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.

Header 1

List View

General Information | Contact | Default Values | Discount | Document Information | Clarification Request

Procurement Folder: 1150159
Procurement Type: Central Master Agreement
Vendor ID: 000000191225
Legal Name: MYERS & STAUFFER LC
Alias/DBA:
Total Bid: $698,830.00
Response Date: 04/20/2023
Response Time: 10:16
Responded By User ID: MyersStauffer
First Name: Marketing
Last Name: Coordinator
Email: BIDS@mslc.com
Phone: 816-945-5300

SO Doc Code: CRFQ
SO Dept: 0511
SO Doc ID: BMS2300000004
Published Date: 4/13/23
Close Date: 4/20/23
Close Time: 13:30
Status: Closed
Solicitation Description: DISPROPORTIONATE SHARE HOSPITAL AUDIT SERVICES
Total of Header Attachments: 1
Total of All Attachments: 1

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

State of West Virginia
Solicitation Response

Proc Folder:	1150159
Solicitation Description:	DISPROPORTIONATE SHARE HOSPITAL AUDIT SERVICES
Proc Type:	Central Master Agreement

Solicitation Closes	Solicitation Response	Version
2023-04-20 13:30	SR 0511 ESR04192300000005175	1

VENDOR

000000191225
MYERS & STAUFFER LC

Solicitation Number: CRFQ 0511 BMS2300000004

Total Bid: 698830 **Response Date:** 2023-04-20 **Response Time:** 10:16:33

Comments:

FOR INFORMATION CONTACT THE BUYER
Crystal G Hustead
(304) 558-2402
crystal.g.hustead@wv.gov

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

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

Line	Comm Ln Desc	Qty	Unit Issue	Unit Price	Ln Total Or Contract Amount
1	Audit for SFY2021				155000.00

Comm Code	Manufacturer	Specification	Model #
84111600			

Commodity Line Comments:

Extended Description:

Audit Services SFY2021 (07/01/2020-06/30/2021)
Service Period: 03/01/2024-02/28/2025

Line	Comm Ln Desc	Qty	Unit Issue	Unit Price	Ln Total Or Contract Amount
2	Audit for SFY2022				159700.00

Comm Code	Manufacturer	Specification	Model #
84111600			

Commodity Line Comments:

Extended Description:

Audit Services SFY2022 (07/01/2021-06/30/2022)
Service Period: 03/01/2025-02/28/2026

Line	Comm Ln Desc	Qty	Unit Issue	Unit Price	Ln Total Or Contract Amount
3	Audit for SFY2023				164500.00

Comm Code	Manufacturer	Specification	Model #
84111600			

Commodity Line Comments:

Extended Description:

Audit Services SFY2023 (07/01/2022-06/30/2023)
Service Period: 03/01/2026-02/28/2027

Line	Comm Ln Desc	Qty	Unit Issue	Unit Price	Ln Total Or Contract Amount
4	Audit for SFY2024				169425.00

Comm Code	Manufacturer	Specification	Model #
84111600			

Commodity Line Comments:

Extended Description:

Audit Services SFY2024 (07/01/2023-06/30/2024)
Service Period: 03/01/2027-02/29/2028

Line	Comm Ln Desc	Qty	Unit Issue	Unit Price	Ln Total Or Contract Amount
5	Additional Services-Base Year One (1)				12000.00

Comm Code	Manufacturer	Specification	Model #
84111600			

Commodity Line Comments:

Extended Description:

Total Cost for Additional Services (Cost Per Hour X 100 Hours)-Base Year One (1).
Service Period: 03/01/2024-02/28/2025

Line	Comm Ln Desc	Qty	Unit Issue	Unit Price	Ln Total Or Contract Amount
6	Additional Services-Optional Renewal Year One (1)				12360.00

Comm Code	Manufacturer	Specification	Model #
84111600			

Commodity Line Comments:

Extended Description:

Additional Services- (Cost Per Hour X 100 Hours)-Optional Renewal Year One (1).
Service Period: 03/01/2025-02/28/2026

Line	Comm Ln Desc	Qty	Unit Issue	Unit Price	Ln Total Or Contract Amount
7	Additional Services-Optional Renewal Year Two (2)				12730.00

Comm Code	Manufacturer	Specification	Model #
84111600			

Commodity Line Comments:

Extended Description:

Additional Services- (Cost Per Hour X 100 Hours)-Optional Renewal Year Two (2)
Service Period: 03/01/2026-02/28/2027

Line	Comm Ln Desc	Qty	Unit Issue	Unit Price	Ln Total Or Contract Amount
8	Additional Services-Optional Renewal Year Three (3)				13115.00

Comm Code	Manufacturer	Specification	Model #
84111600			

Commodity Line Comments:

Extended Description:

Additional Services- (Cost Per Hour X 100 Hours)-Optional Renewal Year Three (3)
Service Period: 03/01/2027-02/29/2028

WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES

Bureau for Medical Services

Disproportionate Share Hospital Audit Services

CRFQ No. 0511 BMS2300000004

April 20, 2023

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

April 20, 2023

Ms. Crystal G. Hustead
Department of Administration, Purchasing Division
2019 Washington Street East
Charleston, WV 25305

Dear Ms. Hustead and Members of the Evaluation Committee:

Myers and Stauffer LC (Myers and Stauffer) is pleased to provide our proposal in response to the Centralized Request for Quotation (CRFQ) No. 0511 BMS2300000004, *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 42 states where we are conducting current DSH work. We also have past DSH experience with West Virginia. Myers and Stauffer will provide BMS with insight and understanding of DSH programs other firms simply cannot. 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). In addition, our team members have served as CMS, state Medicaid, fiscal intermediaries, and hospital leaders charged specifically with addressing the spectrum of data, calculations, and regulations required for this examination. 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 needs and timelines for this effort.

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 dkovar@mslc.com.

Sincerely,

Diane Kovar

Diane Kovar, 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

List of Tables

List of Figures

Myers and Stauffer is a nationally-based CPA firm, specializing in accounting, consulting, program integrity, and operational support services to public health care auditing and social service agencies. We are a limited liability company organized in the state of Kansas. Myers and Stauffer is wholly-owned and managed by its partners, and does not have parent or subsidiary companies.

We have elected to operate our CPA firm under an alternative practice structure, as defined by the American Institute of Certified Public Accountants (AICPA). Under this structure our staffing resources are obtained through a contract with the publicly-traded company Century Business Services, Inc. (CBIZ). All of the staff we obtain through this relationship work exclusively for Myers and Stauffer. Specifically, in 1998, we entered into a transaction with 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. 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.

(Printed Name and Title) Diane Kovar, CPA - Member

(Address) 10200 Grand Central Avenue, Suite 200, Owings Mills, MD 21117

(Phone Number) / (Fax Number) Tel. 800.505.1698/Fax. 410.356.0188

(Email address) DKovar@mslc.com

CERTIFICATION AND SIGNATURE: By signing below, or submitting documentation through *wv*OASIS, I certify that: I have reviewed this Solicitation/Contract 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/Contract 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 this bid or offer was made without prior understanding, agreement, or connection with any entity submitting a bid or offer for the same material, supplies, equipment or services; that this bid or offer is in all respects fair and without collusion or fraud; that this Contract is accepted or entered into without any prior understanding, agreement, or connection to any other entity that could be considered a violation of law; 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.

By signing below, I further certify that I understand this Contract is subject to the provisions of West Virginia Code § 5A-3-62, which automatically voids certain contract clauses that violate State law; and that pursuant to W. Va. Code 5A-3-63, the entity entering into this contract is prohibited from engaging in a boycott against Israel.

Myers and Stauffer LC
(Company)

Diane Kovar
(Signature of Authorized Representative)

Diane Kovar, CPA - Member 4/18/23
(Printed Name and Title of Authorized Representative) (Date)

Tel. 800.505.1698/Fax. 410.356.0188
(Phone Number) (Fax Number)

DKovar@mslc.com
(Email Address)

Revised 11/1/2022

Cover Pages/Addendum Acknowledgement

CRFQ Cover Page: Version 1

Department of Administration Purchasing Division 2019 Washington Street East Post Office Box 50130 Charleston, WV 25305-0130	State of West Virginia Centralized Request for Quote Service - Prof

Proc Folder: 1150159 **Doc Description:** DISPROPORTIONATE SHARE HOSPITAL AUDIT SERVICES **Proc Type:** Central Master Agreement	**Reason for Modification:**

Date Issued	Solicitation Closes	Solicitation No	Version
2023-03-27	2023-04-20 13:30	CRFQ 0511 BMS2300000004	1

BID RECEIVING LOCATION

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

VENDOR

Vendor Customer Code: 715150015
Vendor Name : Myers and Stauffer LC
Address : 10200
Street : Grand Central Avenue, Suite 200
City : Owings Mills
State : Maryland **Country :** United States of America **Zip :** 21117
Principal Contact : Diane Kovar, CPA
Vendor Contact Phone: 800.505.1698 **Extension:**

FOR INFORMATION CONTACT THE BUYER
Crystal G Hustead
(304) 558-2402
crystal.g.hustead@wv.gov

Vendor Signature X Diane Kovar **FEIN#** 48-1164042 **DATE** 4/18/23

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

Date Printed: Mar 27, 2023 Page: 1 FORM ID: WV-PRC-CRFQ-002 2020/05

ADDITIONAL INFORMATION
THE STATE OF WEST VIRGINIA PURCHASING DIVISION FOR THE AGENCY, WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES (DHHR), BUREAU FOR MEDICAL SERVICES (BMS), IS SOLICITING BIDS TO ESTABLISH A CONTRACT FOR AUDIT SERVICES FOR THE WEST VIRGINIA DISPROPORTIONATE SHARE HOSPITAL ("DSH") PROGRAM PER THE ATTACHED DOCUMENTS. ***QUESTIONS REGARDING THE SOLICITATION MUST BE SUBMITTED IN WRITING TO CRYSTAL.G.HUSTEAD@WV.GOV PRIOR TO THE QUESTION PERIOD DEADLINE CONTAINED IN THE INSTRUCTIONS TO VENDORS SUBMITTING BIDS***

INVOICE TO		SHIP TO	
HEALTH AND HUMAN RESOURCES		HEALTH AND HUMAN RESOURCES	
BUREAU FOR MEDICAL SERVICES		BUREAU FOR MEDICAL SERVICES	
350 CAPITOL ST, RM 251		350 CAPITOL ST, RM 251	
CHARLESTON	WV	CHARLESTON	WV
US		US	

Line	Comm Ln Desc	Qty	Unit Issue	Unit Price	Total Price
1	Audit for SFY2021	1	1	$155,000	$155,000

Comm Code	Manufacturer	Specification	Model #
84111600			

Extended Description:
Audit Services SFY2021 (07/01/2020-06/30/2021)

Service Period: 03/01/2024-02/28/2025

INVOICE TO		SHIP TO	
HEALTH AND HUMAN RESOURCES		HEALTH AND HUMAN RESOURCES	
BUREAU FOR MEDICAL SERVICES		BUREAU FOR MEDICAL SERVICES	
350 CAPITOL ST, RM 251		350 CAPITOL ST, RM 251	
CHARLESTON	WV	CHARLESTON	WV
US		US	

Line	Comm Ln Desc	Qty	Unit Issue	Unit Price	Total Price
2	Audit for SFY2022	1	1	$159,700	$159,700

Comm Code	Manufacturer	Specification	Model #
84111600			

Extended Description:
Audit Services SFY2022 (07/01/2021-06/30/2022)

Service Period: 03/01/2025-02/28/2026

INVOICE TO	SHIP TO
HEALTH AND HUMAN RESOURCES BUREAU FOR MEDICAL SERVICES 350 CAPITOL ST, RM 251 CHARLESTON WV US	HEALTH AND HUMAN RESOURCES BUREAU FOR MEDICAL SERVICES 350 CAPITOL ST, RM 251 CHARLESTON WV US

Line	Comm Ln Desc	Qty	Unit Issue	Unit Price	Total Price
3	Audit for SFY2023	1	1	$164,500	$164,500

Comm Code	Manufacturer	Specification	Model #
84111600			

Extended Description:
Audit Services SFY2023 (07/01/2022-06/30/2023)

Service Period: 03/01/2026-02/28/2027

INVOICE TO	SHIP TO
HEALTH AND HUMAN RESOURCES BUREAU FOR MEDICAL SERVICES 350 CAPITOL ST, RM 251 CHARLESTON WV US	HEALTH AND HUMAN RESOURCES BUREAU FOR MEDICAL SERVICES 350 CAPITOL ST, RM 251 CHARLESTON WV US

Line	Comm Ln Desc	Qty	Unit Issue	Unit Price	Total Price
4	Audit for SFY2024	1	1	$169,425	$169,425

Comm Code	Manufacturer	Specification	Model #
84111600			

Extended Description:
Audit Services SFY2024 (07/01/2023-06/30/2024)

Service Period: 03/01/2027-02/29/2028

INVOICE TO		SHIP TO	
HEALTH AND HUMAN RESOURCES		HEALTH AND HUMAN RESOURCES	
BUREAU FOR MEDICAL SERVICES		BUREAU FOR MEDICAL SERVICES	
350 CAPITOL ST, RM 251		350 CAPITOL ST, RM 251	
CHARLESTON	WV	CHARLESTON	WV
US		US	

Line	Comm Ln Desc	Qty	Unit Issue	Unit Price	Total Price
5	Additional Services-Base Year One (1)	1	1	$12,000	$12,000

Comm Code	Manufacturer	Specification	Model #
84111600			

Extended Description:
Total Cost for Additional Services (Cost Per Hour X 100 Hours)-Base Year One (1).

Service Period: 03/01/2024-02/28/2025

INVOICE TO		SHIP TO	
HEALTH AND HUMAN RESOURCES		HEALTH AND HUMAN RESOURCES	
BUREAU FOR MEDICAL SERVICES		BUREAU FOR MEDICAL SERVICES	
350 CAPITOL ST, RM 251		350 CAPITOL ST, RM 251	
CHARLESTON	WV	CHARLESTON	WV
US		US	

Line	Comm Ln Desc	Qty	Unit Issue	Unit Price	Total Price
6	Additional Services-Optional Renewal Year One (1)	1	1	$12,360	$12,360

Comm Code	Manufacturer	Specification	Model #
84111600			

Extended Description:
Additional Services- (Cost Per Hour X 100 Hours)-Optional Renewal Year One (1).

Service Period: 03/01/2025-02/28/2026

INVOICE TO		SHIP TO	
HEALTH AND HUMAN RESOURCES		HEALTH AND HUMAN RESOURCES	
BUREAU FOR MEDICAL SERVICES		BUREAU FOR MEDICAL SERVICES	
350 CAPITOL ST, RM 251		350 CAPITOL ST, RM 251	
CHARLESTON	WV	CHARLESTON	WV
US		US	

Line	Comm Ln Desc	Qty	Unit Issue	Unit Price	Total Price
7	Additional Services-Optional Renewal Year Two (2)	1	1	$12,730	$12,730

Comm Code	Manufacturer	Specification	Model #
84111600			

Extended Description:
Additional Services- (Cost Per Hour X 100 Hours)-Optional Renewal Year Two (2)

Service Period: 03/01/2026-02/28/2027

INVOICE TO		SHIP TO	
HEALTH AND HUMAN RESOURCES		HEALTH AND HUMAN RESOURCES	
BUREAU FOR MEDICAL SERVICES		BUREAU FOR MEDICAL SERVICES	
350 CAPITOL ST, RM 251		350 CAPITOL ST, RM 251	
CHARLESTON	WV	CHARLESTON	WV
US		US	

Line	Comm Ln Desc	Qty	Unit Issue	Unit Price	Total Price
8	Additional Services-Optional Renewal Year Three (3)	1	1	$13,115	$13,115

Comm Code	Manufacturer	Specification	Model #
84111600			

Extended Description:
Additional Services- (Cost Per Hour X 100 Hours)-Optional Renewal Year Three (3)

Service Period: 03/01/2027-02/29/2028

SCHEDULE OF EVENTS

Line	Event	Event Date
1	VENDOR QUESTION DEADLINE	2023-04-03

CRFQ Cover Page: Version 2

Department of Administration Purchasing Division 2019 Washington Street East Post Office Box 50130 Charleston, WV 25305-0130	State of West Virginia Centralized Request for Quote Service - Prof

Proc Folder: 1150159 Doc Description: DISPROPORTIONATE SHARE HOSPITAL AUDIT SERVICES Proc Type: Central Master Agreement	Reason for Modification: ADDENDUM 1 TO PROVIDE ANSWERS TO VENDOR QUESTIONS

Date Issued	Solicitation Closes	Solicitation No	Version
2023-04-13	2023-04-20 13:30	CRFQ 0511 BMS2300000004	2

BID RECEIVING LOCATION

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

VENDOR

Vendor Customer Code: 715150015
Vendor Name : Myers and Stauffer LC
Address : 10200
Street : Grand Central Avenue, Suite 200
City : Owings Mills
State : Maryland **Country :** United States of America **Zip :** 21117
Principal Contact : Diane Kovar, CPA
Vendor Contact Phone: 800.505.1698 **Extension:**

FOR INFORMATION CONTACT THE BUYER
Crystal G Hustead
(304) 558-2402
crystal.g.hustead@wv.gov

Vendor Signature X Diane Kovar **FEIN#** 48-1164042 **DATE** 4/18/23

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

Date Printed: Apr 13, 2023 Page: 1 FORM ID: WV-PRC-CRFQ-002 2020/05

ADDITIONAL INFORMATION
THE STATE OF WEST VIRGINIA PURCHASING DIVISION FOR THE AGENCY, WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES (DHHR), BUREAU FOR MEDICAL SERVICES (BMS), IS SOLICITING BIDS TO ESTABLISH A CONTRACT FOR AUDIT SERVICES FOR THE WEST VIRGINIA DISPROPORTIONATE SHARE HOSPITAL ("DSH") PROGRAM PER THE ATTACHED DOCUMENTS. ***QUESTIONS REGARDING THE SOLICITATION MUST BE SUBMITTED IN WRITING TO CRYSTAL.G.HUSTEAD@WV.GOV PRIOR TO THE QUESTION PERIOD DEADLINE CONTAINED IN THE INSTRUCTIONS TO VENDORS SUBMITTING BIDS***

INVOICE TO		SHIP TO	
HEALTH AND HUMAN RESOURCES		HEALTH AND HUMAN RESOURCES	
BUREAU FOR MEDICAL SERVICES		BUREAU FOR MEDICAL SERVICES	
350 CAPITOL ST, RM 251		350 CAPITOL ST, RM 251	
CHARLESTON	WV	CHARLESTON	WV
US		US	

Line	Comm Ln Desc	Qty	Unit Issue	Unit Price	Total Price
1	Audit for SFY2021	1	1	$155,000	$155,000

Comm Code	Manufacturer	Specification	Model #
84111600			

Extended Description:
Audit Services SFY2021 (07/01/2020-06/30/2021)

Service Period: 03/01/2024-02/28/2025

INVOICE TO		SHIP TO	
HEALTH AND HUMAN RESOURCES		HEALTH AND HUMAN RESOURCES	
BUREAU FOR MEDICAL SERVICES		BUREAU FOR MEDICAL SERVICES	
350 CAPITOL ST, RM 251		350 CAPITOL ST, RM 251	
CHARLESTON	WV	CHARLESTON	WV
US		US	

Line	Comm Ln Desc	Qty	Unit Issue	Unit Price	Total Price
2	Audit for SFY2022	1	1	$159,700	$159,700

Comm Code	Manufacturer	Specification	Model #
84111600			

Extended Description:
Audit Services SFY2022 (07/01/2021-06/30/2022)

Service Period: 03/01/2025-02/28/2026

INVOICE TO		SHIP TO	
HEALTH AND HUMAN RESOURCES		HEALTH AND HUMAN RESOURCES	
BUREAU FOR MEDICAL SERVICES		BUREAU FOR MEDICAL SERVICES	
350 CAPITOL ST, RM 251		350 CAPITOL ST, RM 251	
CHARLESTON	WV	CHARLESTON	WV
US		US	

Line	Comm Ln Desc	Qty	Unit Issue	Unit Price	Total Price
3	Audit for SFY2023	1	1	$164,500	$164,500

Comm Code	Manufacturer	Specification	Model #
84111600			

Extended Description:
Audit Services SFY2023 (07/01/2022-06/30/2023)

Service Period: 03/01/2026-02/28/2027

INVOICE TO		SHIP TO	
HEALTH AND HUMAN RESOURCES		HEALTH AND HUMAN RESOURCES	
BUREAU FOR MEDICAL SERVICES		BUREAU FOR MEDICAL SERVICES	
350 CAPITOL ST, RM 251		350 CAPITOL ST, RM 251	
CHARLESTON	WV	CHARLESTON	WV
US		US	

Line	Comm Ln Desc	Qty	Unit Issue	Unit Price	Total Price
4	Audit for SFY2024	1	1	$169,425	$169,425

Comm Code	Manufacturer	Specification	Model #
84111600			

Extended Description:
Audit Services SFY2024 (07/01/2023-06/30/2024)

Service Period: 03/01/2027-02/29/2028

INVOICE TO		SHIP TO	
HEALTH AND HUMAN RESOURCES		HEALTH AND HUMAN RESOURCES	
BUREAU FOR MEDICAL SERVICES		BUREAU FOR MEDICAL SERVICES	
350 CAPITOL ST, RM 251		350 CAPITOL ST, RM 251	
CHARLESTON	WV	CHARLESTON	WV
US		US	

Line	Comm Ln Desc	Qty	Unit Issue	Unit Price	Total Price
5	Additional Services-Base Year One (1)	1	1	$12,000	$12,000

Comm Code	Manufacturer	Specification	Model #
84111600			

Extended Description:
Total Cost for Additional Services (Cost Per Hour X 100 Hours)-Base Year One (1).

