compute the per diems and cost-to-charge ratios used to calculate uncompensated care costs.
Pre-populated with hospital-specific HCRIS data.
Hospital should update the pre-populated HCRIS costs coming from B Part I to agree with the Medicaid version of the cost report. RCE adjustments may need to be updated also.
Provider tax flows from Section L of the DSH survey and is added to cost centers.
All other pre-populated HCRIS data should be verified to Medicaid version of the cost report by the hospital. Changes should be made if HCRIS values don't agree to the Medicaid cost report.
DEDICATED TO GOVERNMENT HEALTH PROGRAMS


MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS
NEW SECTION: Routine charges are populated here. These are strictly informational and do not flow into any calculations.
All Cost Report Data. Calculation of Routine Cost Per Diems.
Calculation of observation CCR. Users per diems calculated in first section to carve out and calculate observation cost.
DEDICATED TO GOVERNMENT HEALTH PROGRAMS


MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS
All cost report data. Calculations of ancillary cost-to-charge ratios.
DEDICATED TO GOVERNMENT HEALTH PROGRAMS

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

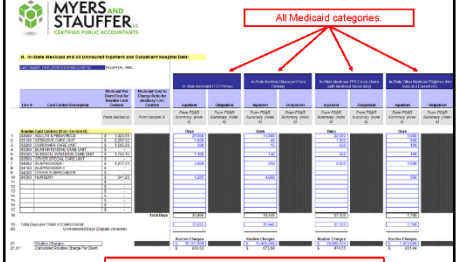
DSH SURVEY PART II
SECTION H, IN-STATE MEDICAID

- 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) from state's paid claims summaries.*
  - In-State Medicaid Managed Care Primary *(Medicaid MCO) supported by an Exhibit C.*
  - In-State Medicare FFS Cross-Overs *(Traditional Medicare with Medicaid [Traditional or MCO] Secondary) supported by an Exhibit C.*
  - In-State Other Medicaid Eligibles *(would include Medicare MCO/Medicaid secondary, private insurance/Medicaid secondary and other Medicaid not included elsewhere) supported by an Exhibit C.*

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

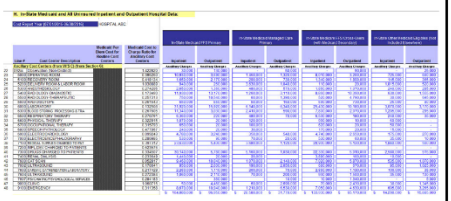
All Medicaid categories.



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
CERTIFIED PUBLIC ACCOUNTANTS



Enter in all Medicaid ancillary charges. Cost-to-charge ratios carry over from Section G cost report data.

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

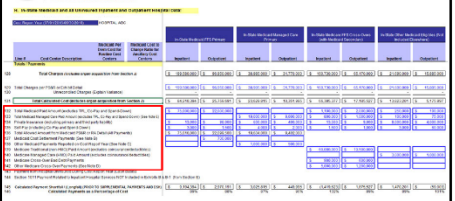
MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

DSH SURVEY PART II
SECTION H, IN-STATE MEDICAID

- Medicaid Payments Include:
  - Claim payments (all payors, all payments)
    - Payments should be broken out between payor sources (separate lines for Medicaid FFS, Medicaid MCO, Medicare Traditional FFS, Medicare HMO, Private Insurance, Self Pay)
  - Medicaid cost report settlements.
  - Medicaid Managed Care payments (outside claims process) such as capitation payments, quality incentive payments, or other lump sum payments received from Medicaid MCOs.
  - Medicare bad debt payments (cross-overs).
  - Medicare cost report settlement payments (cross-overs).

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS



Enter all Medicaid FFS, Medicaid MCO, Medicare, Medicare MCO, Private Insurance, self pay payments, cost settlements, other lump sum Medicaid payments, and Medicare Crossover payments.

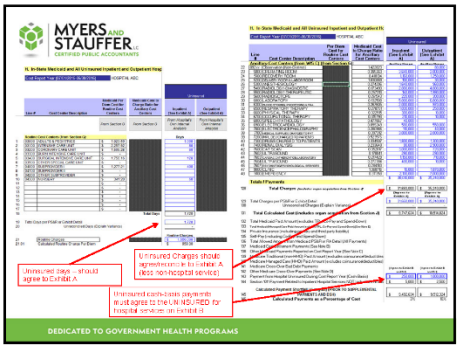
DEDICATED TO GOVERNMENT HEALTH PROGRAMS

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

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



MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

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.
    - The errors occur when the cost report groupings differ from the grouping methodology used to complete the DSH survey.
  - Calculated payments as a percentage of cost by payor (at bottom).
    - Review percentage for reasonableness.

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

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

- Additional Edits
  - On Section H and I, in the cross-over columns, there will be an edit above the days section that will pop up if you enter more cross-over days on the DSH survey than are included in Medicare days on W/S S-3 of the cost report per HCRIS data.
    - Please review your data if this occurs and correct the issue prior to filing the survey.