Service Period: 03/01/2024-02/28/2025

INVOICE TO		SHIP TO	
HEALTH AND HUMAN RESOURCES		HEALTH AND HUMAN RESOURCES	
BUREAU FOR MEDICAL SERVICES		BUREAU FOR MEDICAL SERVICES	
350 CAPITOL ST, RM 251		350 CAPITOL ST, RM 251	
CHARLESTON	WV	CHARLESTON	WV
US		US	

Line	Comm Ln Desc	Qty	Unit Issue	Unit Price	Total Price
6	Additional Services-Optional Renewal Year One (1)	1	1	$12,360	$12,360

Comm Code	Manufacturer	Specification	Model #
84111600			

Extended Description:
Additional Services- (Cost Per Hour X 100 Hours)-Optional Renewal Year One (1).

Service Period: 03/01/2025-02/28/2026

INVOICE TO		SHIP TO	
HEALTH AND HUMAN RESOURCES		HEALTH AND HUMAN RESOURCES	
BUREAU FOR MEDICAL SERVICES		BUREAU FOR MEDICAL SERVICES	
350 CAPITOL ST, RM 251		350 CAPITOL ST, RM 251	
CHARLESTON	WV	CHARLESTON	WV
US		US	

Line	Comm Ln Desc	Qty	Unit Issue	Unit Price	Total Price
7	Additional Services-Optional Renewal Year Two (2)	1	1	$12,730	$12,730

Comm Code	Manufacturer	Specification	Model #
84111600			

Extended Description:
Additional Services- (Cost Per Hour X 100 Hours)-Optional Renewal Year Two (2)

Service Period: 03/01/2026-02/28/2027

INVOICE TO		SHIP TO	
HEALTH AND HUMAN RESOURCES		HEALTH AND HUMAN RESOURCES	
BUREAU FOR MEDICAL SERVICES		BUREAU FOR MEDICAL SERVICES	
350 CAPITOL ST, RM 251		350 CAPITOL ST, RM 251	
CHARLESTON	WV	CHARLESTON	WV
US		US	

Line	Comm Ln Desc	Qty	Unit Issue	Unit Price	Total Price
8	Additional Services-Optional Renewal Year Three (3)	1	1	$13,115	$13,115

Comm Code	Manufacturer	Specification	Model #
84111600			

Extended Description:
Additional Services- (Cost Per Hour X 100 Hours)-Optional Renewal Year Three (3)

Service Period: 03/01/2027-02/29/2028

SCHEDULE OF EVENTS

Line	Event	Event Date
1	VENDOR QUESTION DEADLINE	2023-04-03

Signed Addendum Acknowledgement Form

ADDENDUM ACKNOWLEDGEMENT FORM
SOLICITATION NO.: CRFQ BMS2300000004

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)

- [x] Addendum No. 1
- [ ] Addendum No. 2
- [ ] Addendum No. 3
- [ ] Addendum No. 4
- [ ] Addendum No. 5
- [ ] Addendum No. 6
- [ ] Addendum No. 7
- [ ] Addendum No. 8
- [ ] Addendum No. 9
- [ ] 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

Diane Kovar
Authorized Signature

4/18/23
Date

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

Revised 11/1/2022

Federal Funds Addendum

Attachment 1

FEDERAL FUNDS ADDENDUM
2 C.F.R. §§ 200.317 – 200.327

Purpose: This addendum is intended to modify the solicitation in an attempt to make the contract compliant with the requirements of 2 C.F.R. §§ 200.317 through 200.327 relating to the expenditure of certain federal funds. This solicitation will allow the State to obtain one or more contracts that satisfy standard state procurement, state federal funds procurement, and county/local federal funds procurement requirements.

Instructions: Vendors who are willing to extend their contract to procurements with federal funds and the requirements that go along with doing so, should sign the attached document identified as: "REQUIRED CONTRACT PROVISIONS FOR NON-FEDERAL ENTITY CONTRACTS UNDER FEDERAL AWARDS (2 C.F.R. § 200.317)"

Should the awarded vendor be unwilling to extend the contract to federal funds procurement, the State reserves the right to award additional contracts to vendors that can and are willing to meet federal funds procurement requirements.

Changes to Specifications: Vendors should consider this solicitation as containing two separate solicitations, one for state level procurement and one for county/local procurement.

State Level: In the first solicitation, bid responses will be evaluated with applicable preferences identified in sections 15, 15A, and 16 of the "Instructions to Vendors Submitting Bids" to establish a contract for both standard state procurements and state federal funds procurements.

County Level: In the second solicitation, bid responses will be evaluated with applicable preferences identified in Sections 15, 15A, and 16 of the "Instructions to Vendors Submitting Bids" omitted to establish a contract for County/Local federal funds procurement.

Award: If the two evaluations result in the same vendor being identified as the winning bidder, the two solicitations will be combined into a single contract award. If the evaluations result in a different bidder being identified as the winning bidder, multiple contracts may be awarded. The State reserves the right to award to multiple different entities should it be required to satisfy standard state procurement, state federal funds procurement, and county/local federal funds procurement requirements.

State Government Use Caution: State agencies planning to utilize this contract for procurements subject to the above identified federal regulations should first consult with the federal agency providing the applicable funding to ensure the contract is complaint.

County/Local Government Use Caution: County and Local government entities planning to utilize this contract for procurements subject to the above identified federal regulation should first consult with the federal agency providing the applicable funding to ensure the contract is complaint. For purposes of County/Local government use, the solicitation resulting in this contract was conducted in accordance with the procurement laws, rules, and procedures governing the West Virginia Department of Administration, Purchasing Division, except that vendor preference has been omitted for County/Local use purposes and the contract terms contained in the document entitled "REQUIRED CONTRACT PROVISIONS FOR NON-FEDERAL ENTITY CONTRACTS UNDER FEDERAL AWARDS (2 C.F.R. § 200.317)" have been added.

FEDERAL FUNDS ADDENDUM

REQUIRED CONTRACT PROVISIONS FOR NON-FEDERAL ENTITY CONTRACTS UNDER FEDERAL AWARDS (2 C.F.R. § 200.317):

The State of West Virginia Department of Administration, Purchasing Division, and the Vendor awarded this Contract intend that this Contract be compliant with the requirements of the Procurement Standards contained in the Uniform Administrative Requirements, Cost Principles, and Audit Requirements found in 2 C.F.R. § 200.317, et seq. for procurements conducted by a Non-Federal Entity. Accordingly, the Parties agree that the following provisions are included in the Contract.

1. **MINORITY BUSINESSES, WOMEN'S BUSINESS ENTERPRISES, AND LABOR SURPLUS AREA FIRMS:** (2 C.F.R. § 200.321)

    a. The State confirms that it has taken all necessary affirmative steps to assure that minority businesses, women's business enterprises, and labor surplus area firms are used when possible. Those affirmative steps include:

        (1) Placing qualified small and minority businesses and women's business enterprises on solicitation lists;
        (2) Assuring that small and minority businesses, and women's business enterprises are solicited whenever they are potential sources;
        (3) Dividing total requirements, when economically feasible, into smaller tasks or quantities to permit maximum participation by small and minority businesses, and women's business enterprises;
        (4) Establishing delivery schedules, where the requirement permits, which encourage participation by small and minority businesses, and women's business enterprises;
        (5) Using the services and assistance, as appropriate, of such organizations as the Small Business Administration and the Minority Business Development Agency of the Department of Commerce; and
        (6) Requiring the prime contractor, if subcontracts are to be let, to take the affirmative steps listed in paragraphs (1) through (5) above.

    b. Vendor confirms that if it utilizes subcontractors, it will take the same affirmative steps to assure that minority businesses, women's business enterprises, and labor surplus area firms are used when possible.

2. **DOMESTIC PREFERENCES:** (2 C.F.R. § 200.322)

    a. The State confirms that as appropriate and to the extent consistent with law, it has, to the greatest extent practicable under a Federal award, provided a preference for the purchase, acquisition, or use of goods, products, or materials produced in the United

States (including but not limited to iron, aluminum, steel, cement, and other manufactured products).

b. Vendor confirms that will include the requirements of this Section 2. Domestic Preference in all subawards including all contracts and purchase orders for work or products under this award.

c. Definitions: For purposes of this section:

(1) "Produced in the United States" means, for iron and steel products, that all manufacturing processes, from the initial melting stage through the application of coatings, occurred in the United States.
(2) "Manufactured products" means items and construction materials composed in whole or in part of non-ferrous metals such as aluminum; plastics and polymer-based products such as polyvinyl chloride pipe; aggregates such as concrete; glass, including optical fiber; and lumber.

3. **BREACH OF CONTRACT REMEDIES AND PENALTIES:**
(2 C.F.R. § 200.327 and Appendix II)

(a) The provisions of West Virginia Code of State Rules § 148-1-5 provide for breach of contract remedies, and penalties. A copy of that rule is attached hereto as Exhibit A and expressly incorporated herein by reference.

4. **TERMINATION FOR CAUSE AND CONVENIENCE:**
(2 C.F.R. § 200.327 and Appendix II)

(a) The provisions of West Virginia Code of State Rules § 148-1-5 govern Contract termination. A copy of that rule is attached hereto as Exhibit A and expressly incorporated herein by reference.

5. **EQUAL EMPLOYMENT OPPORTUNITY:**
(2 C.F.R. § 200.327 and Appendix II)

Except as otherwise provided under 41 CFR Part 60, and if this contract meets the definition of "federally assisted construction contract" in 41 CFR Part 60–1.3, this contract includes the equal opportunity clause provided under 41 CFR 60–1.4(b), in accordance with Executive Order 11246, "Equal Employment Opportunity" (30 FR 12319, 12935, 3 CFR Part, 1964–1965 Comp., p. 339), as amended by Executive Order 11375, "Amending Executive Order 11246 Relating to Equal Employment Opportunity," and implementing regulations at 41 CFR part 60, "Office of Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor."

6. **DAVIS-BACON WAGE RATES:**
(2 C.F.R. § 200.327 and Appendix II)

Vendor agrees that if this Contract includes construction, all construction work in excess of $2,000 will be completed and paid for in compliance with the Davis–Bacon Act (40 U.S.C. 3141–3144, and 3146–3148) as supplemented by Department of Labor regulations (29 CFR Part 5, "Labor Standards Provisions Applicable to Contracts Covering Federally Financed and Assisted Construction"). In accordance with the statute, contractors must:

(a) pay wages to laborers and mechanics at a rate not less than the prevailing wages specified in a wage determination made by the Secretary of Labor.
(b) pay wages not less than once a week.

A copy of the current prevailing wage determination issued by the Department of Labor is attached hereto as Exhibit B. The decision to award a contract or subcontract is conditioned upon the acceptance of the wage determination. The State will report all suspected or reported violations to the Federal awarding agency.

7. **ANTI-KICKBACK ACT:**
(2 C.F.R. § 200.327 and Appendix II)

Vendor agrees that it will comply with the Copeland Anti-KickBack Act (40 U.S.C. 3145), as supplemented by Department of Labor regulations (29 CFR Part 3, "Contractors and Subcontractors on Public Building or Public Work Financed in Whole or in Part by Loans or Grants from the United States"). Accordingly, Vendor, Subcontractors, and anyone performing under this contract are prohibited from inducing, by any means, any person employed in the construction, completion, or repair of public work, to give up any part of the compensation to which he or she is otherwise entitled. The State must report all suspected or reported violations to the Federal awarding agency.

8. **CONTRACT WORK HOURS AND SAFETY STANDARDS ACT**
(2 C.F.R. § 200.327 and Appendix II)

Where applicable, and only for contracts awarded by the State in excess of $100,000 that involve the employment of mechanics or laborers, Vendor agrees to comply with 40 U.S.C. 3702 and 3704, as supplemented by Department of Labor regulations (29 CFR Part 5). Under 40 U.S.C. 3702 of the Act, Vendor is required to compute the wages of every mechanic and laborer on the basis of a standard work week of 40 hours. Work in excess of the standard work week is permissible provided that the worker is compensated at a rate of not less than one and a half times the basic rate of pay for all hours worked in excess of 40 hours in the work week. The requirements of 40 U.S.C. 3704 are applicable to construction work and provide that no laborer or mechanic must be required to work in surroundings or under working conditions which are unsanitary, hazardous or dangerous. These requirements do not apply to the purchases of supplies or materials or articles ordinarily available on the open market, or contracts for transportation or transmission of intelligence.

9. **RIGHTS TO INVENTIONS MADE UNDER A CONTRACT OR AGREEMENT.**
(2 C.F.R. § 200.327 and Appendix II)

If the Federal award meets the definition of "funding agreement" under 37 CFR § 401.2 (a) and the recipient or subrecipient wishes to enter into a contract with a small business firm or nonprofit organization regarding the substitution of parties, assignment or performance of experimental, developmental, or research work under that "funding agreement," the recipient or subrecipient must comply with the requirements of 37 CFR Part 401, "Rights to Inventions Made by Nonprofit Organizations and Small Business Firms Under Government Grants, Contracts and Cooperative Agreements," and any implementing regulations issued by the awarding agency.

10. **CLEAN AIR ACT**
(2 C.F.R. § 200.327 and Appendix II)

Vendor agrees that if this contract exceeds $150,000, Vendor is to comply with all applicable standards, orders or regulations issued pursuant to the Clean Air Act (42 U.S.C. 7401–7671q) and the Federal Water Pollution Control Act as amended (33 U.S.C. 1251–1387). Violations must be reported to the Federal awarding agency and the Regional Office of the Environmental Protection Agency (EPA).

11. **DEBARMENT AND SUSPENSION**
(2 C.F.R. § 200.327 and Appendix II)

The State will not award to any vendor that is listed on the governmentwide exclusions in the System for Award Management (SAM), in accordance with the OMB guidelines at 2 CFR 180 that implement Executive Orders 12549 (3 CFR part 1986 Comp., p. 189) and 12689 (3 CFR part 1989 Comp., p. 235), "Debarment and Suspension." SAM Exclusions contains the names of parties debarred, suspended, or otherwise excluded by agencies, as well as parties declared ineligible under statutory or regulatory authority other than Executive Order 12549.

12. **BYRD ANTI–LOBBYING AMENDMENT**
(2 C.F.R. § 200.327 and Appendix II)

Vendors that apply or bid for an award exceeding $100,000 must file the required certification. Each tier certifies to the tier above that it will not and has not used Federal appropriated funds to pay any person or organization for influencing or attempting to influence an officer or employee of any agency, a member of Congress, officer or employee of Congress, or an employee of a member of Congress in connection with obtaining any Federal contract, grant or any other award covered by 31 U.S.C. 1352. Each tier must also disclose any lobbying with non–Federal funds that takes place in connection with obtaining any Federal award. Such disclosures are forwarded from tier to tier up to the non–Federal award.

13. **PROCUREMENT OF RECOVERED MATERIALS**
(2 C.F.R. § 200.327 and Appendix II; 2 C.F.R. § 200.323)

Vendor agrees that it and the State must comply with section 6002 of the Solid Waste Disposal Act, as amended by the Resource Conservation and Recovery Act. The requirements of Section 6002 include procuring only items designated in guidelines of the

Environmental Protection Agency (EPA) at 40 CFR part 247 that contain the highest percentage of recovered materials practicable, consistent with maintaining a satisfactory level of competition, where the purchase price of the item exceeds $10,000 or the value of the quantity acquired during the preceding fiscal year exceeded $10,000; procuring solid waste management services in a manner that maximizes energy and resource recovery; and establishing an affirmative procurement program for procurement of recovered materials identified in the EPA guidelines.

14. PROHIBITION ON CERTAIN TELECOMMUNICATIONS AND VIDEO SURVEILLANCE SERVICES OR EQUIPMENT.
(2 C.F.R. § 200.327 and Appendix II; 2 CFR § 200.216)

Vendor and State agree that both are prohibited from obligating or expending funds under this Contract to:

(1) Procure or obtain;
(2) Extend or renew a contract to procure or obtain; or
(3) Enter into a contract (or extend or renew a contract) to procure or obtain equipment, services, or systems that uses covered telecommunications equipment or services as a substantial or essential component of any system, or as critical technology as part of any system. As described in Public Law 115–232, section 889, covered telecommunications equipment is telecommunications equipment produced by Huawei Technologies Company or ZTE Corporation (or any subsidiary or affiliate of such entities).

(i) For the purpose of public safety, security of government facilities, physical security surveillance of critical infrastructure, and other national security purposes, video surveillance and telecommunications equipment produced by Hytera Communications Corporation, Hangzhou Hikvision Digital Technology Company, or Dahua Technology Company (or any subsidiary or affiliate of such entities).
(ii) Telecommunications or video surveillance services provided by such entities or using such equipment.
(iii) Telecommunications or video surveillance equipment or services produced or provided by an entity that the Secretary of Defense, in consultation with the Director of the National Intelligence or the Director of the Federal Bureau of Investigation, reasonably believes to be an entity owned or controlled by, or otherwise connected to, the government of a covered foreign country.

In implementing the prohibition under Public Law 115–232, section 889, subsection (f), paragraph (1), heads of executive agencies administering loan, grant, or subsidy programs shall prioritize available funding and technical support to assist affected businesses, institutions and organizations as is reasonably necessary for those affected entities to transition from covered communications equipment and services, to procure replacement equipment and services, and to ensure that communications service to users and customers is sustained.

State of West Virginia	Vendor Name:
By: _____	By: Diane Kovar
Printed Name: _____	Printed Name: Diane Kovar, CPA
Title: _____	Title: Member
Date: _____	Date: 4/18/23

EXHIBIT A To:
REQUIRED CONTRACT PROVISIONS FOR NON-FEDERAL ENTITY CONTRACTS UNDER FEDERAL AWARDS (2 C.F.R. § 200.317):

W. Va. CSR § 148-1-5

West Virginia Code of State Rules
Title 148. Department of Administration
Legislative Rule (Ser. 1)
Series 1. Purchasing

W. Va. Code St. R. § 148-1-5
§ 148-1-5. Remedies.
Currentness

5.1. The Director may require that the spending unit attempt to resolve any issues that it may have with the vendor prior to pursuing a remedy contained herein. The spending unit must document any resolution efforts and provide copies of those documents to the Purchasing Division.

5.2. Contract Cancellation.

5.2.1. Cancellation. The Director may cancel a purchase or contract immediately under any one of the following conditions including, but not limited to:

5.2.1.a. The vendor agrees to the cancellation;

5.2.1.b. The vendor has obtained the contract by fraud, collusion, conspiracy, or is in conflict with any statutory or constitutional provision of the State of West Virginia;

5.2.1.c. Failure to honor any contractual term or condition or to honor standard commercial practices;

5.2.1.d. The existence of an organizational conflict of interest is identified;

5.2.1.e. Funds are not appropriated or an appropriation is discontinued by the legislature for the acquisition;

5.2.1.f. Violation of any federal, state, or local law, regulation, or ordinance, and

5.2.1.g. The contract was awarded in error.

5.2.2. The Director may cancel a purchase or contract for any reason or no reason, upon providing the vendor with 30 days' notice of the cancellation.

5.2.3. Opportunity to Cure. In the event that a vendor fails to honor any contractual term or condition, or violates any provision of federal, state, or local law, regulation, or ordinance, the Director may request that the vendor remedy the contract breach or legal violation within a time frame the Director determines to be appropriate. If the vendor fails to remedy the contract breach or legal violation or the Director determines, at his or her sole discretion, that such a request is unlikely to yield a satisfactory result, then he or she may cancel immediately without providing the vendor an opportunity to perform a remedy.

5.2.4. Re-Award. The Director may award the cancelled contract to the next lowest responsible bidder (or next highest scoring bidder if best value procurement) without a subsequent solicitation if the following conditions are met:

5.2.4.a. The next lowest responsible bidder (or next highest scoring bidder if best value procurement) is able to perform at the price contained in its original bid submission, and

5.2.4.b. The contract is an open-end contract, a one-time purchase contract, or a contract for work which has not yet commenced.

Award to the next lowest responsible bidder (or next highest scoring bidder if best value procurement) will not be an option if the vendor's failure has in any way increased or significantly changed the scope of the original contract. The vendor failing to honor contractual and legal obligations is responsible for any increase in cost the state incurs as a result of the re-award.

5.3. Non-Responsible. If the Director believes that a vendor may be non-responsible, the Director may request that a vendor or spending unit provide evidence that the vendor either does or does not have the capability to fully perform the contract requirements, and the integrity and reliability necessary to assure good faith performance. If the Director determines that the vendor is non-responsible, the Director shall reject that vendor's bid and shall not award the contract to that vendor. A determination of non-responsibility must be evaluated on a case-by-case basis and can only be made after the vendor in question has submitted a bid. A determination of non-responsibility will only extend to the contract for which the vendor has submitted a bid and does not operate as a bar against submitting future bids.

5.4. Suspension.

5.4.1. The Director may suspend, for a period not to exceed 1 year, the right of a vendor to bid on procurements issued by the Purchasing Division or any state spending unit under its authority if:

5.4.1.a. The vendor has submitted a bid and then requested that its bid be withdrawn after bids have been publicly opened.

5.4.1.b. The vendor has exhibited poor performance in fulfilling his or her contractual obligations to the State. Poor performance includes, but is not limited to any of the following: violations of law, regulation, or ordinance; failure to deliver timely; failure to deliver quantities ordered; poor performance reports; or failure to deliver commodities, services, or printing at the quality level required by the contract.

5.4.1.c. The vendor has breached a contract issued by the Purchasing Division or any state spending unit under its authority and refuses to remedy that breach.

5.4.1.d. The vendor's actions have given rise to one or more of the grounds for debarment listed in W. Va. Code § 5A-3-33d.

5.4.2. Vendor suspension for the reasons listed in section 5.4 above shall occur as follows:

5.4.2.a. Upon a determination by the Director that a suspension is warranted, the Director will serve a notice of suspension to the vendor.

5.4.2.b. A notice of suspension must inform the vendor:

5.4.2.b.1. Of the grounds for the suspension;

5.4.2.b.2. Of the duration of the suspension;

5.4.2.b.3. Of the right to request a hearing contesting the suspension;

5.4.2.b.4. That a request for a hearing must be served on the Director no later than 5 working days of the vendor's receipt of the notice of suspension;

5.4.2.b.5. That the vendor's failure to request a hearing no later than 5 working days of the receipt of the notice of suspension will be deemed a waiver of the right to a hearing and result in the automatic enforcement of the suspension without further notice or an opportunity to respond; and

5.4.2.b.6. That a request for a hearing must include an explanation of why the vendor believes the Director's asserted grounds for suspension do not apply and why the vendor should not be suspended.

5.4.2.c. A vendor's failure to serve a request for hearing on the Director no later than 5 working days of the vendor's receipt of the notice of suspension will be deemed a waiver of the right to a hearing and may result in the automatic enforcement of the suspension without further notice or an opportunity to respond.

5.4.2.d. A vendor who files a timely request for hearing but nevertheless fails to provide an explanation of why the asserted grounds for suspension are inapplicable or should not result in a suspension, may result in a denial of the vendor's hearing request.

5.4.2.e. Within 5 working days of receiving the vendor's request for a hearing, the Director will serve on the vendor a notice of hearing that includes the date, time and place of the hearing.

5.4.2.f. The hearing will be recorded and an official record prepared. Within 10 working days of the conclusion of the hearing, the Director will issue and serve on the vendor, a written decision either confirming or reversing the suspension.

5.4.3. A vendor may appeal a decision of the Director to the Secretary of the Department of Administration. The appeal must be in writing and served on the Secretary no later than 5 working days of receipt of the Director's decision.

5.4.4. The Secretary, or his or her designee, will schedule an appeal hearing and serve on the vendor, a notice of hearing that includes the date, time and place of the hearing. The appeal hearing will be recorded and an official record prepared. Within 10 working days of the conclusion of the appeal hearing, the Secretary will issue and serve on the vendor a written decision either confirming or reversing the suspension.

5.4.5. Any notice or service related to suspension actions or proceedings must be provided by certified mail, return receipt requested.

5.5. Vendor Debarment. The Director may debar a vendor on the basis of one or more of the grounds for debarment contained in W. Va. Code § 5A-3-33d or if the vendor has been declared ineligible to participate in procurement related activities under federal laws and regulation.

5.5.1. Debarment proceedings shall be conducted in accordance with W. Va. Code § 5A-3-33e and these rules. A vendor that has received notice of the proposed debarment by certified mail, return receipt requested, must respond to the proposed debarment within 30 working days after receipt of notice or the debarment will be instituted without further notice. A vendor is deemed to have received notice, notwithstanding the vendor's failure to accept the certified mail, if the letter is addressed to the vendor at its last known address. After considering the matter and reaching a decision, the Director shall notify the vendor of his or her decision by certified mail, return receipt requested.

5.5.2. Any vendor, other than a vendor prohibited from participating in federal procurement, undergoing debarment proceedings is permitted to continue participating in the state's procurement process until a final debarment decision has been reached. Any contract that a debarred vendor obtains prior to a final debarment decision shall remain in effect for the current term, but may not be extended or renewed. Notwithstanding the foregoing, the Director may cancel a contract held by a debarred vendor if the Director determines, in his or her sole discretion, that doing so is in the best interest of the State. A vendor prohibited from participating in federal procurement will not be permitted to participate in the state's procurement process during debarment proceedings.

5.5.3. If the Director's final debarment decision is that debarment is warranted and notice of the final debarment decision is mailed, the Purchasing Division shall reject any bid submitted by the debarred vendor, including any bid submitted prior to the final debarment decision if that bid has not yet been accepted and a contract consummated.

5.5.4. Pursuant to W.Va. Code § 5A-3-33e(e), the length of the debarment period will be specified in the debarment decision and will be for a period of time that the Director finds necessary and proper to protect the public from an irresponsible vendor.

5.5.5. List of Debarred Vendors. The Director shall maintain and publicly post a list of debarred vendors on the Purchasing Division's website.

5.5.6. Related Party Debarment. The Director may pursue debarment of a related party at the

same time that debarment of the original vendor is proceeding or at any time thereafter that the Director determines a related party debarment is warranted. Any entity that fails to provide the Director with full, complete, and accurate information requested by the Director to determine related party status will be presumed to be a related party subject to debarment.

5.6. Damages.

5.6.1. A vendor who fails to perform as required under a contract shall be liable for actual damages and costs incurred by the state.

5.6.2. If any commodities delivered under a contract have been used or consumed by a spending unit and on testing the commodities are found not to comply with specifications, no payment may be approved by the Spending Unit for the merchandise until the amount of actual damages incurred has been determined.

5.6.3. The Spending Unit shall seek to collect damages by following the procedures established by the Office of the Attorney General for the collection of delinquent obligations.

Credits

History: Filed 4-1-19, eff. 4-1-19; Filed 4-16-21, eff. 5-1-21.

Current through register dated May 7, 2021. Some sections may be more current. See credits for details.
W. Va. C.S.R. § 148-1-5, WV ADC § 148-1-5

End of Document

EXHIBIT B To:
REQUIRED CONTRACT PROVISIONS FOR NON-FEDERAL ENTITY CONTRACTS UNDER FEDERAL AWARDS (2 C.F.R. § 200.317):

Prevailing Wage Determination

☒ – Not Applicable Because Contract Not for Construction

[ ] – Federal Prevailing Wage Determination on Next Page

HIPAA Business Associate Agreement (BAA)

WV STATE GOVERNMENT

HIPAA BUSINESS ASSOCIATE ADDENDUM

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

2. **Permitted Uses and Disclosures.**

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

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

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

3. **Obligations of Associate.**

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

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

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

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

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

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

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

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

e. **Mitigation.** Associate agrees to mitigate, to the extent practicable, any harmful effect that is known to Associate of a use or disclosure of the PHI by Associate in violation of the requirements of this Addendum, and report its mitigation activity back to the Agency.

f. **Support of Individual Rights.**

i. **Access to PHI.** Associate shall make the PHI maintained by Associate or its agents or subcontractors in Designated Record Sets available to Agency for inspection and copying, and in electronic format, if requested, within ten (10) days of a request by Agency to enable Agency to fulfill its obligations under the Privacy Rule, including, but not limited to, 45 CFR § 164.524 and consistent with Section 13405 of the HITECH Act.

ii. **Amendment of PHI.** Within ten (10) days of receipt of a request from Agency for an amendment of the PHI or a record about an individual contained in a Designated Record Set, Associate or its agents or subcontractors shall make such PHI available to Agency for amendment and incorporate any such amendment to enable Agency to fulfill its obligations under the Privacy Rule, including, but not limited to, 45 CFR § 164.526.

iii. **Accounting Rights.** Within ten (10) days of notice of a request for an accounting of disclosures of the PHI, Associate and its agents or subcontractors shall make available to Agency the documentation required to provide an accounting of disclosures to enable Agency to fulfill its obligations under the Privacy Rule, including, but not limited to, 45 CFR §164.528 and consistent with Section 13405 of the HITECH Act. Associate agrees to document disclosures of the PHI and information related to such disclosures as would be required for Agency to respond to a request by an individual for an accounting of disclosures of PHI in accordance with 45 CFR § 164.528. This should include a process that allows for an accounting to be collected and maintained by Associate and its agents or subcontractors for at least six (6) years from the date of disclosure, or longer if required by state law. At a minimum, such documentation shall include:

- the date of disclosure;
- the name of the entity or person who received the PHI, and if known, the address of the entity or person;
- a brief description of the PHI disclosed; and
- a brief statement of purposes of the disclosure that reasonably informs the individual of the basis for the disclosure, or a copy of the individual's authorization, or a copy of the written request for disclosure.

iv. **Request for Restriction**. Under the direction of the Agency, abide by any individual's request to restrict the disclosure of PHI, consistent with the requirements of Section 13405 of the HITECH Act and 45 CFR § 164.522, when the Agency determines to do so (except as required by law) and if the disclosure is to a health plan for payment or health care operations and it pertains to a health care item or service for which the health care provider was paid in full "out-of-pocket."

v. **Immediate Discontinuance of Use or Disclosure.** The Associate will immediately discontinue use or disclosure of Agency PHI pertaining to any individual when so requested by Agency. This includes, but is not limited to, cases in which an individual has withdrawn or modified an authorization to use or disclose PHI.

g. **Retention of PHI.** Notwithstanding section 4.a. of this Addendum, Associate and its subcontractors or agents shall retain all PHI pursuant to state and federal law and shall continue to maintain the PHI required under Section 3.f. of this Addendum for a period of six (6) years after termination of the Agreement, or longer if required under state law.

h. **Agent's, Subcontractor's Compliance.** The Associate shall notify the Agency of all subcontracts and agreements relating to the Agreement, where the subcontractor or agent receives PHI as described in section 2.a. of this Addendum. Such notification shall occur within 30 (thirty) calendar days of the execution of the subcontract and shall be delivered to the Agency Procurement Officer. The Associate will ensure that any of its subcontractors, to whom it provides any of the PHI it receives hereunder, or to whom it provides any PHI which the Associate creates or receives on behalf of the Agency, agree to the restrictions and conditions which apply to the Associate hereunder. The Agency may request copies of downstream subcontracts and agreements to determine whether all restrictions, terms and conditions have been flowed down. Failure to ensure that downstream contracts, subcontracts and agreements contain the required restrictions, terms and conditions may result in termination of the Agreement.

j. **Federal and Agency Access.** The Associate shall make its internal practices, books, and records relating to the use and disclosure of PHI, as well as the PHI, received from, or created or received by the Associate on behalf of the Agency available to the U.S. Secretary of Health and Human Services consistent with 45 CFR § 164.504. The Associate shall also make these records available to Agency, or Agency's contractor, for periodic audit of Associate's compliance with the Privacy and Security Rules. Upon Agency's request, the Associate shall provide proof of compliance with HIPAA and HITECH data privacy/protection guidelines, certification of a secure network and other assurance relative to compliance with the Privacy and Security Rules. This section shall also apply to Associate's subcontractors, if any.

k. **Security.** The Associate shall take all steps necessary to ensure the continuous security of all PHI and data systems containing PHI. In addition, compliance with 74 FR 19006 Guidance Specifying the Technologies and Methodologies That Render PHI Unusable, Unreadable, or Indecipherable to Unauthorized Individuals for Purposes of the Breach Notification Requirements under Section 13402 of Title XIII is required, to the extent practicable. If Associate chooses not to adopt such methodologies as defined in 74 FR 19006 to secure the PHI governed by this Addendum, it must submit such written rationale, including its Security Risk Analysis, to the Agency Procurement Officer for review prior to the execution of the Addendum. This review may take up to ten (10) days.

l. **Notification of Breach.** During the term of this Addendum, the Associate shall notify the Agency and, unless otherwise directed by the Agency in writing, the WV Office of Technology immediately by e-mail or web form upon the discovery of any Breach of unsecured PHI; or within 24 hours by e-mail or web form of any suspected Security Incident, intrusion or unauthorized use or disclosure of PHI in violation of this Agreement and this Addendum, or potential loss of confidential data affecting this Agreement. Notification shall be provided to the Agency Procurement Officer at www.state.wv.us/admin/purchase/vrc/agencyli.htm and,

unless otherwise directed by the Agency in writing, the Office of Technology at incident@wv.gov or https://apps.wv.gov/ot/ir/Default.aspx.

The Associate shall immediately investigate such Security Incident, Breach, or unauthorized use or disclosure of PHI or confidential data. Within 72 hours of the discovery, the Associate shall notify the Agency Procurement Officer, and, unless otherwise directed by the Agency in writing, the Office of Technology of: (a) Date of discovery; (b) What data elements were involved and the extent of the data involved in the Breach; (c) A description of the unauthorized persons known or reasonably believed to have improperly used or disclosed PHI or confidential data; (d) A description of where the PHI or confidential data is believed to have been improperly transmitted, sent, or utilized; (e) A description of the probable causes of the improper use or disclosure; and (f) Whether any federal or state laws requiring individual notifications of Breaches are triggered.

Agency will coordinate with Associate to determine additional specific actions that will be required of the Associate for mitigation of the Breach, which may include notification to the individual or other authorities.

All associated costs shall be borne by the Associate. This may include, but not be limited to costs associated with notifying affected individuals.

If the Associate enters into a subcontract relating to the Agreement where the subcontractor or agent receives PHI as described in section 2.a. of this Addendum, all such subcontracts or downstream agreements shall contain the same incident notification requirements as contained herein, with reporting directly to the Agency Procurement Officer. Failure to include such requirement in any subcontract or agreement may result in the Agency's termination of the Agreement.

m. **Assistance in Litigation or Administrative Proceedings.** The Associate shall make itself and any subcontractors, workforce or agents assisting Associate in the performance of its obligations under this Agreement, available to the Agency at no cost to the Agency to testify as witnesses, or otherwise, in the event of litigation or administrative proceedings being commenced against the Agency, its officers or employees based upon claimed violations of HIPAA, the HIPAA regulations or other laws relating to security and privacy, which involves inaction or actions by the Associate, except where Associate or its subcontractor, workforce or agent is a named as an adverse party.

4. **Addendum Administration.**

a. **Term.** This Addendum shall terminate on termination of the underlying Agreement or on the date the Agency terminates for cause as authorized in paragraph (c) of this Section, whichever is sooner.

b. **Duties at Termination.** Upon any termination of the underlying Agreement, the Associate shall return or destroy, at the Agency's option, all PHI received from, or created or received by the Associate on behalf of the Agency that the Associate still maintains in any form and retain no copies of such PHI or, if such return or destruction is not feasible, the Associate shall extend the protections of this Addendum to the PHI and limit further uses and disclosures to the purposes that make the return or destruction of the PHI infeasible. This shall also apply to all agents and subcontractors of Associate. The duty of the Associate and its agents

and subcontractors to assist the Agency with any HIPAA required accounting of disclosures survives the termination of the underlying Agreement.

c. **Termination for Cause.** Associate authorizes termination of this Agreement by Agency, if Agency determines Associate has violated a material term of the Agreement. Agency may, at its sole discretion, allow Associate a reasonable period of time to cure the material breach before termination.

d. **Judicial or Administrative Proceedings.** The Agency may terminate this Agreement if the Associate is found guilty of a criminal violation of HIPAA. The Agency may terminate this Agreement if a finding or stipulation that the Associate has violated any standard or requirement of HIPAA/HITECH, or other security or privacy laws is made in any administrative or civil proceeding in which the Associate is a party or has been joined. Associate shall be subject to prosecution by the Department of Justice for violations of HIPAA/HITECH and shall be responsible for any and all costs associated with prosecution.

e. **Survival.** The respective rights and obligations of Associate under this Addendum shall survive the termination of the underlying Agreement.

5. **General Provisions/Ownership of PHI.**

a. **Retention of Ownership.** Ownership of the PHI resides with the Agency and is to be returned on demand or destroyed at the Agency's option, at any time, and subject to the restrictions found within section 4.b. above.

b. **Secondary PHI.** Any data or PHI generated from the PHI disclosed hereunder which would permit identification of an individual must be held confidential and is also the property of Agency.

c. **Electronic Transmission.** Except as permitted by law or this Addendum, the PHI or any data generated from the PHI which would permit identification of an individual must not be transmitted to another party by electronic or other means for additional uses or disclosures not authorized by this Addendum or to another contractor, or allied agency, or affiliate without prior written approval of Agency.

d. **No Sales.** Reports or data containing the PHI may not be sold without Agency's or the affected individual's written consent.

e. **No Third-Party Beneficiaries.** Nothing express or implied in this Addendum is intended to confer, nor shall anything herein confer, upon any person other than Agency, Associate and their respective successors or assigns, any rights, remedies, obligations or liabilities whatsoever.

f. **Interpretation.** The provisions of this Addendum shall prevail over any provisions in the Agreement that may conflict or appear inconsistent with any provisions in this Addendum. The interpretation of this Addendum shall be made under the laws of the state of West Virginia.

g. **Amendment.** The parties agree that to the extent necessary to comply with applicable law they will agree to further amend this Addendum.

h. **Additional Terms and Conditions.** Additional discretionary terms may be included in the release order or change order process.

AGREED:

Name of Agency:_____

Signature:_____

Title:_____

Date:_____

Name of Associate: Diane Kovar, CPA

Signature: Diane Kovar

Title: Member

Date: 4/18/23

Form - WVBAA-012004
Amended 06.26.2013

APPROVED AS TO FORM THIS 26th
DAY Of June 20 23
Patrick Morrisey
Attorney General
BY _____

Appendix A

(To be completed by the Agency's Procurement Officer prior to the execution of the Addendum, and shall be made a part of the Addendum. PHI not identified prior to execution of the Addendum may only be added by amending Appendix A and the Addendum, via Change Order.)