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

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

- Additional Edits
  - New Edit: On Section H, in column AY, there is a % Survey to Cost Report Totals column. The percentages listed in this column are calculating total in-state and out-of-state days and charges divided by total cost report days and charges by cost center, and in total.
    - Please review your data if this occurs and correct the issue prior to filing the survey.

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

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.

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

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.

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

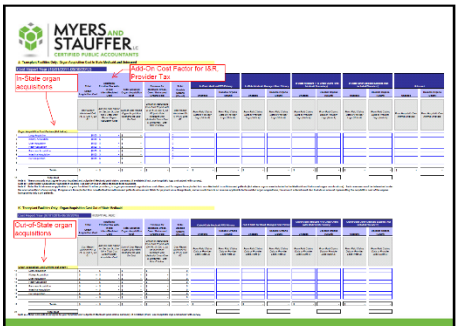
MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

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.

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS



DEDICATED TO GOVERNMENT HEALTH PROGRAMS

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

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.

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

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

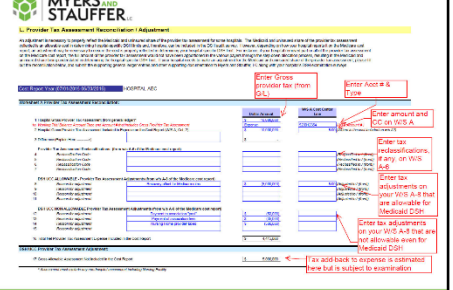
MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

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., costs).

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS



DEDICATED TO GOVERNMENT HEALTH PROGRAMS

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

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 discharge dates 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.

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

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, Private Insurance, Claim Status fields, and Medical Record #.
  - A complete list (key) of payor plans is required to be submitted separately with the survey.

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

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).
- Data not submitted in the correct format may be returned to the hospital requesting revisions to get the data into the prescribed Exhibit A format.

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

Claim Type (A)	Primary Payor Plan (B)	Secondary Payor Plan (C)	Hospital's Medicaid Provider # (D)	Account # (E)	Patient's Birth Date (F)	Patient's Social Security Number (G)	Patient's Gender (H)	Name (I)	Admit Date (J)	Discharge Date (K)
Uninsured Charges	Charity	Self-Pay	12345	2222222	1/1/1960	999-99-9999	Female	Doe, Jane	3/1/2013	3/11/2013
Uninsured Charges	Charity	Self-Pay	12345	2222222	1/1/1960	999-99-9999	Female	Doe, Jane	3/1/2013	3/11/2013
Uninsured Charges	Charity	Self-Pay	12345	2222222	1/1/1960	999-99-9999	Female	Doe, Jane	3/1/2013	3/11/2013
Uninsured Charges	Charity	Self-Pay	12345	2222222	1/1/1960	999-99-9999	Female	Doe, Jane	3/1/2013	3/11/2013
Uninsured Charges	Charity	Self-Pay	12345	2222222	1/1/1960	999-99-9999	Female	Doe, Jane	3/1/2013	3/11/2013
Uninsured Charges	Charity	Self-Pay	12345	2222222	1/1/1960	999-99-9999	Female	Doe, Jane	3/1/2013	3/11/2013
Uninsured Charges	Medicare		12345	4444444	7/12/1985	999-99-9999	Male	Jones, James	6/15/2013	6/15/2013
Uninsured Charges	Medicare		12345	4444444	7/12/1985	999-99-9999	Male	Jones, James	6/15/2013	6/15/2013
Uninsured Charges	Blue Cross		12345	1111111	3/5/2000	999-99-9999	Male	Smith, Mike	8/10/2013	8/10/2013

Discharge Date (K)	Service Indicator (Inpatient / Outpatient) (L)	Revenue Code (M)	Total Charges for Services Provided (by Revenue Code) (N)	Routine Days of Care (by Revenue Code) (O)	Total Patient Payments for Services Provided (P)	Total Private Insurance Payments for Services Provided (Q)	Claim Status (Exhausted or Non-Covered Service, if applicable) (R)	Medical Record Number (S)
3/11/2013	Inpatient	110	$ 4,000.00	7				55555
3/11/2013	Inpatient	200	$ 4,500.00	3				55555
3/11/2013	Inpatient	250	$ 5,200.25					55555
3/11/2013	Inpatient	300	$ 2,700.00					55555
3/11/2013	Inpatient	360	$ 15,000.75					55555
3/11/2013	Inpatient	450	$ 1,000.25					55555
6/15/2013	Outpatient	250	$ 150.00		$ 500.00		Exhausted	66666
6/15/2013	Outpatient	450	$ 750.00		$ 500.00		Exhausted	66666
8/10/2013	Outpatient	450	$ 1,100.00				Non-Covered Service	77777

Exhibit A – Uninsured Charges/Days

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

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 <u>cash basis</u>.
  - 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 <u>uninsured hospital</u> patient payments and enter them in Section H of the survey.

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

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 <u>received</u> during the 2015 cost report year that relates to a service provided in the 2005 cost report year, must be used to reduce uninsured cost for the 2015 cost report year.

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

10

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

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).
  - Data not submitted in the correct format may be returned to the hospital requesting revisions to get the data into the prescribed Exhibit B format.

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

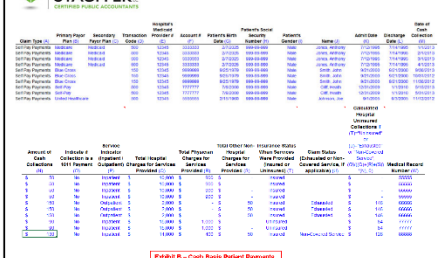


Exhibit B – Cash Basis Patient Payments

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

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.

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

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 Medicare Traditional/Medicaid 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).

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

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 Traditional Payments, Medicare Managed Care Payments, Medicaid FFS Payments, Medicaid Managed Care Payments, Private Insurance 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).

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

EXHIBIT C – HOSPITAL-PROVIDED MEDICAID DATA

- Exhibit C
  - Data not submitted in the correct format may be returned to the hospital requesting revisions to get the data into the prescribed Exhibit C format.
    - In particular, claims data submitted for a population with days, charges, and/or payments in separate Excel files or separate tabs within one excel file rather than combined into one Excel tab as prescribed in Exhibit C may be sent back to the hospital to combine.
    - Note that payments being repeated on every line of an Exhibit C claim is acceptable and will be properly accounted for during the desk review.

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

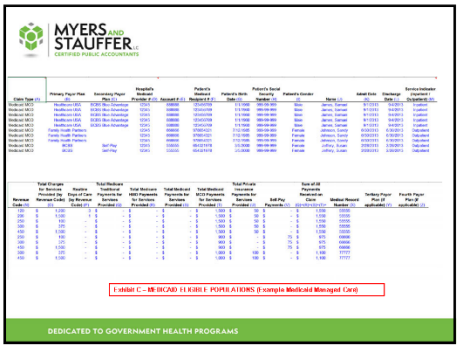
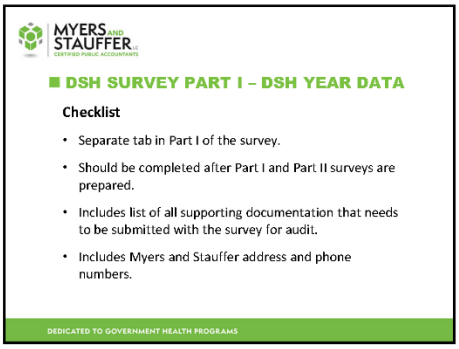

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

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

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

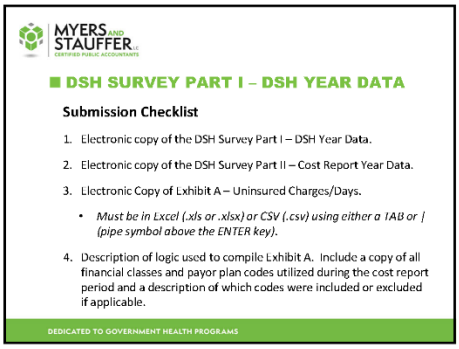

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

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.

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

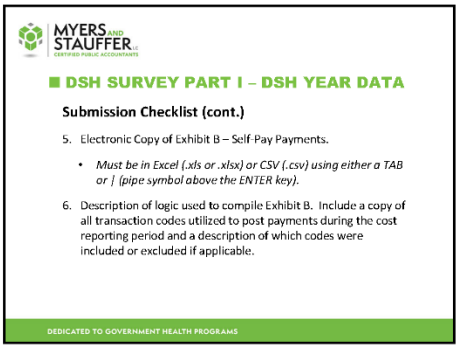

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

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.

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

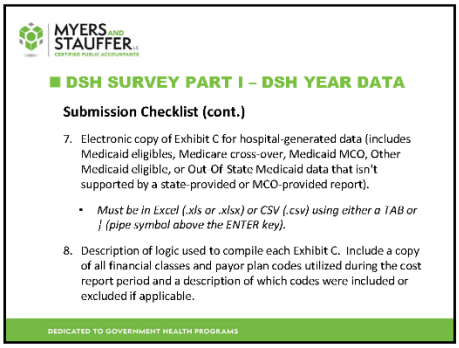

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

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.

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

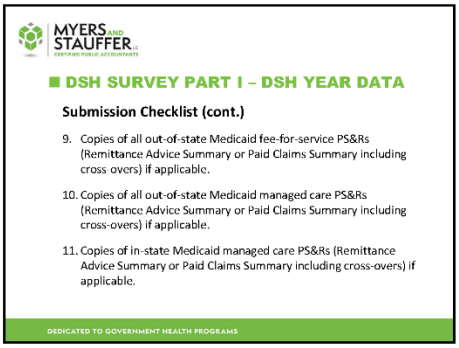

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

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.