Name of Associate: _____

Name of Agency: Bureau for Medical Services (BMS)

Describe the PHI (do not include any actual PHI). If not applicable, please indicate the same.

Claim ID, Claim Header Status, Paid Date, Bill Type, Claim Type, Plan Provider Number, Provider Name, Member ID, Member First Name, Member Last Name, Member Middle Name, Control Number, Claim Line Number, Claim Line Status, Date of Service-From, Date of Service-To, Revenue Code, Revenue Code Description, Modifier, Billed Units, Services Units, Line Billed Amount, Line Paid Amount, Coordination of Benefits Amount, Medicare Paid Amount, State Fiscal Year, Total Paid Amount, and End Date.

Firm Background

Myers and Stauffer is a national certified public accounting (CPA) and consulting firm specializing in auditing, strategic planning, delivery system and payment transformation consulting, and operational support services for government health care and social service agencies. We manage engagements in 49 states, including West Virginia.

We are one of very few firms whose sole focus is on these agencies, working to ensure Medicare and Medicaid funds are spent in compliance with state and federal laws and regulations. We have served heath care regulatory and enforcement agencies and worked with Medicare and Medicaid agencies for more than 45 years.

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.

Throughout our more than 45 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 20 offices that collectively manage active engagements with Medicaid and other public agencies in 49 states and U.S. territories, CMS, the U.S. Department of Justice, and state Medicaid Fraud Control Units. The vast majority of our client engagements have continued for longer than 15 years — a clear indication of our clients' ongoing satisfaction with the services we provide. Our exemplary track record has led to the development of a team of professionals who are committed to providing the highest-quality, most responsive and personal service, while staying abreast of regulatory changes and receiving formal training that exceeds professional requirements.

More importantly, our team understands government health care, especially state Medicaid financing. Our experience ranges from those who have been with the firm for decades, actively engaged in government health care compliance and consulting, to former state Medicaid directors and managed care plan executives. We have been in the trenches with our state and federal partners, and we know the challenges you face every day: managing scarce resources while being called upon to ensure millions of our most vulnerable citizens receive the important health care they desperately need.

Why Myers and Stauffer

- ***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 42 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 timeline for this effort.*
- ***Knowledge of National 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 closely monitor the activities of the state and national health care regulatory environment regarding Medicaid policy, innovation, payment and reimbursement strategies, health information technology, federal guidance and/or funding authorities, best practices, social determinants of health, and*

other matters to keep a current knowledge base of issues that may be relevant to this engagement. From our CMS relationships and experience in other states, we can provider BMS with current views and information on national issues. An example is keeping abreast of current developments with events and CMS response to the changes relating to the Consolidated Appropriations Act.

- ***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.*
- ***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 four-and-a-half decade 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 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 and social service agencies, thereby minimizing possible conflicts of interest. Our vast experience with public agencies has established a deep understanding of the exceptionally high degree of integrity, professionalism, and accountability that are both expected and required within our firm.

Firm Qualifications (CRFQ Section 3.1)

Proof of CPA License (3.1.1)

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

6/16/22, 4:03 PM 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	OUT-OF-STATE
Permit Number	F0188
Effective Date	07/01/2022
Current Status	Active
Expiration Date	06/30/2023

Authorization to Perform Attest/Compilation Services

Active	06/30/2023

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

https://www.boa.wv.gov/verifications/details-firm.asp 1/1

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 West Virginia 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.*

Upon the request of the State, we agree to provide "Chapter 2: Ethical Requirements" from our *Quality Control Manual* prior to contract award.

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 2*.

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 (3.1.4)

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 42

Medicaid programs to perform their DSH audits and engaged with 17 Medicaid programs for DSH payment related services 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.

Table 1. DSH Audit Clients

DSH Audit Clients – Past 10 Years (State Plan Rate Years 2009 – 2019)											
State Medicaid Client	Dates of Service	Audit Performed for State Plan Rate Year									
		2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
Alabama Medicaid Agency	2010 – 2012	✓										
Alaska Department of Health and Social Services*	2009 – Present	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Arizona Health Care Cost Containment System+	2018 – Present							✓	✓	✓	✓	✓
Arkansas Department of Human Services*	2009 – Present	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
California Department of Health Care Services*	2016 – Present					✓	✓	✓	✓	✓	✓	✓
Colorado Department of Health Care Policy & Financing*	2011 – Present	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Connecticut Department of Social Services*	2011 – Present	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Florida Agency for Health Care Administration*	2014 – Present			✓	✓	✓	✓	✓	✓	✓	✓	✓
Georgia Department of Community Health*	2009 – Present	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Hawaii Department of Human Services*	2009 – Present	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Idaho Department of Health and Welfare*	2009 – Present	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓

DSH Audit Clients – Past 10 Years (State Plan Rate Years 2009 – 2019)												
State Medicaid Client	Dates of Service	Audit Performed for State Plan Rate Year										
		2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
Illinois Department of Health Care and Family Services*	2010 – Present	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Indiana Family and Social Services Administration*	2009 – Present	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Kansas Department of Health and Environment*	2009 – Present	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Kentucky Cabinet for Health and Family Services*	2009 – Present	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Louisiana Department of Health*	2009 – Present	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Maine Department of Health and Human Services*/**	2016 – Present					✓	✓	✓	✓	✓	✓	✓
Maryland Department of Health*	2009 – Present	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Michigan Department of Health and Human Services*	2009 – Present	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Minnesota Department of Human Services*	2015 – Present			✓	✓	✓	✓	✓	✓	✓	✓	✓
Mississippi Office of the Governor*	2009 – Present	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Missouri Department of Social Services*	2010 – Present	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Montana Department of Public Health and Human Services^	2009 – Present	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
Nebraska Department of Health and Human Services*	2009 – Present	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Nevada Department of Health and Human Services*	2009 – Present	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
New Hampshire Department of Health and Human Services*	2009 – Present	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
New Jersey Department of Human Services*	2012 – Present	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
New Mexico Human Services Department*	2009 – Present	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
North Carolina Department of Health and Human Services*	2009 – Present	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
North Dakota Department of Human Services*	2009 – Present	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Ohio Department of Medicaid*	2010 – Present	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Oklahoma Health Care Authority*	2009 – Present	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓

DSH Audit Clients – Past 10 Years (State Plan Rate Years 2009 – 2019)												
State Medicaid Client	Dates of Service	Audit Performed for State Plan Rate Year										
		2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
Oregon Department of Human Services*	2009 – Present	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Rhode Island Department of Human Services*	2010 – Present	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
South Carolina Department of Health and Human Services*	2006 – Present	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
South Dakota Department of Social Services*	2020 – Present										✓	✓
Tennessee Department of Finance and Administration*	2010 – Present	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Texas Health and Human Services Commission*	2009 – Present	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Utah Department of Health*	2019 – Present									✓	✓	✓
Virginia Department of Medical Assistance Services*	2009 – Present	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Washington Health Care Authority*	2009 – Present	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
West Virginia Health Care Authority	2010 – 2015	✓	✓	✓	✓							
Wisconsin Department of Health Services*	2012 – Present	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Wyoming Department of Health*	2009 – Present	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓

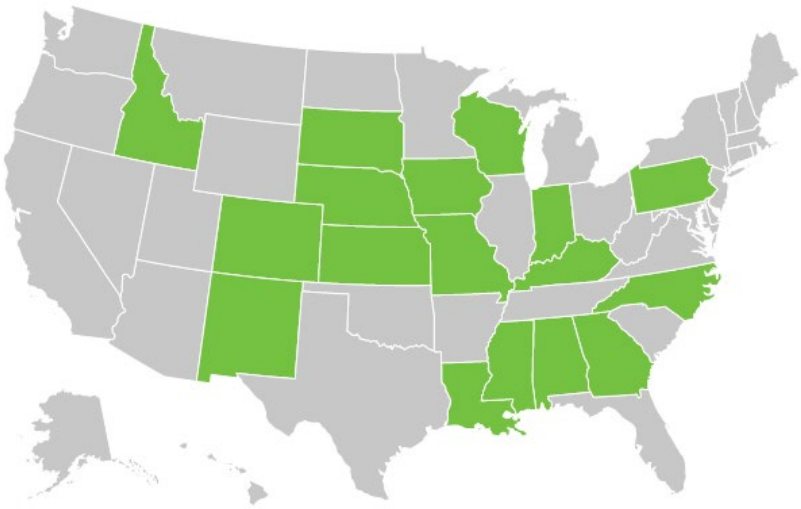
**Denotes current (2023) DSH audit client.*
***Myers and Stauffer was hired by the state of Maine to redo the 2011 and 2012 audits previously completed by their prior audit contractor.*
^2018 was the last audit year. We still have a contract but the state stopped making DSH payments to hospitals after 2018. If any providers fall back in to the program then we are still the contracted auditor.
+ Agreed-upon procedures contract for client.

As requested in the CRFQ, we will provide letters verifying successful completion and acceptance by CMS within three business days of request by the state.

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.

The following map highlights our current state Medicaid DSH payment clients.

Figure 1. Medicaid DSH Payment Clients



Engagement Partner Experience (3.1.4.1)

Our audit engagement partner, Ms. Diane Kovar, CPA, has experience working on Medicaid DSH audits since before the 2008 DSH Final Rule, covering more than 13 years of experience and 15 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. Ms. Kovar meets and exceeds the requirement of five years prior federal Medicaid DSH audit experience for each of the DSH types. Below, we have summarized her five years of DSH audit experience by hospital type, noting states and years.

- *Acute Care (DSH Years 2015 – 2019) – Connecticut, New Hampshire, Oregon, Rhode Island, South Carolina.*
- *Critical Access Hospital (DSH Years 2015 – 2019) – New Hampshire, Oregon, South Carolina.*
- *Children's Hospital (DSH Years 2015 – 2019) – Connecticut, Oregon, South Carolina.*
- *IMD (DSH Years 2015 – 2019) – Connecticut, New Hampshire, Oregon, Rhode Island, South Carolina.*
- *LTC Hospital (DSH Years 2015 – 2019) – 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 A: Engagement Partner Experience by Hospital Type.*

Organizational Chart (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.

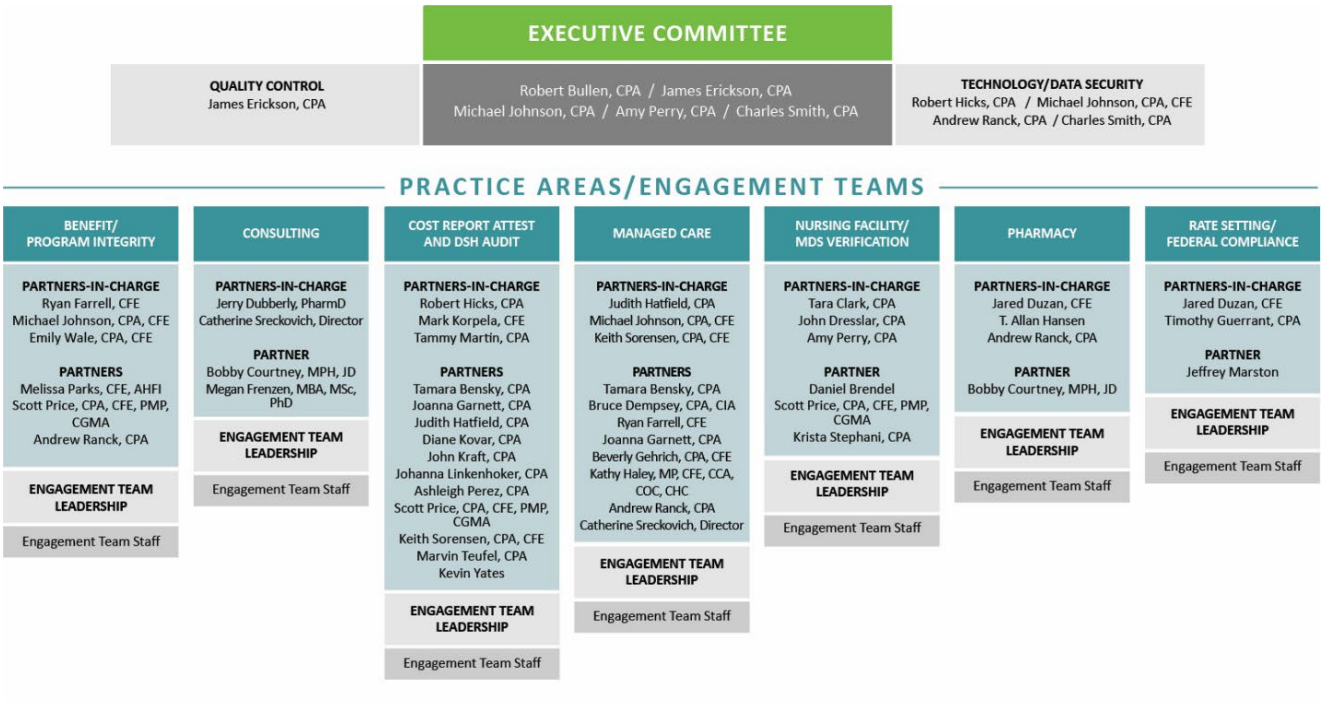
We know our clients will not be successful unless we provide them with the highest levels of accuracy, accountability, responsiveness, and experience in health care policy and auditing staff. We, as a firm and as individuals, pride ourselves on our professionals' depth of experience and will provide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

Firm-Wide Organizational Chart

Myers and Stauffer's organizational chart is headed by an executive committee and subdivided into seven engagement teams. We have structured our organization by service lines to facilitate the development of highly-specialized technical skills and coordinated delivery of services to government-sponsored health and human service agencies. These service lines, or "engagement teams," address the full spectrum of health and human services and are categorized as the following: benefit and program integrity; consulting; cost report attest and DSH audits; managed care; nursing facility (NF) rate setting and minimum data set (MDS) verification; pharmacy; and rate setting and federal compliance. The chart below identifies the members and principals (collectively referred to as "partners") leading each engagement team and a brief description of each team immediately follows.

Figure 2. Firm-Wide Organizational Chart



- ***Cost Report Attest and DSH Audit.*** *This engagement team provides attest services ensuring provider costs are properly reported in accordance with program policies. They also perform required audits of state Medicaid DSH payment programs.*
- ***Benefit/Program Integrity.*** *This engagement team focuses on the integrity of various payment programs and operating systems. This includes activities focused on fraud, waste, and abuse; eligibility accuracy; regulatory compliance; risk assessments; payment accuracy; and systems security.*
- ***Consulting.*** *This engagement team works with state government agencies to address issues impacting the complexities of the program, evaluation of care required by program beneficiaries, integrating physical medicine with behavioral health treatment pathways, as well as the data and technical infrastructure that supports them. The consulting team provides innovative solutions that align with overarching health care and social service objectives to address quality improvement, care integration, data and health information technology, change management, alternative payment models (APMs), performance measurement, and evaluation while addressing social determinants of health and the unique needs of local patient populations.*
- ***Managed Care.*** *This engagement team focuses on a broad spectrum of managed care-related services including contract compliance performance audits; encounter data validation and reconciliation; medical loss ratio (MLR) audits; external quality review activities, network*

adequacy, grievance and appeal issues, subcontractor oversight, and policy and program development consulting, including readiness reviews, contracting best practices, APMs, and pass-through and supplemental payments.

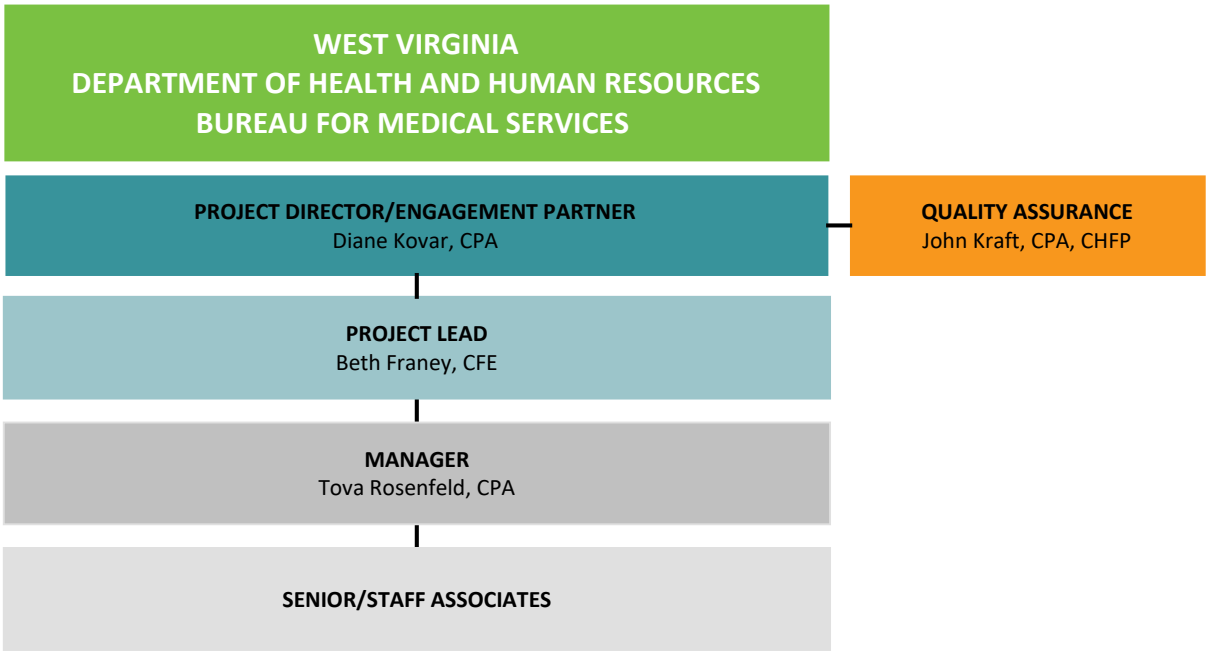
- ***NF Rate Setting.*** *This engagement team focuses on the development, implementation, and maintenance of NF payment systems, especially case mix systems. These systems may also include value-based purchasing (VBP) and pay-for-performance (P4P). In addition, the team performs MDS reviews to ensure pricing accuracy.*
- ***Pharmacy.*** *This engagement team focuses on various components of a pharmacy program, including rate setting for drug ingredients and dispensing fees; National Average Drug Acquisition Cost pricing benchmark; pharmacy benefit manager audits; and other consulting services to address subjects such as specialty drugs, compound drugs, and 340B programs.*
- ***Rate Setting/Federal Compliance.*** *This engagement team develops rates and reimbursement systems, Medicaid financing, and payment ecosystems that support and promote program policies and health care objectives. They work with clients to address the need of reimbursement due to rapidly evolving changes in health care as a result of the behavioral health crisis that states have been grappling with over the last decade or more. Services include Medicaid financing and supplemental payments (e.g., provider assessments, upper payment limits [UPLs] and DSH payment calculations); reimbursement and rate setting for both systems and ambulatory services: acute care, ambulance, ambulatory payment classification, behavioral health, clinics, dental, diagnosis-related group (DRG), durable medical equipment (DME), enhanced ambulatory patient groups, FQHC, graduate medical education, outpatient (OP), physician and practitioner, transportation, and other fee schedules.*

The services under this CRFQ will be performed by the Cost Report Attest and DSH Audit engagement team.

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.

Figure 3. Engagement Team Organizational Chart



Experience of Proposed Supervisory Staff (3.3)

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. Following, 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 B: Resumes*. You will note that all supervisory staff have between eight and 17 years of hands-on DSH audit experience which significantly exceeds the required minimum of three years' experience working with other Federal DSH audit engagements. 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.