DEDICATED TO GOVERNMENT HEALTH PROGRAMS


MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

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.

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

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.

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

MYERS AND STAUFFER

DSH SURVEY PART I – DSH YEAR DATA

Submission Checklist (cont.)

15. Revenue code cross-walk used to prepare cost report (i.e. revenue code to Medicare cost report cost center crosswalk). If a revenue code is mapped to multiple cost centers, please include % split.

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).

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

MYERS AND STAUFFER

DSH SURVEY PART I – DSH YEAR DATA

Submission Checklist (cont.)

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).

20. Documentation supporting any Medicaid Managed Care payments outside the normal claims process for the cost reporting period under review, such as Medicaid MCO quality incentive payments, capitation payments, or any other Medicaid MCO lump sum payments.

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

MYERS AND STAUFFER

DSH SURVEY PART I – DSH YEAR DATA

Submission Checklist (cont.)

21. Electronic copy of recalculated Medicaid DSH cost report - If the hospital included all or a portion of the Provider Tax on the Medicare cost report Worksheet A Column 7, to ensure the provider tax is recorded consistently among providers (i.e. added back to expense via Survey Part II Section G), the hospital may rework the Medicare cost report excluding the provider tax from the cost report (via a WS A-8 adjustment) and submit the revised Worksheet B Part I and Worksheet A-8 to MSLC.

Please update Survey II, Section G (CR Data), Total Allowable Cost Column to reflect your revised Worksheet B Part I, Col. 26. Survey II. Also, be sure to update Section L (Tax) for revised WS A-8 adjustment (Line 17 Gross Allowable Assessment Not Included in the Cost Report should reflect the provider tax that will be added back on Section G, Excel column H).

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

MYERS AND STAUFFER

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

MYERS AND STAUFFER

OTHER INFORMATION

Please use the DSH Survey Part I Submission Checklist when preparing to submit your surveys and supporting documentation.

Upload survey and other data to NEW Web Portal:
https://dsh.msic.com

Submit questions to:
(800) 505-1698
kmasliek@msic.com or dkovar@msic.com

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

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

13

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

WEB PORTAL

Website: https://dsh.mslc.com

- Contact kmasilek@mslc.com or dkovar@mslc.com to request registration form or update contact information.
- Must provide valid IP address to be set up to send/receive data.

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

WEB PORTAL

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

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

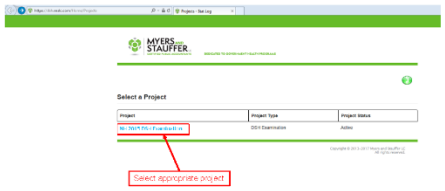
MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

WEB PORTAL

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

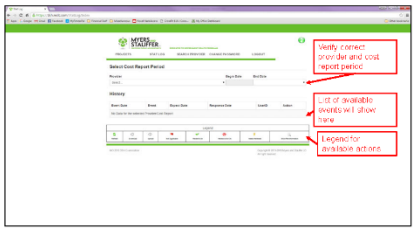
DEDICATED TO GOVERNMENT HEALTH PROGRAMS

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS



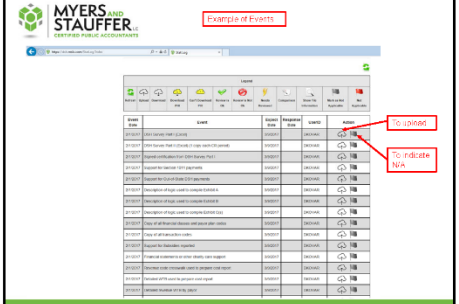
DEDICATED TO GOVERNMENT HEALTH PROGRAMS

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

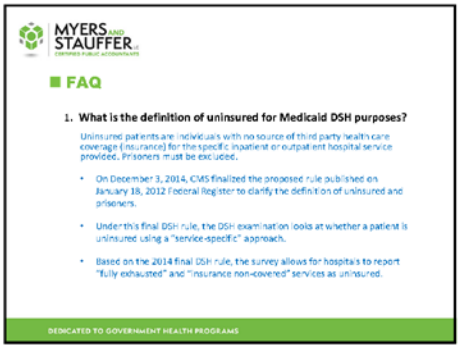


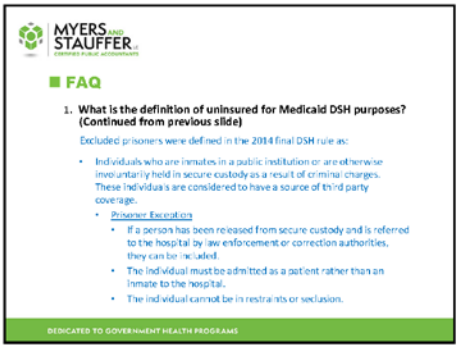
DEDICATED TO GOVERNMENT HEALTH PROGRAMS

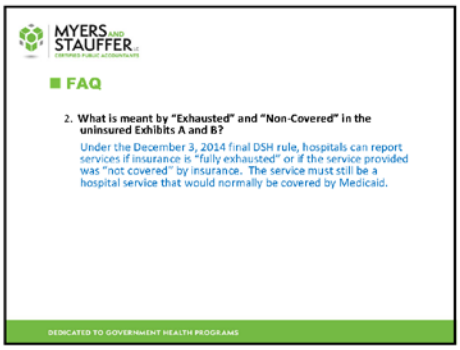
MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