Table 2. Proposed Supervisory Staff

Myers and Stauffer: Proposed Supervisory Staff				
Team Member	**Role in Project**	**Health Care Exp.**	**Exp. with WV**	**Qualifications**
Diane Kovar, CPA *Member/Partner*	***Project Director/Engagement Partner:*** Ms. Kovar will have overall responsibility for all aspects of the project and will ensure total client satisfaction and establish the overall client service approach. She will work with the Project Lead and Project Manager to ensure successful outcomes.	25 years (including 17 years of DSH audits)	✓	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, New Hampshire, Oregon, 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.
John Kraft, CPA, CHFP *Member/Partner*	***Quality Assurance:*** Mr. Kraft will provide technical support on high-level audit issues and input on standard procedures and reports, and establish quality control standards.	36 years (including 17 years of DSH audits)	✓	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 Colorado, Connecticut, New Hampshire, Oregon, Rhode Island, South Carolina, and Tennessee. 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' DSH and 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.
Beth Franey, CFE *Senior Manager*	***Project Lead:*** Ms. Franey will work with Ms. Kovar 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	16 years (including 14 years of DSH audits)	✓	Ms. Franey has worked in the Medicare and Medicaid audit and investigation arena for many years. She has performed and reviewed DSH desk reviews for West Virginia, Colorado, Connecticut, Massachusetts, New Hampshire, Oregon, Rhode Island, South Carolina, Tennessee, and Vermont. She has also performed Medicaid cost settlements for Georgia and South Carolina, as well as performed health care litigation support and fraud investigation in federal health care programs.

Myers and Stauffer: Proposed Supervisory Staff				
Team Member	**Role in Project**	**Health Care Exp.**	**Exp. with WV**	**Qualifications**
	available to BMS staff on a daily basis.			
Tova Rosenfeld, CPA *Manager*	***Manager:*** Ms. Rosenfeld will be available to serve as a contact for hospitals and assist with directing the work of staff auditors and accountants.	22 years (including 8 years of DSH audits)		Ms. Rosenfeld has significant experience in health care compliance and consulting, working with various states on DSH audits, including Connecticut, New Hampshire, Oregon, South Carolina, and Tennessee. Additionally, she has provided litigation support services as a subcontractor for the Federal Bureau of Investigation.

GAGAS Training (3.4)

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.*

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 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.

Our proposed key staff have training and experience that includes GAGAS training and government program audits. We have included CPE documentation for our key management staff in *Appendix B: 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 Requirements (CRFQ Section 4)

Our Understanding of the Project

The CMS implemented Section 1923(j)(2) of the Act under 42 Code of Federal Regulations (CFR) §455.300 when they issued their final DSH Audit Rule on December 19, 2008 (73 FR 77904). This is the rule that established the requirement that an independent certified audit be performed for all Medicaid DSH programs nationally. Under 42 CFR §455.304, CMS required submission of the independent audit report annually and established six verifications that must be addressed in the report along with established timelines that the report be submitted to the state by September 30 each year and to CMS by December 31 of each year. Myers and Stauffer's independent audit report addresses all six of these required verifications, and we have assisted many states, including West Virginia in the past, in meeting these deadlines each year since the rule was published.

The service we provide requires commitment to and an understanding of the client's goals and objectives, as well as specialized industry knowledge to help our clients achieve success.

As part of the December 19, 2008 DSH Audit Rule, CMS also implemented annual reporting requirements under 42 CFR §447.299 that a state is required to submit along with their annual independent audit report. There are currently 21 items listed under the reporting requirements, and Myers and Stauffer helps all of their state clients prepare this report as part of the annual DSH examination.

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).*
- *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.*
- *Third Party Payments in DSH: April 3, 2017 (82 FR 16114).*

- *CMS bulletin withdrawing Questions 33 and 34 from the Additional Information on the DSH Reporting and Audit Requirements FAQ issued on December 31, 2018.*
- *Informational Bulletin on the Treatment of Third-Party Payers in Calculating Uncompensated Care Cost (UCC) issued by CMS: August 18, 2020.*
- *H.R. 133/Public Law 116-260 Consolidated Appropriations Act, 2021 (Dec. 27, 2020: 134 Stat/ 1182: 2, 124 pages).*
- *H.R. 1319/American Rescue Plan Act signed March 11, 2021 addressing allotments during the temporary Medicaid Federal Medical Assistance Percentages increase.*
- *Proposed Regulation; Medicaid Program; Disproportionate Share Hospital Third-Party Payer Rule: February 24, 2023 (88 FR 11865).*

A key item to highlight as impacts upcoming DSH audits is the Consolidated Appropriations Act of 2021, signed into law on December 27, 2020, which brought additional changes to the DSH program concerning the treatment of the cost of services related to dually-enrolled individuals (Medicare and Medicaid, or private insurance and Medicaid). In general, the Act now only allows the inclusion of costs and payments for which the Medicaid program is the primary payer. However, the Act does allow for an exception to this general requirement if including the cost and payments related to dually-enrolled individuals results in a higher hospital-specific DSH limit. To qualify for this exception, the hospital must be in the 97th percentile of all hospitals in either the number of Medicare supplemental security income (SSI) days or percentage of Medicare SSI days to total inpatient days in its most recent cost reporting period. These provisions of the Act are effective for fiscal years beginning on or after October 1, 2021. The Proposed Medicaid Program; Disproportionate Share Hospital Third-Party Payer Rule (February 24, 2023) proposes to address changes as a result of the Consolidated Appropriations Act of 2021 as well as other administrative inefficiencies and DSH program clarifications. At this point in time, the proposed rule has not been finalized.

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.

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 continuous monitoring of current regulatory developments that may impact our state clients.

Mandatory Contract Services Requirements and Deliverables (4.1)

We understand that contract services must meet or exceed the mandatory requirements listed in CRFQ 4.1.1 – 4.1.6.

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 4.1.5: Work Plan* for more details. Travel and incidental costs will be included in the all-inclusive, firm fixed price.

Engagement Performance (4.1.2)

We agree to perform the engagement so that it includes each of the following:

- ***Compliance (4.1.2.1).*** *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 15 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 (4.1.2.2).*** *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 2021, we will complete our work procedures by September 30, 2024. We will then complete a draft report by October 31, 2024, and a final report by November 30, 2024. Please see our Timeline included in Section 4.1.5: Work Plan.*

- ***Source Documents (4.1.2.3).*** *To complete our examination, we will utilize the Medicaid State Plan, State Fiscal Agent payment and utilization data, Medicare 2552-10 or related cost reports, and hospital audited financial statements and accounting records.*

Verifications (4.1.3)

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 4.1.5: Work Plan* and have included a draft format of the schedule in *Appendix C: Hospital Schedule.*

CMS Confirmation (4.1.4)

To the best of our knowledge, all DSH reports that we have compiled for our clients have been accepted by CMS. Upon the request of the state, we agree to provide letters verifying CMS acceptance of three state DSH reports.

Work Plan (4.1.5)

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 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 management information systems (MMIS) reports, cost reports, state plan, and other data from the State.*
- *Conduct an annual training session for hospitals, to educate them regarding DSH regulations, the examination approach and protocol we follow, and their responsibilities for responding to the DSH examination request.*
- *Send surveys to the hospitals for them to complete and submit to us for examination.*
- *Conduct desk reviews on the surveys.*
- *Using a risk-based approach, select hospitals for expanded procedures.*
- *Complete expanded procedures for hospitals selected.*
- *Perform senior management review of desk reviews and audits.*
- *Prepare a draft examination report and management letter for submission to the State.*
- *Meet with the State to discuss the examination report and findings.*
- *Issue the final examination report for submission to CMS.*
- *We will continue to provide you with continuous communication throughout the examination process. In addition to the entrance and exit conferences, we will hold intermittent status meetings as needed to discuss the detailed project plan and our progress towards completion. Further, we will be available to answer any questions and address any concerns during the course of the examination.*

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 hospitals' concerns with providing data and complying with this federally mandated audit.

DSH Examination Approach

The examination process will encompass examining data from each DSH hospital for the state fiscal year being audited. To complete the reports, we will gather information, including detailed claims data, for the cost reporting periods that cover the state plan rate year under examination. 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. Due to the Consolidated Appropriations Act of 2021, changes to the DSH examination survey tool will be necessary to ensure provider claims are appropriately included or excluded as defined by the Act and any additional guidance provided by CMS. Myers and Stauffer has already begun the process of implementing necessary revisions in anticipation of the changes required by the Consolidation Appropriations Act. We will put in the time required to ensure updates are made and any issues that arise or future CMS guidance are appropriately addressed.

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 examination, 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 examination. It is important that the state select a contractor that is not only able to conduct the examination, 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 and ensure that only costs eligible for DSH payments are included in the development of the hospital-specific DSH limit.

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 examination. 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.**

**Please note due to the proposed DSH Third-Party Payer Rule's removal of Medicaid individuals with third-party payers, these payer types will be excluded for any provider not meeting the 97th percentile exception. The exception to the exclusion of Medicaid services with third-party coverage can be applied to the 97th percentile hospitals, if it is beneficial for the hospital to do so. Refer to the proposed DSH Third-Party Payer Rule's updated language for Section 447.295(d)(3): (3) Effective for each State's first Medicaid state plan rate year (SPRY) beginning on or after October 1, 2021, and thereafter, the hospital-specific DSH limit for a 97th percentile hospital defined in paragraph (b) of this section is the higher of the values from the calculations described in paragraphs (d)(1) and (2) of this section.*

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 (MMIS 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. In addition, DSH payments received by the hospitals from other states, if any, will be compiled. DSH 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 examination. The schedule will also include the adjusted hospital-specific DSH limit (uncompensated care costs) for the period under examination. 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 utilize 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 Medicaid 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 examination.*
- *Payment and utilization information from the state's MMIS reports.*
- *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 obtain representations from the hospitals to determine if any hospitals were required to return all or a portion of their DSH payment. Additional testing, if needed, will include tracing the DSH payment into the accounting records and identifying any indications of credits or amounts being returned to the State.

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

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

After obtaining the data for costs and payments, we will recalculate the hospital-specific DSH limit for each hospital and determine if DSH payments made to the hospital were within this limit. Any variances will be fully communicated to the Department and each of the hospitals.

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 and testing for accuracy and appropriateness of costs reported by the hospitals. The survey isolates the cost of hospital services (excluding non-hospital services) related to Medicaid-eligible and uninsured individuals. Our testing includes tests for accuracy and allowability of costs.

For hospitals selected for expanded testing, we will begin testing the hospital's representations of Medicaid or uninsured (depending on population(s) selected for additional testing) charges and payments by reviewing the hospital 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 Medicaid-eligible and uninsured.

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

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 for such items as follows:

- *Dates of service for Medicaid and uninsured charges and days were within the service period of the cost report under review.*
- *All applicable payments received for Medicaid patient dates of service were included in the analysis.*
- *Payment dates, regardless of date of service, were within the service period of the cost report under review for uninsured payments.*
- *All uninsured payments received for the patient during the cost reporting period were included in the analysis.*
- *No evidence of available third-party coverage (even if no payments were received from the third party) for uninsured.*
- *Evidence of Medicaid coverage for Medicaid patients.*

- *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 uninsured claims for evidence of large payments that may indicate insurance coverage.*

If exceptions are noted during the testing of Medicaid or uninsured data, 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 Medicaid-eligible or 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 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.

Only allowable costs will be included in the final hospital-specific disproportionate share limit. Please see *Appendix D: DSH Survey Tool* for an example survey.

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, Medicaid managed care (if applicable and/or available) and Medicare crossover services 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 a UPL). As part of the survey document sent to hospitals, we will request information on Medicaid services provided to out-of-state residents, in-state Medicaid services provided not included in state data (if applicable) 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.

*Please note due to the proposed DSH Third-Party Payer Rule's removal of Medicaid individuals with third-party payers, the proposed DSH Third-Party Payer Rule proposes to change the language for several sections of the 42 CFR to remove references to "Medicaid eligible individuals." DSH examination reports will require an update to the new language (including the verifications 3 and 4) once the proposed rule is finalized.

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 Department 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.

For each verification, we will provide recommendations to the Department and hospitals to assist in addressing any findings resulting from our DSH examination.

DSH Examination Report

Myers and Stauffer will provide an annual DSH examination report, which includes an independent accountant's report in accordance with attestation standards established by the American Institute of Certified Public Accountants and the standards applicable to attestation engagements contained in Government Auditing Standards issued by the Comptroller General of the United States, as well as General DSH Audit and Reporting Protocol as required by 42 CFR §455.301 and §455.304(d). Following the accountant's report will be the Schedule of Data Caveats Relating to the DSH Verifications. The reporting requirements in the Final Rule require the examiner to identify any data deficiencies or caveats detected 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 used to verify the data. Any unresolved data issues or caveats will be documented and disclosed in the final examination report as deemed necessary.

Additionally, under 42 CFR Section 447.299, states must submit additional reporting along with the completed audit required under Section 455.304. This includes a number of required data items. Our report will comply with this requirement and include a schedule that summarizes all in-state hospitals that received a DSH payment in the state fiscal year under examination. The schedule will also include the adjusted hospital-specific DSH limit (UCC) for the period under examination. Hospitals that received DSH funds in excess of their hospital-specific DSH limits will be clearly identified.

The report will include the following information for each DSH hospital to which West Virginia made a DSH payment in order to permit verification of the appropriateness of such payments:

1. ***Hospital name.*** *The name of the hospital that received a DSH payment from the state, identifying facilities that are 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 Managed Care Organization (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 MCO 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 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 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 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 MCO 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. ***Medicaid provider number.*** *The provider identification number assigned by the Medicaid program.*
19. ***Medicare provider number.*** *The provider identification number assigned by the Medicare program.*
20. ***Total hospital cost.*** *The total annual costs incurred by each hospital for furnishing IPhospital and OP hospital services.*
21. ***Reporting out-of-state.*** *For out-of-state hospitals, states must report, at a minimum, the information identified in Numbers 6, 8, 9, 17, 18, and 19.*[1]

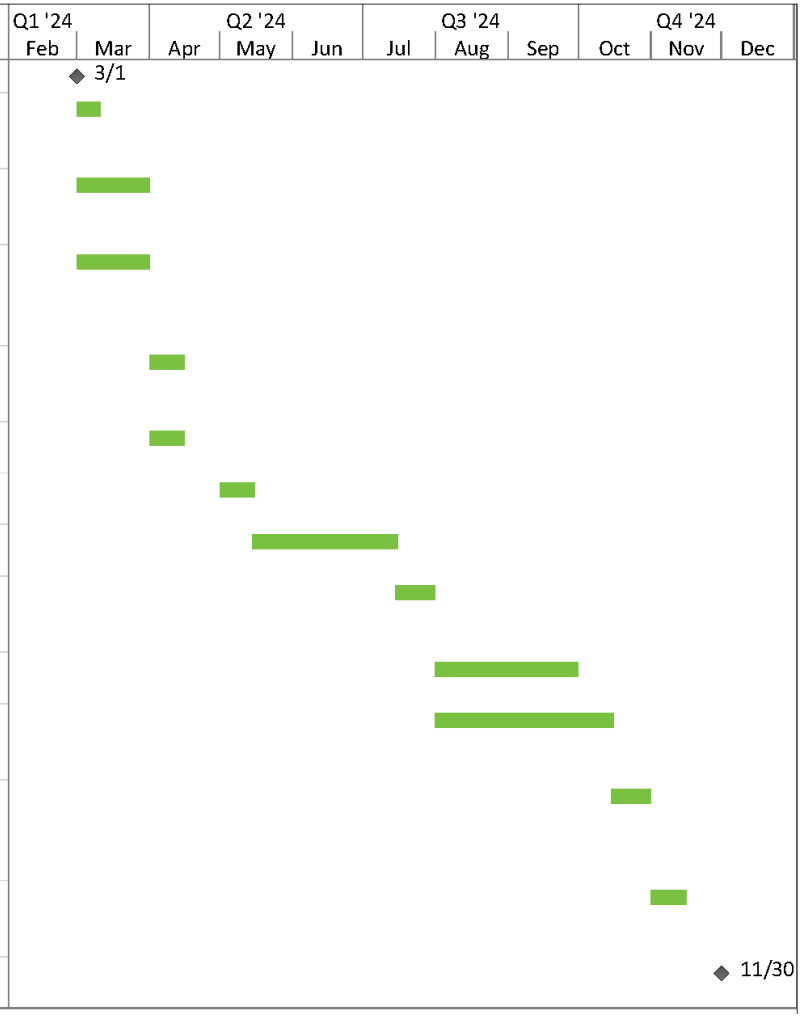
[1] *Please note the proposed DSH Third-Party Payer Rule will move this data element to (22) and add a new data element (21) Financial impact of audit findings. The proposed data element is an attempt to identify actual or estimated financial impacts of audit findings. The proposed rule is currently open for comments and subject to change. We are prepared to help the State make any necessary updates and modifications to the annual reporting requirements once the proposed rule becomes final.*

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.

Timeline

Figure 4. Proposed Timeline

Task Name	Purpose	Start
Approximate Date Contract Begins		Fri 3/1/24
Meet with State to discuss project and timelines	To explain nature of procedures, answer questions, and obtain initial information	Fri 3/1/24
Update DSH survey tool to reflect any changes needed specific to West Virginia and obtain necessary state approvals	To ensure appropriate data collection and approvals	Fri 3/1/24
Gather necessary data such as state MMIS reports, cost reports, state plan, schedule of DSH payments, and other data from the State	To understand nature of payments made and develop examination plan	Fri 3/1/24
Conduct an annual training session for hospitals	To educate and provide instructions to hospitals on DSH examination and requested information	Mon 4/1/24
Send surveys to the hospitals	Information on which hospital-specific procedures will be performed	Mon 4/1/24
Obtain survey data from the hospitals	Information on which hospital-specific procedures will be performed	Wed 5/1/24
Conduct desk reviews on the surveys	Ensure the data used to determine hospital-specific DSH limits is proper	Wed 5/15/24
Using a risk-based approach, select hospitals for expanded procedures.	Conduct planning to ensure for an efficient examination with the proper level of coverage	Mon 7/15/24
Complete expanded procedures for hospitals selected	Ensure the data used to determine hospital-specific DSH limits is proper	Thu 8/1/24
Perform senior management review of desk reviews and audits	To perform independent review of work papers to ensure that quality standards are met	Thu 8/1/24
Prepare a draft examination report and management letter for submission to the State	To allow state the opportunity to review a draft copy of the report and provide comments and/or additional documentation	Tue 10/15/24
Meet with the state to discuss the examination report and findings	Discuss results of procedures with state representatives and allow adequate time for response	Fri 11/1/24
Issue the final examination report for submission to CMS	Summarize findings and comply with the DSH Audit Rule	Sat 11/30/24



GAGAS Standards (4.1.6)

We will conduct the examination 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.

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.

Prior to beginning work, we agree to deliver a training plan to the agency within five business days. 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 42 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. 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 E: Sample Training Materials*. These materials have been used in our presentations to Colorado, Tennessee, and Washington.

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 and will 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.

Service Level Agreements (4.2.8)

We agree to be bound by all service level agreements included in Exhibit B of the CRFQ.

Additional Services (4.2.9)

We agree to provide additional services to comply with externally driven changes to programs and requirements as addressed in the CRFQ.

Transition to New Vendor (4.2.10)

We will assist and fully cooperate with the Agency when transitioning to a new Vendor at the end of the contract executed from this CRFQ. This will include providing a Close-Out and Turnover plan that identifies our approach, tasks, staffing, and schedule for turnover of contract responsibilities within 30 calendar days. Also within 30 calendar days of the request, we will transfer any data requested related to the services executed from the CRFQ.

Pricing Page (CRFQ Section 5.2)

Our pricing is based on our understanding of your request and our previous experience conducting DSH audits for 42 states, many of which had a diverse hospital community similar to West Virginia's in terms of hospital types, size and sophistication of management.

Table 3. Pricing

Myers and Stauffer Pricing		
Commodity Line	**Description**	**Price**
1	Total Cost for Audit for SFY 2021	$155,000
2	Total Cost for Audit for SFY 2022	$159,700
3	Total Cost for Audit for SFY 2023	$164,500
4	Total Cost for Audit for SFY 2024	$169,425
5	Additional Services – Base Year One ($120.00 x 100 Hours)	$12,000
6	Additional Services – Optional Renewal Year One ($123.60 x 100 Hours)	$12,360
7	Additional Services – Optional Renewal Year Two ($127.30 x 100 Hours)	$12,730
8	Additional Services – Optional Renewal Year Three ($131.15 x 100 Hours)	$13,115
	Total Not-to-Exceed Cost	**$698,830**

Our pricing is based on the following assumptions as outlined in the CRFQ:

- *Additional Services will be invoiced in arrears upon receipt of services by the Agency.*
- *The hours included in the additional services lines are an estimate, for bid purposes only, and are not meant to be an annual cap. Actual utilization may be more or less.*
- *Basis for award will be lowest Grand Total Estimated Cost.*
- *Our total not to exceed cost includes 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.*

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
Member
PH: 800.505.1698
FX: 410.356.0188
Email: dkovar@mslc.com

Appendix

- *Appendix A: Engagement Partner Experience by Hospital Type.*
- *Appendix B: Resumes.*
- *Appendix C: Hospital Schedule.*
- *Appendix D: Sample DSH Survey Tool.*
- *Appendix E: Sample Training Materials.*
- *Appendix F: Certificates of Insurance.*

Appendix A: Engagement Partner Experience by Hospital Type

Following is a breakdown of our engagement partner's last five years of DSH audit experience, denoted by audit year.