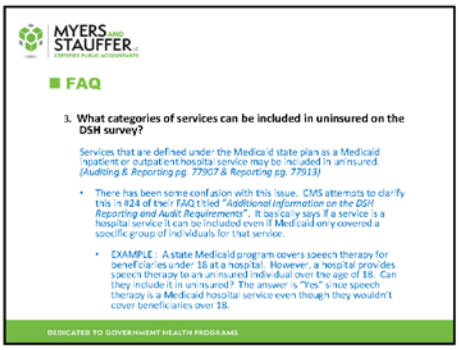


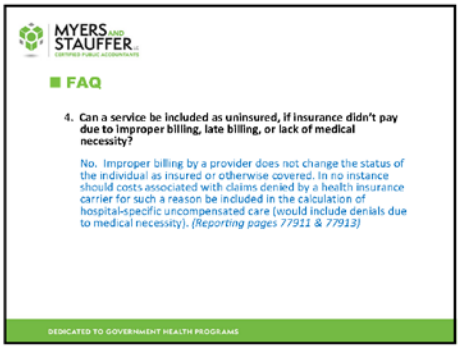
DEDICATED TO GOVERNMENT HEALTH PROGRAMS

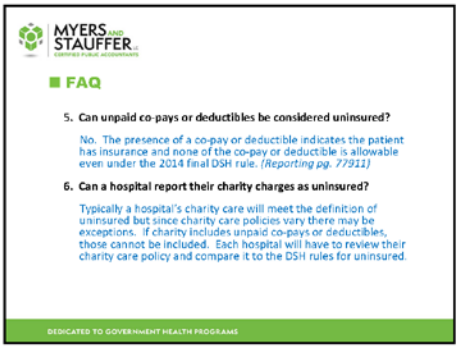

MYERS AND STAUFFER
FAQ
1. What is the definition of uninsured for Medicaid DSH purposes?
Uninsured patients are individuals with no source of third party health care coverage (insurance) for the specific inpatient or outpatient hospital service provided. Prisoners must be excluded.
• On December 3, 2014, 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.
DEDICATED TO GOVERNMENT HEALTH PROGRAMS


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 Exceptions
• 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.
DEDICATED TO GOVERNMENT HEALTH PROGRAMS

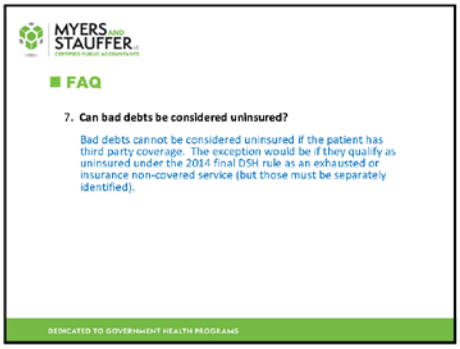

MYERS AND STAUFFER
FAQ
2. What is meant by "Exhausted" and "Non-Covered" in the uninsured Exhibits A and B?
Under the December 3, 2014 final DSH rule, hospitals can report services if insurance is "fully exhausted" or if the service provided was "not covered" by insurance. The service must still be a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

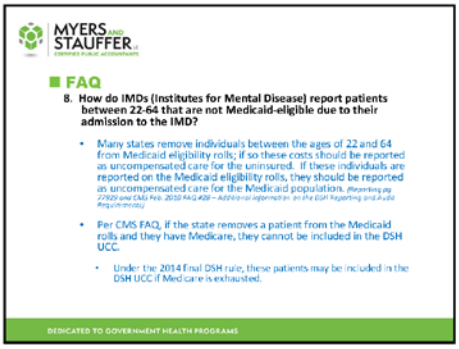

MYERS AND STAUFFER
FAQ
3. What categories of services can be included in uninsured on the DSH survey?
Services that are defined under the Medicaid state plan as a Medicaid inpatient or outpatient hospital service may be included in uninsured. (Auditing & Reporting pg. 77907 & Reporting pg. 77913)
• There 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.
DEDICATED TO GOVERNMENT HEALTH PROGRAMS