Engagement Partner Experience by Hospital Type Acute Care Providers						
	Audit Year					
Facility	**2015**	**2016**	**2017**	**2018**	**2019**	**Grand Total**
Connecticut						
Bridgeport Hospital		1				1
Day Kimball Hospital	1	1	1			3
John Dempsey Hospital	1	1	1	1	1	5
St. Mary's Hospital	1	1	1	1		4
Waterbury Hospital	1			1	1	3
Yale New Haven Hospital		1	1			2
New Hampshire						
Catholic Medical Center	1	1	1	1	1	5
Concord Hospital Inc.	1	1	1	1	1	5
Elliot Hospital	1	1	1	1	1	5
Exeter Hospital	1	1	1	1	1	5
Frisbie Memorial Hospital	1	1	1	1	1	5
Lakes Region General Hospital	1	1	1	1	1	5
Mary Hitchcock Memorial Hospital	1	1	1	1	1	5
Parkland Medical Center	1	1	1	1	1	5
Portsmouth Regional Hospital	1	1	1	1	1	5
Southern New Hampshire Medical Center	1	1	1	1	1	5
St Joseph Hospital	1	1	1	1	1	5
The Cheshire Medical Center	1	1	1	1	1	5
Wentworth Douglass Hospital	1	1	1	1	1	5
Oregon						
Adventist Medical Center-Portland	1	1			1	3
Ashland Community Hospital	1	1	1			3
Bay Area Hospital	1	1	1	1	1	5
Good Samaritan Hospital Corvallis	1	1	1		1	4
Kaiser Sunnyside Medical Center	1					1
Legacy Emanuel Hospital & Health Center	1	1	1	1	1	5
Legacy Good Samaritan Hospital & Medical Center	1	1	1	1	1	5

Engagement Partner Experience by Hospital Type Acute Care Providers						
	Audit Year					
Facility	2015	2016	2017	2018	2019	Grand Total
Legacy Meridian Park Hospital	1	1	1	1	1	5
Legacy Mount Hood Medical Center	1	1	1	1	1	5
Legacy Salmon Creek Hospital	1	1	1	1	1	5
McKenzie-Willamette Medical Center	1	1				2
Mercy Medical Center	1	1	1			3
Mid-Columbia Medical Center	1	1	1			3
Oregon Health Sciences University	1	1	1	1		4
Providence Medford Medical Center	1	1	1	1	1	5
Providence Milwaukie Hospital	1					1
Providence Newberg Medical Center	1	1	1			3
Providence Portland Medical Center	1	1	1	1		4
Providence St Vincent Medical Center	1	1	1	1	1	5
Providence Willamette Falls Medical Center	1	1	1	1	1	5
Rogue Regional Medical Center	1	1	1	1		4
Sacred Heart Medical Center at Riverbend	1	1	1			3
Sacred Heart Medical Center University District	1	1				2
Saint Alphonsus Medical Center-Ontario	1	1	1		1	4
Salem Hospital	1	1	1			3
Samaritan Albany General Hospital	1	1	1	1		4
Santiam Memorial Hospital	1	1	1			3
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		4
St Charles Medical Center - Redmond	1	1	1	1		4
Three Rivers Medical Center	1	1	1			3
Tuality Healthcare	1	1	1		1	4
Rhode Island						
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		4
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

Engagement Partner Experience by Hospital Type Acute Care Providers						
	Audit Year					
Facility	2015	2016	2017	2018	2019	Grand Total
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
South Carolina						
Aiken Regional Medical Center	1	1	1	1	1	5
Anmed Health	1	1	1	1	1	5
Baptist Easley Hospital	1	1	1	1	1	5
Beaufort Memorial Hospital	1	1	1	1	1	5
Cannon Memorial Hospital	1	1	1	1	1	5
Carolina Pines Regional	1	1	1	1	1	5
Carolinas Medical Center	1	1	1	1	1	5
Chester RMC (MUSC Chester Med Center)	1	1	1	1	1	5
Chesterfield General Hospital	1					1
CHS - Florence (MUSC Florence Med Center)	1	1	1	1	1	5
Clarendon Memorial Hospital	1	1				2
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
Doctors 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 Hospital	1	1	1	1	1	5
Grand Strand Regional Medical Center	1	1	1	1	1	5
Greenville Hospital Center	1	1	1	1	1	5
Greer Memorial	1	1	1	1	1	5
Hampton Regional Medical Center	1	1	1	1	1	5
Hillcrest Hospital	1	1	1	1	1	5
Hilton Head Hospital	1	1	1	1	1	5
Kershaw County Memorial Hospital	1	1	1	1	1	5
Lake City Community Hospital	1	1	1	1	1	5
Lexington Medical Center	1	1	1	1	1	5
Marion County Medical Center	1	1	1	1	1	5

Engagement Partner Experience by Hospital Type Acute Care Providers						
	Audit Year					
Facility	2015	2016	2017	2018	2019	Grand Total
Marlboro Park Hospital	1					1
Mary Black Gaffney (Cherokee Med Center)	1	1	1	1	1	5
Mary Black Memorial Hospital	1	1	1	1	1	5
McLeod Cheraw	1	1	1	1	1	5
McLeod Health Clarendon		1	1	1	1	4
McLeod Loris Hospital	1	1	1	1	1	5
McLeod Regional Medical Center	1	1	1	1	1	5
McLeod Regional Medical Center - Dillon	1	1	1	1	1	5
Medical College Of Georgia	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 Health Baptist	1	1	1	1	1	5
Palmetto Health Richland	1	1	1	1	1	5
Palmetto Parkridge	1	1	1	1	1	5
Patewood Memorial Hospital	1	1	1	1	1	5
Pelham Medical Center	1	1	1	1	1	5
Piedmont Medical Center	1	1	1	1	1	5
Providence Hospital	1	1	1	1	1	5
Roper Hospital	1	1	1	1	1	5
Self Regional Healthcare	1	1	1	1	1	5
Southern Palmetto (Barnwell)	1	1				2
Spartanburg Regional Medical Center	1	1	1	1	1	5
Springs Memorial (MUSC - Lancaster Med Center)	1	1	1	1	1	5
St Francis Health System	1	1	1	1	1	5
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	1	1	5
Union Medical Center (Wallace Thompson)		1	1	1	1	4
Waccamaw Community Hospital	1	1	1	1	1	5
Wallace Thomson Hospital	1					1
Grand Total	**120**	**118**	**112**	**100**	**96**	**546**

Engagement Partner Experience by Hospital Type Acute Care Providers						
	Audit Year					
Facility	2015	2016	2017	2018	2019	Grand Total

Engagement Partner Experience by Hospital Type Critical Access Hospital Providers						
Facility	2015	2016	2017	2018	2019	Grand Total
New Hampshire						
Alice Peck Day Memorial Hospital	1	1	1	1	1	5
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
Valley Regional Hospital	1	1	1	1	1	5
Weeks Medical Center	1	1	1	1	1	5
Oregon						
Blue Mountain Hospital	1					1
Columbia Memorial Hospital	1	1	1			3
Coquille Valley Hospital	1					1
Cottage Grove Community Hospital	1	1	1			3
Curry General Hospital	1					1
Good Shepherd Medical Center	1	1	1	1	1	5
Grande Ronde Hospital	1	1	1			3
Harney District Hospital	1					1
Hood River Memorial Hospital	1	1	1			3
Lake Health District	1				1	2
Lower Umpqua Hospital	1					1
Peace Harbor Hospital	1	1	1			3
Pioneer Memorial Hospital (Heppner)	1		1	1	1	4
Pioneer Memorial Hospital (Prineville)	1					1
Providence Seaside Hospital	1	1	1			3
Saint Alphonsus Medical Center - Baker	1	1	1			3
Samaritan Lebanon Community Hospital	1	1	1	1		4
Samaritan North Lincoln Hospital	1	1	1			3

Engagement Partner Experience by Hospital Type Acute Care Providers						
	Audit Year					
Facility	2015	2016	2017	2018	2019	Grand Total
Samaritan Pacific Communities Hospital	1	1				2
Southern Coos General Hospital	1					1
St Anthony Hospital	1	1	1			3
St Charles Madras (Mountain View Hospital)	1	1	1	1	1	5
Tillamook County General Hospital	1	1	1			3
Wallowa County Health Care District	1					1
West Valley Hospital	1					1
South Carolina						
Abbeville County Memorial	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
Grand Total	**41**	**30**	**30**	**20**	**20**	**141**

Engagement Partner Experience by Hospital Type Children's Hospital Providers						
Facility	2015	2016	2017	2018	2019	Grand Total
Connecticut						
Connecticut Childrens Medical Center	1	1	1	1	1	5
Oregon						
Shriners Childrens	1	1	1		1	4
South Carolina						
Shriners Hospital for Children	1	1	1	1	1	5
Grand Total	**3**	**3**	**3**	**2**	**3**	**14**

Engagement Partner Experience by Hospital Type IMD Providers						
Facility	2015	2016	2017	2018	2019	Grand Total
Connecticut						
Connecticut Mental Health Center	1	1	1	1	1	5
Connecticut Valley Hospital	1	1	1	1	1	5
Southwest Connecticut Mental Health System	1	1	1	1	1	5

Engagement Partner Experience by Hospital Type IMD Providers						
Facility	**2015**	**2016**	**2017**	**2018**	**2019**	**Grand Total**
New Hampshire						
Hampstead Hospital				1	1	2
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				2
Emma P Bradley Hospital	1	1				2
South Carolina						
Bryan Psychiatric Hospital	1	1	1	1	1	5
Patrick B Harris Psych Hospital	1	1	1	1	1	5
William J McCord Adolescent			1	1	1	3
William S Hall Psychiatric Institute	1	1				2
Grand Total	**10**	**10**	**8**	**9**	**9**	**46**

Engagement Partner Experience by Hospital Type LTC Hospital Providers						
Facility	**2015**	**2016**	**2017**	**2018**	**2019**	**Grand Total**
Connecticut						
Connecticut Veterans Home & Hospital (DVA)	1	1				2
Rhode Island						
Eleanor Slater Hospital	1	1				2
South Carolina						
North Greenville Hospital	1	1	1	1	1	5
Grand Total	**3**	**3**	**1**	**1**	**1**	**9**

Engagement Partner Experience by Hospital Type Rehabilitation Hospital Providers*						
Facility	**2008**	**2009**	**2010**	**2011**	**2014**	**Grand Total**
New Hampshire						
Healthsouth Rehabilitation Hospital	1	1	1	1	1	5
Northeast Rehabilitation Hospital	1	1	1	1	1	5
Grand Total	**2**	**2**	**2**	**2**	**2**	**10**

*Rehabilitation hospitals that previously received DSH payments in this state no longer receive DSH payments as they do not qualify due to the OB requirement, state plan and/or lack of uncompensated care cost.

Appendix B: Resumes

Diane Kovar, CPA

Member/Partner

Summary

Ms. Kovar has performed Medicare and Medicaid audit, desk review, and litigation support services. She plays a key role in managing the Medicaid DSH audit engagements for numerous states. She has been the project manager for DSH audits in Connecticut, New Hampshire, Oregon, Rhode Island, South Carolina, and West Virginia. She has also worked on health care engagements with the Maryland Department of Health and the Centers for Medicare & Medicaid Services.

Education

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

Experience

25 years of 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 Examinations

Scope of Work:
Myers and Stauffer conducts DSH examinations compliant with the requirement of 42 CFR Parts 445 and 447 as well as the Final Rule, 73 FR 77904, published December 19, 2008.

Responsibilities:

- Served as project manager and coordinated the West Virginia Medicaid DSH examinations, was involved in working with the state of West Virginia, along with hospital contacts, in performing annual DSH examinations as required by the DSH Rule.
- Participated in meetings and provided trainings on federal DSH requirements as well as provided feedback on areas of focus to ensure compliance and consistency with DSH Rule and audit methodology.
- Oversaw as well as prepared and/or reviewed the performance of procedures on information submitted by the state and hospitals in order to prepare and issue federally required examination reports.

Centers for Medicare & Medicaid Services (2000 – 2010)

CMS CFO Engagements, CMS AR Engagements, CMS SAS-70s, CMS Medicare Advantage Compliance Engagements

Scope of Work:

Compliance services, agreed upon procedures and examination procedures for various areas of CMS, including but not limited to the examination of financial information reported to CMS and review of compliance program internal control procedures.

Responsibilities:

- 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.
- Assisted in planning, directing, and completing bid plan audits, examinations and agreed-upon financial reviews of CMS Medicare Advantage and/or Prescription Drug plans (2005 – 2010).

Connecticut Department of Social Services (2010 – Present)

DSH Audit

Scope of Work:

Myers and Stauffer conducts DSH examinations compliant with the requirement of 42 CFR Parts 445 and 447 and the Final Rule, 73 FR 77904, published December 19, 2008.

Responsibilities: 2010 – 2014

- Served as project manager and coordinated the Connecticut Medicaid DSH examinations, was involved in working with the state of Connecticut, along with hospital contacts, in performing annual DSH examinations as required by the DSH Rule.
- Participated in meetings and provided trainings on federal DSH requirements as well as provided feedback on areas of focus to ensure compliance and consistency with DSH Rule and audit methodology.
- Oversaw as well as prepared and/or reviewed the performance of procedures on information submitted by the state and hospitals in order to prepare and issue federally required examination reports.

Responsibilities: 2015 – Present

- Provide support and advise current project manager as needed.
- Assist in development of standard procedures, work papers and data collection procedures.
- Assist in identifying audit risk and cost effective strategies.

District of Columbia Department of Health Care Finance (2009 – 2011)

Medical Audit Services

Scope of Work:

Myers and Stauffer conducts medical audit services for the District of Columbia (DC) Department of Health Care Finance.

Responsibilities:

- Involved in working with the District of Columbia, along with hospital contacts, in performing annual DSH procedures as required by the DSH Rule.
- Participated in meetings and provided trainings on federal DSH requirements as well as provided feedback on areas of focus to ensure compliance and consistency with DSH Rule and audit methodology.
- Oversaw as well as prepared and/or reviewed the performance of procedures on information submitted by the state and hospitals in order to prepare and issue federally required reports.

Maryland Department of Health (1998 – 2006)

Auditing, Accounting and Consulting Services

Scope of Work:

Myers and Stauffer provides nursing facility, hospital, residential treatment centers, ICF-alcoholic and state facility auditing, rate setting, and consulting services to ensure that medical assistance reimbursements are in compliance with state and federal laws and regulations.

Responsibilities:

- Conducted desk reviews and field audits of federally qualified health centers (FQHC), residential treatment centers, intermediate care facilities, psychiatric hospitals, state-operated hospitals, and alcohol/drug treatment centers.
- Conducted Medicare focus review and desk reviews of hospitals, skilled nursing facilities and rehabilitation facilities.

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

DSH Audit

Scope of Work:

Myers and Stauffer conducts DSH examinations compliant with the requirement of 42 CFR Parts 445 and 447 as well as the Final Rule, 73 FR 77904, published December 19, 2008.

Responsibilities:

- Manage completion of DSH audits and related examination reports and oversees development of standard procedures, work papers and data collection procedures.
- Identify audit risk areas and cost effective audit strategies.
- Manage audit teams and set workload objectives and deadlines.
- Oversee as well as prepares and/or reviews the performance of procedures on information submitted by the state and hospitals.

- Attend meetings and work with the state of New Hampshire, along with hospital contacts, in performing annual DSH examination as well as provide trainings as requested.
- Advise client on complex DSH issues.

Oregon Health Authority (2009 – Present)

DSH Examination

Scope of Work:

Myers and Stauffer conducts DSH examinations compliant with the requirement of 42 CFR Parts 445 and 447 as well as the Final Rule, 73 FR 77904, published December 19, 2008.

Responsibilities:

- Manage completion of DSH audits and related examination reports and oversees development of standard procedures, work papers and data collection procedures.
- Identify audit risk areas and cost effective audit strategies.
- Manage audit teams and set workload objectives and deadlines.
- Oversee as well as prepares and/or reviews the performance of procedures on information submitted by the state and hospitals.
- Attend meetings and work with the state of Oregon, along with hospital contacts, in performing annual DSH examination as well as provide trainings as requested.
- Advise client on complex DSH issues.

Rhode Island Department of Human Services (2010 – Present)

DSH Audit

Scope of Work:

Myers and Stauffer conducts DSH examinations compliant with the requirement of 42 Code of Federal Regulations (CFR) Parts 445 and 447 as well as the Final Rule, 73 FR 77904, published December 19, 2008.

Responsibilities:

- Manage completion of DSH audits and related examination reports and oversees development of standard procedures, work papers and data collection procedures.
- Identify audit risk areas and cost effective audit strategies.
- Manage audit teams and set workload objectives and deadlines.
- Oversee as well as prepares and/or reviews the performance of procedures on information submitted by the state and hospitals.
- Attend meetings and work with the state of Rhode Island, along with hospital contacts, in performing annual DSH examination as well as provide trainings as requested.
- Advise client on complex DSH issues.

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

Scope of Work:
Myers and Stauffer conducts DSH examinations compliant with the requirement of 42 CFR Parts 445 and 447 as well as the Final Rule, 73 FR 77904, published December 19, 2008.

Responsibilities: 2006 – 2021

- Served as project manager overseeing South Carolina Medicaid DSH examinations, was involved in working with the state of South Carolina, along with hospital contacts, in performing annual DSH examinations as required by the DSH Rule.
- Participated in meetings and provides trainings on federal DSH requirements as well as provided feedback on areas of focus to ensure compliance and consistency with DSH Rule and audit methodology.
- Oversaw as well as prepared and/or reviewed the performance of procedures on information submitted by the state and hospitals in order to prepare and issue federally required examination reports.

Responsibilities: 2022 – Present

- Provide support and advise current project manager as needed.
- Assist in development of standard procedures, work papers and data collection procedures.
- Assist in identifying audit risk and cost effective strategies.

Diane Kovar CPE (Yellow Book): January 1, 2020 – Present			
Program	**Completion Date**	**Sponsor Name**	**Credits**
2023 Institute on Medicare and Medicaid Payment Issues	03/24/2023	AHLA	19.2
AICPA Town Hall Series (December 15, 2022)	12/15/2022	American Institute of CPAs (AICPA)	1.0
2022 Institute on Medicare and Medicaid Payment Issues CLE-eProgram	12/06/2022	American Health Lawyers Association (AHLA)	20.2
AICPA Town Hall Series (November 3, 2022)	11/03/2022	AICPA	1.0
Proposal Evaluation: What Do They Really Want and How to Give it to Them?	11/01/2022	Myers and Stauffer LC	1.0
AICPA Town Hall Series	09/22/2022	AICPA	1.0
AAPC HEALTHCON 2022 Conference Highlights Webinar	07/21/2022	Myers and Stauffer LC	2.0
AICPA Town Hall Series	07/07/2022	AICPA	1.0
2022 Institute on Medicare and Medicaid Payment Issues	03/25/2022	AHLA	16.6
DHG Webinar - CMS Final Rule, GME-Consolidated Appropriations Act 2021	02/22/2022	Health Financial Systems	1.0

Diane Kovar CPE (Yellow Book): January 1, 2020 – Present			
Program	**Completion Date**	**Sponsor Name**	**Credits**
AICPA Town Hall Series	02/03/2022	AICPA	1.0
Managing Remote and Hybrid Teams	09/29/2021	Myers and Stauffer LC	2.5
M&S Interviewing	08/31/2021	Myers and Stauffer LC	1.0
DSH Expanded Testing Workpaper Updates	06/10/2021	Myers and Stauffer LC	1.0
AAPC HEALTHCON 2021 Conference Highlights Webinar	05/27/2021	Myers and Stauffer LC	1.5
The Ethics of Change – Keeping Your Balance in Risky Times	04/01/2021	Business Learning Institute, Inc	2.0
Ethics: Why We Stray: A Different Look at Ethical Decision-Making	04/01/2021	Business Learning Institute, Inc	2.0
AICPA Town Hall Series	04/01/2021	AICPA	1.0
AHLA Seminar Institute on Medicare and Medicaid Payment Issues 2021	03/26/2021	AHLA	31.8
AICPA Town Hall Series	01/06/2021	AICPA	1.0
170-CMS Uncompensated Care, The History	12/22/2020	Myers and Stauffer LC	1.0
HFS Provider User Meeting	12/10/2020	Health Financial Systems	13.3
Mentoring 101 - Mentor Training	09/24/2020	Myers and Stauffer LC	1.0
Webinar – PBM Expertise and Client Engagement	09/01/2020	Myers and Stauffer LC	1.0
2020 AAPC HEALTHCON Highlights Webinar Series	05/20/2020	Myers And Stauffer LC	1.0
COVID-19 Impact on CPAs - Weekly Update	05/18/2020	The Business Learning Institute, Inc.	1.0
COVID-19 Impact on CPAs - Weekly Update	05/11/2020	Business Learning Institute, Inc	1.0
COVID-19 Impact on CPAs - Weekly Update	05/04/2020	The Business Learning Institute, Inc.	1.0
Webinar - CMS Disaster Flexibilities	04/24/2020	Myers And Stauffer LC	1.0
Understanding Market Implications and Bringing Calm Amid Chaos	04/01/2020	AICPA	1.5
Getting through the Storm of COVID-19	03/30/2020	Business Learning Institute, Inc	4.0
Pandemic Risk Mitigation and Practical Considerations for CPA firms	03/27/2020	AICPA	1.0
Risky Business Conducting Remote Audits in Uncertain Times	03/25/2020	AICPA	1.0
2020 PEAK Summit Leadership Development Program	03/04/2020	Myers And Stauffer LC	10.5
Credits Per Year: 2020 – 39.3; 2021 – 43.8; 2022 – 45.8; 2023 – 19.2		**Total Credits**	**148.10**

John Kraft, CPA, CHFP

Member/Partner

Summary

Mr. Kraft 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' DSH and 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

36 years of 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

Scope of Work:
Myers and Stauffer conducts DSH examinations compliant with the requirement of 42 CFR Parts 445 and 447 as well as the Final Rule, 73 FR 77904, published December 19, 2008.

Responsibilities:

- Managed completion of DSH audits and related examination reports and oversaw 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)

DSH Audit

Scope of Work:

Myers and Stauffer conducts DSH examinations compliant with the requirement of 42 CFR Parts 445 and 447 and the Final Rule, 73 FR 77904, published December 19, 2008.

Responsibilities:

- 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.

District of Columbia Department of Health Care Finance (2009 – 2011)

Medical Audit Services

Scope of Work:

Myers and Stauffer conducts medical audit services for the District of Columbia Department of Health Care Finance.

Responsibilities:

- Managed completion of DSH audits and related examination reports and oversaw 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 clients on complex DSH issues.

Georgia Department of Community Health (2009 – Present)

Medicaid Cost Report Settlement

Scope of Work:

Myers and Stauffer provides Medicaid hospital desk review services to the state of Georgia, Department of Community Health.

Responsibilities:

- Manages and reviews desk and focused reviews of Medicaid hospital cost reports.
- Provides appeal and litigation support services; and oversees development of standard work papers, procedures, and workload objectives.

New Hampshire Department of Health and Human Services (2010 – Present)

DSH Audit

Scope of Work:

Myers and Stauffer conducts DSH examinations compliant with the requirement of 42 CFR Parts 445 and 447 as well as the Final Rule, 73 FR 77904, published December 19, 2008.

Responsibilities:

- 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.

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

Medicaid Cost Settlement Services

Scope of Work:

Myers and Stauffer provides Medicaid hospital and rural health clinic (RHC) cost settlement services to the New Hampshire Department of Health and Human Services.

Responsibilities:

- Manages and reviews Medicaid desk reviews and cost settlement calculations of New Hampshire hospitals and RHCs; oversees development of standard work papers, procedures, and workload objectives.

New Jersey Department of Human Services (2009 – Present)

Cost Report Settlements

Scope of Work:

Myers and Stauffer conducts reviews of cost reports submitted by New Jersey hospitals providing care to Medicaid covered patients.

Responsibilities:

- Manages and reviews field audits and desk reviews of Medicaid cost reports and related cost settlement calculations for hospitals and subprovider units.
- Manages tentative settlement calculations; provides appeal and litigation support; and oversees development of standard work papers, procedures, and workload objectives.

Oregon Health Authority (2010 – Present)

DSH Examination

Scope of Work:

Myers and Stauffer conducts DSH examinations compliant with the requirement of 42 CFR Parts 445 and 447 as well as the Final Rule, 73 FR 77904, published December 19, 2008.

Responsibilities:

- 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)

DSH Audit

Scope of Work:

Myers and Stauffer conducts DSH examinations compliant with the requirement of 42 CFR Parts 445 and 447 as well as the Final Rule, 73 FR 77904, published December 19, 2008.

Responsibilities:

- 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)

DSH Audit

Scope of Work:

Myers and Stauffer conducts DSH examinations compliant with the requirement of 42 CFR Parts 445 and 447 as well as the Final Rule, 73 FR 77904, published December 19, 2008.

Responsibilities:

- 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.
- Provides testimony on DSH related appeals.

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

Medicaid Cost Report Settlements

Scope of Work:

Myers and Stauffer provides Medicaid hospital cost report review and cost settlement services to the South Carolina Department of Health and Human Services.

Responsibilities:

- Manages and reviews 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.

- Has experience with Health Financial Systems (HFS) cost reporting software.

Tennessee Department of Finance and Administration (2010 – Present)

DSH Audit and Certified Public Expenditures (CPE) Consulting

Scope of Work:

Myers and Stauffer provides DSH audit and consulting services related to various methods of distribution and redistribution for DSH payments and the annual calculation of CPE.

Responsibilities:

- Manages completion of DSH audits and related examination reports and oversees development of standard procedures and work papers.
- Manages audit teams and sets workload objectives and deadlines.
- Advises clients on complex DSH issues.

Vermont Department of Vermont Health Access (2013 – Present)

Medicaid Cost Settlements

Scope of Work:

Myers and Stauffer provides a range of financial and consulting services for the Department of Vermont Health Access including cost report desk reviews, final and interim settlements, and interim rate calculations.

Responsibilities:

- Manages and reviews desk reviews of Medicaid cost reports and cost settlement calculations for FQHCs and RHCs.
- Managed desk reviews of home health agency (HHA) provider tax calculations.
- Manages tentative settlement, and interim rate calculations; provides appeal and litigation support; and oversees development of standard work papers, procedures, and workload objectives.

Presentations

"Disproportionate Share Update," South Carolina Medicaid and Hospital Personnel, and South Carolina Hospital Association, 2015.

"Disproportionate Share Hospital Auditing," Massachusetts Medicaid and Hospital Personnel, 2011.

"Implementation of Disproportionate Share Hospital Adjustment Payments Audit Rule," West Virginia Medicaid and Hospital Personnel, 2010.

John Kraft CPE (Yellow Book): January 1, 2020 – Present			
Program	**Completion Date**	**Sponsor Name**	**Credits**
2023 Institute on Medicare and Medicaid Payment Issues	03/24/2023	AHLA	14.8
Proposal Evaluation: What Do They Really Want and How to Give it to Them?	11/01/2022	Myers and Stauffer LC	1.0
HFS HCRIS Database	10/19/2022	Health Financial Systems	1.0
Business of our Business	10/17/2022	Myers and Stauffer LC	2.0
Ethics - AICPA Code of Conduct Overview	10/12/2022	Checkpoint Learning	3.0
AAI, API and Data Extractor	09/28/2022	Health Financial Systems	1.0
HFS Auditor - Providers	09/13/2022	Health Financial Systems	1.0
HFS Basics - Provider	09/06/2022	Health Financial Systems	1.0
MACPA Town Hall (August 2022)	08/19/2022	Maryland Association of Certified Public Accountants	1.0
CMS Medicare Disproportionate Share Hospital Regulations and Cost Reporting Basics	08/12/2022	Myers and Stauffer LC	2.0
177-CMS Worksheet D1-D5 - CMS 2552-10	08/09/2022	Myers and Stauffer LC	2.0
Materiality in Planning a Governmental Audit	08/05/2022	Checkpoint Learning	1.0
Impact of New Auditor Reporting on Governments	08/05/2022	Checkpoint Learning	1.0
176-CMS Worksheet C/D-Series - CMS 2552-10	08/04/2022	Myers and Stauffer LC	2.0
183 Encounter Data Training - Part 3	08/03/2022	Myers and Stauffer LC	1.0
182 Encounter Data Training - Part 2	08/03/2022	Myers and Stauffer LC	1.0
Ethics - General Standards and Acts Discreditable	08/01/2022	Checkpoint Learning	2.0
181 Encounter Data Training - Part 1	08/01/2022	Myers and Stauffer LC	1.0
MACPA Town Hall (July 2022)	07/22/2022	Maryland Association of Certified Public Accountants	1.0
AAPC HEALTHCON 2022 Conference Highlights Webinar	07/21/2022	Myers and Stauffer LC	2.0
MACPA Town Hall (May 2022)	05/26/2022	Maryland Association of Certified Public Accountants	1.0
MACPA Town Hall (April 2022)	04/27/2022	Maryland Association of Certified Public Accountants	1.0
2022 Institute on Medicare and Medicaid Payment Issues	03/25/2022	American Health Lawyers Association (AHLA)	13.3
Endnote – Lessons Learned	10/22/2021	Maryland Association of Certified Public Accountants	0.5

John Kraft CPE (Yellow Book): January 1, 2020 – Present			
Program	**Completion Date**	**Sponsor Name**	**Credits**
Preparing Students for an Evolving Profession	10/22/2021	Maryland Association of Certified Public Accountants	1.0
Keynote – Insights from Tom Peters	10/22/2021	Maryland Association of Certified Public Accountants	1.0
Best Practices for CPA Firms to Manage Cash Flow and Get Paid Quickly	10/22/2021	Maryland Association of Certified Public Accountants	1.0
Managing Remote and Hybrid Teams	09/29/2021	Myers and Stauffer LC	2.5
2021 Women to Watch Awards Breakfast	09/24/2021	Maryland Association of Certified Public Accountants	1.0
201 MSLC Examination Methodology Review	08/24/2021	Myers and Stauffer LC	1.0
190 PERM ERC Eligibility Review Hot Topics	08/10/2021	Myers and Stauffer LC	1.0
184 Administrative Costs Review	08/09/2021	Myers and Stauffer LC	1.0
185 Managed Care Final Rule - Updates and FAQ Responses	08/09/2021	Myers and Stauffer LC	1.0
New Jersey Law and Ethics Webinar	07/21/2021	New Jersey Society of CPAs (NJCPA)	4.0
Filing Tips, Updates, and Electronics	06/29/2021	Health Financial Systems	1.5
DSH Expanded Testing Workpaper Updates	06/10/2021	Myers and Stauffer LC	1.0
173-CMS Worksheet S-Series - CMS 2552-10	05/14/2021	Myers and Stauffer LC	2.0
South Carolina Rules and Regulations	05/11/2021	Checkpoint Learning	2.0
Ethics for CPAs	05/10/2021	Checkpoint Learning	4.0
AHLA Seminar Institute on Medicare and Medicaid Payment Issues 2021	03/26/2021	AHLA	14.7
Colorado data aggregation & disproportionate share hospital (DSH) payments	02/25/2021	Plante & Moran, LLC	1.0
142 - Quality Measures and Five Star Initiative	11/16/2020	Myers and Stauffer LC	1.0
Audit and Reimbursement 101 Course	11/16/2020	Myers and Stauffer LC	2.0
202 Audit Documentation II - 2019 Update	11/13/2020	Myers and Stauffer LC	2.0
170-CMS Uncompensated Care, The History	11/12/2020	Myers and Stauffer LC	1.0
207 Intro to GAGAS, 2018 Update	11/12/2020	Myers and Stauffer LC	1.0
180 - Medical Loss Ratio (MLR) Introduction	11/09/2020	Myers and Stauffer LC	1.5
143 - PDPM Update	11/06/2020	Myers and Stauffer LC	1.0
141 IMPACT Act	11/05/2020	Myers and Stauffer LC	1.0
114-CMS The Process: Bills, Laws, Regulations, and Manuals	11/05/2020	Myers and Stauffer LC	1.0

John Kraft CPE (Yellow Book): January 1, 2020 – Present			
Program	**Completion Date**	**Sponsor Name**	**Credits**
131 Intro to Disproportionate Share Hospital	11/05/2020	Myers and Stauffer LC	1.0
125 - DSH Sampling Overview	11/05/2020	Myers and Stauffer LC	1.0
154 DSH Application Acceptability and Upload & Application Reports - 2020 Update	10/23/2020	Myers and Stauffer LC	2.0
126 DSH Analytic Work Paper	10/22/2020	Myers and Stauffer LC	1.0
Anticipate and Reimagine What's Next	10/02/2020	MACPA	1.0
Webinar – PBM Expertise and Client Engagement	09/01/2020	Myers and Stauffer LC	1.0
PS&R Reconciliation - Non-Hospital Provider Update	08/25/2020	Health Financial Systems	1.0
Spring 2020 Professional Issues Update & Annual Meeting: Navigating through the Storm of COVID-19	06/30/2020	Business Learning Institute, Inc.	4.0
HCRIS Database	06/09/2020	Health Financial Systems	1.0
2020 AAPC HEALTHCON HIGHLIGHTS PART TWO	06/03/2020	Myers and Stauffer LC	1.0
2020 AAPC HEALTHCON Highlights Webinar Series	05/20/2020	Myers and Stauffer LC	1.0
Automating the MCR Process and Integrating with Your Workpapers API Excel	05/12/2020	Health Financial Systems	1.0
COVID-19 Impact on CPAs - Weekly Update	05/04/2020	The Business Learning Institute, Inc.	1.0
Guidance in Completing the Hospice Cost Report (1984-14)	04/30/2020	Health Financial Systems	1.0
Webinar - CMS Disaster Flexibilities	04/24/2020	Myers and Stauffer LC	1.0
Filing Tips, Updates and SaFE and Electronic Signatures	04/22/2020	Health Financial Systems	1.0
HFMA's spring meetings	04/09/2020	Healthcare Financial Management Association (HFMA)	4.0
Medicare Bad Debts	04/02/2020	Health Financial Systems	1.0
Management Reports	03/31/2020	Health Financial Systems	1.0
Webinar - MSLC Roll Out of SSAE 19	03/26/2020	Myers and Stauffer LC	1.0
Coronavirus: How to Prepare your Business, Employees, and Customers	03/20/2020	Business Learning Institute	1.5
Credits Per Year: 2020 – 40.0; 2021 – 41.2; 2022 – 42.3; 2023 – 14.8		**Total Credits**	**138.3**

Beth Franey, CFE

Senior Manager

Summary

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

Education

B.S., Sociology, Towson University, 1999

Experience

16 years of professional experience

Affiliations

Association of Certified Fraud Examiners

Licenses/Certifications

Certified Fraud Examiner

Relevant Work Experience

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

Scope of Work:
Myers and Stauffer conducts DSH examinations compliant with the requirement of 42 CFR Parts 445 and 447 as well as the Final Rule, 73 FR 77904, published December 19, 2008.

Responsibilities:

- 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)
DSH Audit

Scope of Work:
Myers and Stauffer conducts DSH examinations compliant with the requirement of 42 CFR Parts 445 and 447 as well as the Final Rule, 73 FR 77904, published December 19, 2008, as well as technical support relating to reconsiderations and redistributions for state fiscal years 2007 to the present.

Responsibilities:

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

Connecticut Department of Social Services (2014 – Present)

DSH Audit

Scope of Work:

Myers and Stauffer conducts DSH examinations compliant with the requirement of 42 CFR Parts 445 and 447 and the Final Rule, 73 FR 77904, published December 19, 2008.

Responsibilities:

- 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)

DSH Audit

Scope of Work:

Myers and Stauffer conducts DSH examinations compliant with the requirement of 42 CFR Parts 445 and 447 as well as the Final Rule, 73 FR 77904, published December 19, 2008.

Responsibilities:

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

Oregon Health Authority (2014 – Present)

DSH Examination

Scope of Work:

Myers and Stauffer conducted DSH examinations compliant with the requirement of 42 CFR Parts 445 and 447 as well as the Final Rule, 73 FR 77904, published December 19, 2008.

Responsibilities:

- 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)

DSH Audit

Scope of Work:

Myers and Stauffer conducts DSH examinations compliant with the requirement of 42 CFR Parts 445 and 447 as well as the Final Rule, 73 FR 77904, published December 19, 2008.

Responsibilities:

- Performs and reviewed DSH examinations.
- Prepares related reports.
- Oversees the development of standard procedures and work papers.
- Manages 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)

DSH Audit

Scope of Work:

Myers and Stauffer conducts DSH examinations compliant with the requirement of 42 CFR Parts 445 and 447 as well as the Final Rule, 73 FR 77904, published December 19, 2008.

Responsibilities:

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

Tennessee Department of Finance and Administration (2013 – Present)

DSH Audit and Certified Public Expenditures Consulting

Scope of Work:

Myers and Stauffer conducts DSH examinations compliant with the requirement of 42 CFR Parts 445 and 447 as well as the Final Rule, 73 FR 77904, published December 19, 2008, as well as consulting services related to various methods of distribution and redistribution for DSH payments and the annual calculation of CPE.

Responsibilities:

- 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.
- Prepared and reviewed calculation of CPE reconciliation reports.
- Prepared and reviewed various consulting ad-hoc reports based on client needs.

U.S. Department of Justice (2008 – 2014)
Labat MEGA 4

Scope of Work:
Myers and Stauffer provides litigation support services for various provider types as a subcontractor for the Federal Bureau of Investigations.