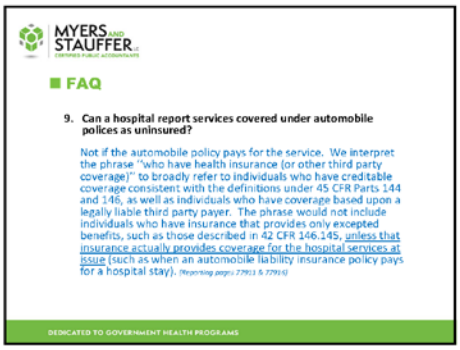

MYERS AND STAUFFER
FAQ
4. Can a service be included as uninsured, if insurance didn't pay due to improper billing, late billing, or lack of medical necessity?
No. Improper billing by a provider does not change the status of the individual as insured or otherwise covered. In no instance should costs associated 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)
DEDICATED TO GOVERNMENT HEALTH PROGRAMS

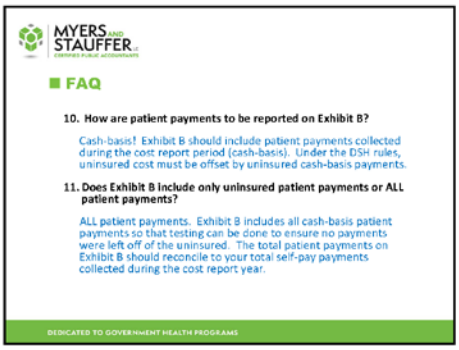

MYERS AND STAUFFER
FAQ
5. Can unpaid co-pays or deductibles be considered uninsured?
No. The presence of a co-pay or deductible indicates the patient has insurance and none of the co-pay or deductible is allowable even under the 2014 final DSH rule. (Reporting pg. 77911)
6. Can a hospital report their 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.
DEDICATED TO GOVERNMENT HEALTH PROGRAMS

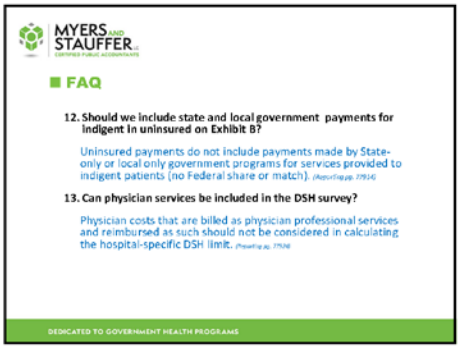
15

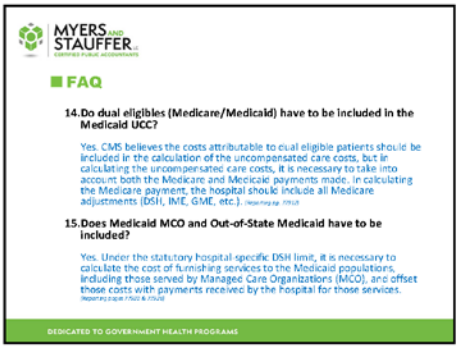

MYERS AND STAUFFER
FAQ
7. Can bad debts be considered uninsured?
Bad debts cannot be considered uninsured if the patient has third party coverage. The exception would be if they qualify as uninsured under the 2014 final DSH rule as an exhausted or insurance non-covered service (but those must be separately identified).
DEDICATED TO GOVERNMENT HEALTH PROGRAMS


MYERS AND STAUFFER
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. 2016 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.
DEDICATED TO GOVERNMENT HEALTH PROGRAMS


MYERS AND STAUFFER
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 77913 & 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 pp. 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. 77926)
DEDICATED TO GOVERNMENT HEALTH PROGRAMS


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. 77918)
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 77920 & 77921)
DEDICATED TO GOVERNMENT HEALTH PROGRAMS

16

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 2008 DSH FAQ #3 titled "Medicaid Eligibles in the DSH Reporting and Audit Requirements")

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

MYERS AND STAUFFER

QUESTIONS/COMMENTS?

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

MYERS AND STAUFFER

CONTACT INFORMATION

John D. Kraft, CPA, CHFP - Member
Jkraft@mslc.com

Diane Kovar, CPA – Senior Manager
dkovar@mslc.com 410.581.4544

Kristie Masilek – Manager
kmasilek@mslc.com 410.581.4546

Myers and Stauffer LC
400 Redland Court, Suite 300
Owings Mills, MD 21117
800-505-1698

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

MYERS AND STAUFFER

APPENDIX - WEBSITES

Final DSH Rule 12/19/2008 https://www.gpo.gov/fdsys/pkg/FR-2008-12-19/pdf/E8-30000.pdf

Final DSH Rule 12/03/2014 https://www.gpo.gov/fdsys/pkg/FR-2014-12-03/pdf/2014-28424.pdf

General DSH Audit and Reporting Protocol https://downloads.cms.gov/cmsgov/archive-downloads/MedicaidGenInfo/downloads/cms2198fprotocol.pdf

CMS Additional Info on DSH Reporting & Audit Requirements https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Financing-and-Reimbursement/Downloads/AdditionalInformationontheDSHReporting.pdf

CMS Additional Info on DSH Reporting & Audit Requirements Part 2 https://www.medicaid.gov/medicaid-chip-program-information/by-topics/financing-and-reimbursement/downloads/part-2-additional-info-on-dsh-reporting-and-auditing.pdf

Final DSH Rule 4/3/2017 https://www.gpo.gov/fdsys/pkg/FR-2017-04-03/pdf/2017-06338.pdf

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

17

Appendix H: Purchasing Affidavit

STATE OF WEST VIRGINIA
Purchasing Division

PURCHASING AFFIDAVIT

CONSTRUCTION CONTRACTS: Under W. Va. Code § 5-22-1(i), the contracting public entity shall not award a construction contract to any bidder that is known to be in default on any monetary obligation owed to the state or a political subdivision of the state, including, but not limited to, obligations related to payroll taxes, property taxes, sales and use taxes, fire service fees, or other fines or fees.

ALL CONTRACTS: 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: (1) for construction contracts, the vendor is not in default on any monetary obligation owed to the state or a political subdivision of the state, and (2) for all other contracts, 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: John D. Lafferty Date: 1/3/2020

State of Maryland

County of Baltimore, to-wit:

Taken, subscribed, and sworn to before me this 3rd day of January, 2020.

My Commission expires March 28, 2020.

AFFIX SEAL HERE

NOTARY PUBLIC

Purchasing Affidavit (Revised 01/19/2018)

Appendix I: Certificates of Insurance

Client#: 52154 MYERSTA

ACORD CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY): 04/23/2019

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 have ADDITIONAL INSURED provisions or 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 any 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: kpeed@cbiz.com	
	INSURER(S) AFFORDING COVERAGE	NAIC #
	INSURER A : Hartford Casualty Insurance Co	29424
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	
A	X COMMERCIAL GENERAL LIABILITY			30SBAUH8895	05/01/2019	05/01/2020	EACH OCCURRENCE	$1,000,000
	CLAIMS-MADE X OCCUR						DAMAGE TO RENTED PREMISES (Ea occurrence)	$300,000
							MED EXP (Any one person)	$10,000
							PERSONAL & ADV INJURY	$1,000,000
	GEN'L AGGREGATE LIMIT APPLIES PER:						GENERAL AGGREGATE	$2,000,000
	X POLICY PRO-JECT LOC						PRODUCTS - COMP/OP AGG	$2,000,000
	OTHER:							$
A	AUTOMOBILE LIABILITY			30SBAUH8895	05/01/2019	05/01/2020	COMBINED SINGLE LIMIT (Ea accident)	$1,000,000
	ANY AUTO						BODILY INJURY (Per person)	$
	OWNED AUTOS ONLY / SCHEDULED AUTOS						BODILY INJURY (Per accident)	$
	X HIRED AUTOS ONLY / X NON-OWNED AUTOS ONLY						PROPERTY DAMAGE (Per accident)	$
								$
A	X UMBRELLA LIAB X OCCUR			30SBAUH8895	05/01/2019	05/01/2020	EACH OCCURRENCE	$5,000,000
	EXCESS LIAB CLAIMS-MADE						AGGREGATE	$5,000,000
	DED X RETENTION $10,000							$
	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY Y / N						PER STATUTE / 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 (ACORD 101, Additional Remarks Schedule, may be attached if more space is required)

CERTIFICATE HOLDER	CANCELLATION
WV Department of Administration, Purchasing Division Attn: April Battle 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 (2016/03) 1 of 1 The ACORD name and logo are registered marks of ACORD
#2096084 51LW

Client#: 2372 CBIZINC

ACORD™ **CERTIFICATE OF LIABILITY INSURANCE**

DATE (MM/DD/YYYY): 5/28/2019

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 have ADDITIONAL INSURED provisions or 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 any 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: kpeed@cbiz.com	
	INSURER(S) AFFORDING COVERAGE	NAIC #
	INSURER A : National Fire & Marine Insurance Co.	20079
INSURED CBIZ, Inc. and Subsidiaries 6050 Oak Tree Blvd., South, Suite 500 Cleveland, OH 44131	INSURER B : Allied World Assurance Co.	19489
	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	
	COMMERCIAL GENERAL LIABILITY						EACH OCCURRENCE	$
	☐ CLAIMS-MADE ☐ OCCUR						DAMAGE TO RENTED PREMISES (Ea occurrence)	$
							MED EXP (Any one person)	$
							PERSONAL & ADV INJURY	$
	GEN'L AGGREGATE LIMIT APPLIES PER:						GENERAL AGGREGATE	$
	☐ POLICY ☐ PRO-JECT ☐ LOC						PRODUCTS - COMP/OP AGG	$
	OTHER:							$
	AUTOMOBILE LIABILITY						COMBINED SINGLE LIMIT (Ea accident)	$
	☐ ANY AUTO						BODILY INJURY (Per person)	$
	☐ OWNED AUTOS ONLY ☐ SCHEDULED AUTOS						BODILY INJURY (Per accident)	$
	☐ HIRED AUTOS ONLY ☐ NON-OWNED AUTOS ONLY						PROPERTY DAMAGE (Per accident)	$
								$
	☐ UMBRELLA LIAB ☐ OCCUR						EACH OCCURRENCE	$
	☐ EXCESS LIAB ☐ CLAIMS-MADE						AGGREGATE	$
	☐ DED ☐ RETENTION $							$
	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY Y / N						☐ PER STATUTE ☐ 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	Primary E&O			42EPP30261104	06/01/2019	06/01/2020	10,000,000 Per Occ/Agg	
B	2nd Layer E&O			03107337	06/01/2019	06/01/2020	10,000,000 x 10,000,000 $1,000,000 Ded	

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

CERTIFICATE HOLDER	CANCELLATION
WV Department of Administration, Purchasing Division Attn: April Battle 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 (2016/03) 1 of 1 The ACORD name and logo are registered marks of ACORD
#S2130722/M2120063 51LW

Appendix J: Disclosure of Interested Parties

West Virginia Ethics Commission

Disclosure of Interested Parties to Contracts

Pursuant to *W. Va. Code* § 6D-1-2, a state agency may not enter into a contract, or a series of related contracts, that has/have an actual or estimated value of $1 million or more until the business entity submits to the contracting state agency a Disclosure of Interested Parties to the applicable contract. In addition, the business entity awarded a contract is obligated to submit a supplemental Disclosure of Interested Parties reflecting any new or differing interested parties to the contract within 30 days following the completion or termination of the applicable contract.

For purposes of complying with these requirements, the following definitions apply:

"Business entity" means any entity recognized by law through which business is conducted, including a sole proprietorship, partnership or corporation, but does not include publicly traded companies listed on a national or international stock exchange.

"Interested party" or *"Interested parties"* means:

(1) A business entity performing work or service pursuant to, or in furtherance of, the applicable contract, including specifically sub-contractors;
(2) the person(s) who have an ownership interest equal to or greater than 25% in the business entity performing work or service pursuant to, or in furtherance of, the applicable contract. (This subdivision does not apply to a publicly traded company); and
(3) the person or business entity, if any, that served as a compensated broker or intermediary to actively facilitate the applicable contract or negotiated the terms of the applicable contract with the state agency. (This subdivision does not apply to persons or business entities performing legal services related to the negotiation or drafting of the applicable contract.)

"State agency" means a board, commission, office, department or other agency in the executive, judicial or legislative branch of state government, including publicly funded institutions of higher education: Provided, that for purposes of W. Va. Code § 6D-1-2, the West Virginia Investment Management Board shall not be deemed a state agency nor subject to the requirements of that provision.

The contracting business entity must complete this form and submit it to the contracting state agency prior to contract award and to complete another form within 30 days of contract completion or termination.

This form was created by the State of West Virginia Ethics Commission, 210 Brooks Street, Suite 300, Charleston, WV 25301-1804. Telephone: (304)558-0664; fax: (304)558-2169; e-mail: ethics@wv.gov; website: www.ethics.wv.gov.

Revised June 8, 2018

West Virginia Ethics Commission

Disclosure of Interested Parties to Contracts

(Required by *W. Va. Code* § 6D-1-2)

Name of Contracting Business Entity: Myers and Stauffer LC **Address:** 10200 Grand Central Avenue, Ste. 200 Owings Mills, MD 21117

Name of Authorized Agent: John D. Kraft **Address:** Same as above

Contract Number: CRFP #0511 BMS 2000000002 **Contract Description:** Disproportionate Share Hospital Program Audit Services

Governmental agency awarding contract: Bureau for Medical Services

☐ **Check here if this is a Supplemental Disclosure**

List the Names of Interested Parties to the contract which are known or reasonably anticipated by the contracting business entity for each category below *(attach additional pages if necessary)*:

1. **Subcontractors or other entities performing work or service under the Contract**
   ☑ Check here if none, otherwise list entity/individual names below.

2. **Any person or entity who owns 25% or more of contracting entity (not applicable to publicly traded entities)**
   ☐ Check here if none, otherwise list entity/individual names below.

   Kevin Londeen
   Keenan Buoy

3. **Any person or entity that facilitated, or negotiated the terms of, the applicable contract (excluding legal services related to the negotiation or drafting of the applicable contract)**
   ☑ Check here if none, otherwise list entity/individual names below.

Signature: John D. Kraft Date Signed: 1/3/2020

Notary Verification

State of Maryland, County of Baltimore:

I, John D. Kraft, the authorized agent of the contracting business entity listed above, being duly sworn, acknowledge that the Disclosure herein is being made under oath and under the penalty of perjury.

Taken, sworn to and subscribed before me this 3rd day of January 2020.

Notary Public's Signature

To be completed by State Agency:
Date Received by State Agency: _____
Date submitted to Ethics Commission: _____
Governmental agency submitting Disclosure: _____

Revised June 8, 2018