Responsibilities:

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

Beth Franey CPE (Yellow Book): January 1, 2020 – Present			
Program	**Completion Date**	**Sponsor Name**	**Credits**
2023 Institute on Medicare and Medicaid Payment Issues	03/24/2023	AHLA	17.7
Fraud Prevention	01/10/2023	Checkpoint Learning	4.0
135 Understanding Federal Reimbursement of Medicaid and CHIP Fee-for-Service Claims and Medicare Capitation Payments	01/06/2023	Myers and Stauffer LC	1.0
Ethics for CPAs	01/05/2023	Checkpoint Learning	4.0
Proposal Evaluation: What Do They Really Want and How to Give it to Them?	11/01/2022	Myers and Stauffer LC	1.0
Business of our Business	10/17/2022	Myers and Stauffer LC	2.0
Fraud Auditing and Investigation	09/09/2022	Checkpoint Learning	4.0
Analytical Fraud Detection	09/02/2022	Checkpoint Learning	4.0
2022 Institute on Medicare and Medicaid Payment Issues	03/25/2022	AHLA	16.0
Overview of Forensic Accounting	02/25/2022	Checkpoint Learning	5.0
Advanced Fraud Techniques	01/06/2022	Checkpoint Learning	6.0
Attestation Engagements	01/05/2022	Checkpoint Learning	1.0
Accounting Basics	01/05/2022	Checkpoint Learning	6.0
202 Audit Documentation II - 2019 Update	01/04/2022	Myers and Stauffer LC	2.0
Analytical Procedures	01/04/2022	Checkpoint Learning	2.0
Ethics - General Standards and Acts Discreditable	01/03/2022	Checkpoint Learning	2.0
Managing Remote and Hybrid Teams	09/29/2021	Myers and Stauffer LC	2.5
AHLA Seminar Institute on Medicare and Medicaid Payment Issues 2021	03/26/2021	AHLA	14.1
Audits of States, Local Governments and Non-Profit Organizations	03/12/2021	Checkpoint Learning	5.0

Beth Franey CPE (Yellow Book): January 1, 2020 – Present			
Program	**Completion Date**	**Sponsor Name**	**Credits**
154 DSH Application Acceptability and Upload & Application Reports - 2020 Update	03/05/2021	Myers and Stauffer LC	2.0
GAO Standards - Yellow Book	03/02/2021	Checkpoint Learning	6.0
Fraud - Who Commits It and Why Does It Occur?	02/16/2021	Checkpoint Learning	4.0
Fraud Auditing and Investigation	02/16/2021	Checkpoint Learning	4.0
201 MSLC Examination Methodology Review	02/15/2021	Myers and Stauffer LC	1.0
Audit and Reimbursement 101 Course	02/15/2021	Myers and Stauffer LC	2.0
120 Costs Related to Patient Care - 2021 Update	02/15/2021	Myers and Stauffer LC	3.0
190 PERM ERC Eligibility Review Hot Topics	09/14/2020	Myers and Stauffer LC	1.0
Mentoring 101 - Mentor Training	09/03/2020	Myers and Stauffer LC	1.0
170-CMS Uncompensated Care, The History	08/28/2020	Myers and Stauffer LC	1.0
M&S Interviewing	08/10/2020	Myers and Stauffer LC	1.0
124 Cost Allocation and Apportionment	04/30/2020	Myers and Stauffer LC	1.0
2019 Auditing Update	04/17/2020	Checkpoint Learning	3.0
Audit Workpapers - Fieldwork Standards	04/10/2020	Checkpoint Learning	2.0
CMS-203 Medical Education 201	04/06/2020	Myers and Stauffer LC	1.0
Benford's Law - The Fraud Detective	03/26/2020	Checkpoint Learning	1.0
Basic Interview Techniques for Forensic Accountants	03/18/2020	Checkpoint Learning	2.0
Accounting Basics	02/12/2020	Checkpoint Learning	6.0
Introduction to Fraud Auditing	02/06/2020	Checkpoint Learning	4.0
Preparing for an Engagement Review	01/31/2020	Checkpoint Learning	2.0
Advanced Fraud Techniques	01/16/2020	Checkpoint Learning	6.0
207 Intro to GAGAS, 2018 Update	01/10/2020	Myers and Stauffer LC	1.0
Ethics for CPAs	01/07/2020	Checkpoint Learning	4.0
Credits Per Year: 2020 – 37.0; 2021 – 43.6; 2022 – 51.0; 2023 – 26.7		**Total Credits**	**158.3**

Tova Rosenfeld, CPA

Manager

Summary

Ms. Rosenfeld has significant experience in health care compliance and tax compliance and consulting, working with various states on DSH audits and cost settlement engagements. Additionally, she has provided litigation support services as a subcontractor for the Federal Bureau of Investigation.

Education

B.A., Accounting, Towson University, 2001

Experience

22 years of professional experience

Affiliations

Maryland Association of Certified Public Accountants

Licenses/Certifications

Certified Public Accountant

Relevant Work Experience

Colorado Department of Health Care Policy and Financing (2017 – Present)

DSH Audit

Scope of Work:

Myers and Stauffer conducts DSH audits as well as technical support relating to reconsiderations and redistributions for state fiscal years 2007 to the present.

Responsibilities:

- Perform and review state DSH procedures.

Connecticut Department of Social Services (2015 – Present)

DSH Audit

Scope of Work:

Myers and Stauffer conducts DSH examinations 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.

Responsibilities:

- Perform and review state DSH procedures.

District of Columbia Department of Health Care Finance (2017 – Present)

Medical Audit Services

Myers and Stauffer provides Medicaid rate setting and cost settlement services to the District of Columbia Department of Health Care Finance.

Scope of Work:

Conduct field examinations and perform and review desk reviews for hospital, public charter schools, home health agencies and federally qualified health centers for rate setting and cost settlement purposes.

Responsibilities:

- Conduct field examinations and perform and review desk reviews for hospital, public charter schools, home health agencies and federally qualified health centers for rate setting and cost settlement purposes.

Florida Agency for Health Care Administration (2015 – 2016)

Hospital Cost Report Audit and DSH Payment Reconciliation

Scope of Work:

Myers and Stauffer provides services to the Florida Agency for Health Care Administration (AHCA) for hospital cost report audits, federal DSH program payment reconciliation services, and for Medicaid Supplemental Schedule DSH Key Components Review (DSR).

Responsibilities:

- Perform desk reviews of Florida Medicaid hospital providers.

Maryland Department of Health (2001 – 2005)

Auditing, Accounting and Consulting Services

Scope of Work:

Myers and Stauffer provides nursing facility, hospital, residential treatment centers, ICF-alcoholic and state facility auditing, rate setting, and consulting services to ensure that medical assistance reimbursements are in compliance with state and federal laws and regulations.

Responsibilities:

- Perform desk reviews and field audits of Maryland Medicaid hospital providers.

New Hampshire Department of Health and Human Services (2016 – Present)

DSH Audit

Scope of Work:

Myers and Stauffer conducts DSH examinations compliant with the requirement of 42 Code of Federal Regulations (CFR) Parts 445 and 447 as well as the Final Rule, 73 FR 77904, published December 19, 2008.

Responsibilities:

- Perform and review state DSH procedures.

Oregon Health Authority (2015 – Present)

DSH Examination

Scope of Work:

Myers and Stauffer conducted DSH examinations compliant with the requirement of 42 Code of Federal Regulations (CFR) Parts 445 and 447 as well as the Final Rule, 73 FR 77904, published December 19, 2008.

Responsibilities:

- Perform and review state DSH procedures.

Rhode Island Department of Human Services (2017 – Present)

DSH Audit

Scope of Work:

Myers and Stauffer conducts DSH examinations compliant with the requirement of 42 Code of Federal Regulations (CFR) Parts 445 and 447 as well as the Final Rule, 73 FR 77904, published December 19, 2008.

Responsibilities:

- Perform and review state DSH procedures.

South Carolina Department of Health and Human Services (2016 – Present)

DSH Audit

Scope of Work:

Myers and Stauffer conducts DSH examinations compliant with the requirement of 42 Code of Federal Regulations (CFR) Parts 445 and 447 as well as the Final Rule, 73 FR 77904, published December 19, 2008.

Responsibilities:

- Perform and review state DSH procedures.

South Carolina Department of Health and Human Services (2012 – Present)

Medicaid Cost Report Settlements

Scope of Work:

Myers and Stauffer provides Medicaid hospital cost report reviews and cost settlement services to the state of South Carolina Department of Health and Human Services.

Responsibilities:

- Perform desk reviews of South Carolina Medicaid hospital providers.

Tennessee Department of Finance and Administration (2016 – Present)

DSH Audit and Certified Public Expenditures Consulting

Scope of Work:

Provide DSH audits and consulting services related to various methods of distribution and redistribution for DSH payments and the annual calculation of CPE.

Responsibilities:

- Perform and review state DSH procedures.

U.S. Department of Justice (2013 – 2016)
Labat MEGA 5

Scope of Work:
Myers and Stauffer provides litigation support services for various provider types as a subcontractor for the Federal Bureau of Investigations.

Responsibilities:

- Input and review financial information in database.

Tova Rosenfeld CPE (Yellow Book): January 1, 2020 – Present			
Program	**Completion Date**	**Sponsor Name**	**Credits**
Ethics for CPAs	03/23/2023	Checkpoint Learning	4.0
Using Excel to Manage Data	01/31/2023	MasterCPE LLC	3.0
Auditing: Compilation and Review Updates	07/26/2022	MasterCPE LLC	20.0
Government Accounting and Reporting	03/30/2022	MasterCPE LLC	8.0
Accountant's Guide to Computers and Information Technology	01/24/2022	MasterCPE LLC	6.0
Governmental Auditing: Course 2 - Performance Audits	01/23/2022	MasterCPE LLC	4.0
Governmental Auditing: Course 3 - Financial Audits and Attestation Engagements	01/23/2022	MasterCPE LLC	4.0
Ethics for CPAs	12/22/2021	Checkpoint Learning	4.0
Governmental Auditing: Course 1 - Fundamental Principles	11/22/2021	MasterCPE LLC	4.0
Accounting and Financial Reporting for COVID-19, the CARES Act, and PPP Loans - Long Version	10/17/2021	MasterCPE LLC	4.0
Current Developments: Accounting and Financial Reporting - 2021	10/10/2021	MasterCPE LLC	16.0
Government Fraud: Prevention and Detection	03/26/2021	MasterCPE LLC	5.0
Government Auditing - Green Book: 3. Information and Communication, Monitoring	02/08/2021	MasterCPE LLC	3.0
Government Auditing - Green Book: 2. Risk Assessment and Control Activities	02/04/2021	MasterCPE LLC	5.0
Financial Statement Fraud: Prevention and Detection	08/10/2020	MasterCPE LLC	4.0
Governmental Auditing: Course 1 - Fundamental Principles for Government Auditing	08/09/2020	MasterCPE LLC	4.0
Government Accounting: Principles and Financial Reporting	05/31/2020	MasterCPE LLC	5.0
Must Know Excel Functions for CPAs	05/30/2020	MasterCPE LLC	5.0

Tova Rosenfeld CPE (Yellow Book): January 1, 2020 – Present			
Program	**Completion Date**	**Sponsor Name**	**Credits**
Computer Security	04/19/2020	MasterCPE LLC	9.0
Government Fraud: Prevention and Detection	04/19/2020	MasterCPE LLC	5.0
Government Auditing: A Complete Guide to Yellow Book	01/15/2020	MasterCPE LLC	11.0
Credits Per Year: 2020 – 32.0; 2021 – 41.0; 2022 – 42.0; 2023 – 7.0		**Total Credits**	**122.0**

Appendix C: Hospital Schedule

Hospital Name	Estimate of Hospital Specific DSH Limit	Medicaid Inpatient Utilization Rate	Low Income Utilization Rate	State Defined DSH Qualification Criteria	IP/OP Medicaid FFS Basic Rate Payments	IP/OP Medicaid MCO Payments	Supplemental/ Enhanced Medicaid IP/OP Payments	Total Medicaid IP/OP Payments	Total Cost of Care for Medicaid IP/OP Services	Total Medicaid Uncompensated Care	Uninsured IP/OP Revenue	Total Applicable Section 1011 Payments	Total Cost of IP/OP Care for the Uninsured	Total Uninsured IP/OP Uncompensated Care Costs	Total Annual Uncompensated Care Costs	Disproportionate Share Hospital Payments	Medicaid Provider Number	Medicare Provider Number	Total Hospital Cost
BECKLEY ARH	0	0.00%	0.00%		0	0	0	0	0	0	0	0	0	0	0	0			0
BERKELEY MEDICAL CENTER	0	0.00%	0.00%		0	0	0	0	0	0	0	0	0	0	0	0			0
BOONE MEMORIAL HOSPITAL	0	0.00%	0.00%		0	0	0	0	0	0	0	0	0	0	0	0			0
BRAXTON COUNTY MEMORIAL HOSPITAL	0	0.00%	0.00%		0	0	0	0	0	0	0	0	0	0	0	0			0
BROADDUS HOSPITAL	0	0.00%	0.00%		0	0	0	0	0	0	0	0	0	0	0	0			0
CABELL-HUNTINGTON HOSPITAL	0	0.00%	0.00%		0	0	0	0	0	0	0	0	0	0	0	0			0
CAMDEN CLARK MEDICAL CENTER	0	0.00%	0.00%		0	0	0	0	0	0	0	0	0	0	0	0			0
CHARLESTON AREA MEDICAL CENTER	0	0.00%	0.00%		0	0	0	0	0	0	0	0	0	0	0	0			0
CHARLESTON SURGICAL HOSPITAL	0	0.00%	0.00%		0	0	0	0	0	0	0	0	0	0	0	0			0
DAVIS MEDICAL CENTER	0	0.00%	0.00%		0	0	0	0	0	0	0	0	0	0	0	0			0
GRAFTON CITY HOSPITAL	0	0.00%	0.00%		0	0	0	0	0	0	0	0	0	0	0	0			0
GRANT MEMORIAL HOSPITAL	0	0.00%	0.00%		0	0	0	0	0	0	0	0	0	0	0	0			0
GREENBRIER VALLEY MEDICAL CENTER	0	0.00%	0.00%		0	0	0	0	0	0	0	0	0	0	0	0			0
HAMPSHIRE MEMORIAL HOSPITAL	0	0.00%	0.00%		0	0	0	0	0	0	0	0	0	0	0	0			0
HIGHLAND HOSPITAL	0	0.00%	0.00%		0	0	0	0	0	0	0	0	0	0	0	0			0
JACKSON GENERAL HOSPITAL	0	0.00%	0.00%		0	0	0	0	0	0	0	0	0	0	0	0			0
JEFFERSON MEDICAL CENTER	0	0.00%	0.00%		0	0	0	0	0	0	0	0	0	0	0	0			0
LOGAN REGIONAL MEDICAL CENTER	0	0.00%	0.00%		0	0	0	0	0	0	0	0	0	0	0	0			0
MINNIE HAMILTON HEALTH SYSTEM	0	0.00%	0.00%		0	0	0	0	0	0	0	0	0	0	0	0			0
MON HEALTH MEDICAL CENTER	0	0.00%	0.00%		0	0	0	0	0	0	0	0	0	0	0	0			0
MONTGOMERY GENERAL HOSPITAL	0	0.00%	0.00%		0	0	0	0	0	0	0	0	0	0	0	0			0
PLATEAU MEDICAL CENTER	0	0.00%	0.00%		0	0	0	0	0	0	0	0	0	0	0	0			0
PLEASANT VALLEY HOSPITAL	0	0.00%	0.00%		0	0	0	0	0	0	0	0	0	0	0	0			0
POCAHONTAS MEMORIAL HOSPITAL	0	0.00%	0.00%		0	0	0	0	0	0	0	0	0	0	0	0			0
POTOMAC VALLEY HOSPITAL	0	0.00%	0.00%		0	0	0	0	0	0	0	0	0	0	0	0			0
PRESTON MEMORIAL HOSPITAL	0	0.00%	0.00%		0	0	0	0	0	0	0	0	0	0	0	0			0
PRINCETON COMMUNITY HOSPITAL	0	0.00%	0.00%		0	0	0	0	0	0	0	0	0	0	0	0			0
RALEIGH GENERAL HOSPITAL	0	0.00%	0.00%		0	0	0	0	0	0	0	0	0	0	0	0			0
REYNOLDS MEMORIAL HOSPITAL	0	0.00%	0.00%		0	0	0	0	0	0	0	0	0	0	0	0			0
ROANE GENERAL HOSPITAL	0	0.00%	0.00%		0	0	0	0	0	0	0	0	0	0	0	0			0
SISTERSVILLE GENERAL HOSPITAL	0	0.00%	0.00%		0	0	0	0	0	0	0	0	0	0	0	0			0
ST. FRANCIS HOSPITAL	0	0.00%	0.00%		0	0	0	0	0	0	0	0	0	0	0	0			0
ST. JOSEPH'S HOSPITAL - BUCKHANNON	0	0.00%	0.00%		0	0	0	0	0	0	0	0	0	0	0	0			0
ST. MARY'S MEDICAL CENTER,	0	0.00%	0.00%		0	0	0	0	0	0	0	0	0	0	0	0			0
STONEWALL JACKSON MEMORIAL HOSPITAL	0	0.00%	0.00%		0	0	0	0	0	0	0	0	0	0	0	0			0
SUMMERS COUNTY ARH	0	0.00%	0.00%		0	0	0	0	0	0	0	0	0	0	0	0			0
SUMMERSVILLE REGIONAL MEDICAL CENTER	0	0.00%	0.00%		0	0	0	0	0	0	0	0	0	0	0	0			0
THOMAS MEMORIAL HOSPITAL	0	0.00%	0.00%		0	0	0	0	0	0	0	0	0	0	0	0			0
UNITED HOSPITAL CENTER, INC.	0	0.00%	0.00%		0	0	0	0	0	0	0	0	0	0	0	0			0
WAR MEMORIAL HOSPITAL, INC.	0	0.00%	0.00%		0	0	0	0	0	0	0	0	0	0	0	0			0
WEBSTER COUNTY MEMORIAL HOSPITAL, INC.	0	0.00%	0.00%		0	0	0	0	0	0	0	0	0	0	0	0			0
WEIRTON MEDICAL CENTER, INC.	0	0.00%	0.00%		0	0	0	0	0	0	0	0	0	0	0	0			0
WELCH COMMUNITY HOSPITAL	0	0.00%	0.00%		0	0	0	0	0	0	0	0	0	0	0	0			0
WEST VIRGINIA UNIVERSITY HOSPITALS	0	0.00%	0.00%		0	0	0	0	0	0	0	0	0	0	0	0			0
WHEELING HOSPITAL, INC.	0	0.00%	0.00%		0	0	0	0	0	0	0	0	0	0	0	0			0
Institute for Mental Disease																			
MILDRED MITCHELL-BATEMAN HOSPITAL	0	0.00%	0.00%		0	0	0	0	0	0	0	0	0	0	0	0			0
RIVER PARK HOSPITAL	0	0.00%	0.00%		0	0	0	0	0	0	0	0	0	0	0	0			0
WILLIAM R. SHARPE JR. HOSPITAL	0	0.00%	0.00%		0	0	0	0	0	0	0	0	0	0	0	0			0
Out of State DSH Hospitals																			
None																			

Appendix D: Sample DSH Survey Tool

State of West Virginia
Disproportionate Share Hospital (DSH) Examination Survey Part I
For State DSH Year 2021

DSH Version 6.02 2/10/2023

A. General DSH Year Information

	Begin	End
1. DSH Year:	07/01/2020	06/30/2021

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

Identification of cost reports needed to cover the DSH Year:

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

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

B. DSH 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 (07/01/20 - 06/30/21)
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?	

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State of West Virginia
Disproportionate Share Hospital (DSH) Examination Survey Part I
For State DSH Year 2021

C. Disclosure of Other Medicaid Payments Received:

1. **Medicaid Supplemental Payments for Hospital Services DSH Year 07/01/2020 - 06/30/2021**
(Should include UPL and non-claim specific payments paid based on the state fiscal year. However, DSH payments should NOT be included.)

2. **Medicaid Managed Care Supplemental Payments for hospital services for DSH Year 07/01/2020 - 06/30/2021**
(Should include all non-claim specific payments for hospital services such as lump sum payments for full Medicaid pricing (FMP), supplementals, quality payments, bonus payments, capitation payments received by the hospital (not by the MCO), or other incentive payments.
NOTE: Hospital portion of supplemental payments reported on DSH Survey Part II, Section E, Question 14 should be reported here if paid on a SFY basis.

3. **Total Medicaid and Medicaid Managed Care Non-Claims Payments for Hospital Services07/01/2020 - 06/30/2021** $ -

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

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State of West Virginia
Disproportionate Share Hospital (DSH) Examination Survey Part I
For State DSH Year 2021

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 - 07/01/2020 - 06/30/2021
	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
	15 (a). A detailed working trial balance used to prepare each cost report (including revenues)
	15 (b). A detailed revenue working trial balance by payer/contract based on final primary payment category. 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.msic.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.

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Disproportionate Share Hospital (DSH) Examination Survey Part II

Version 8.11

DSH Version 8.11 2/10/2023

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

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

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

(List additional states on a separate attachment)

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

1.	Section 1011 Payment Related to Hospital Services Included in Exhibits B & B-1 (See Note 1)			
2.	Section 1011 Payment Related to Inpatient Hospital Services NOT Included in Exhibits B & B-1 (See Note 1)			
3.	Section 1011 Payment Related to Outpatient Hospital Services NOT Included in Exhibits B & B-1 (See Note 1)			
4.	**Total Section 1011 Payments Related to Hospital Services (See Note 1)**	$-		
5.	Section 1011 Payment Related to Non-Hospital Services Included in Exhibits B & B-1 (See Note 1)			
6.	Section 1011 Payment Related to Non-Hospital Services NOT Included in Exhibits B & B-1 (See Note 1)			
7.	**Total Section 1011 Payments Related to Non-Hospital Services (See Note 1)**	$-		
8.	**Out-of-State DSH Payments (See Note 2)**			
		Inpatient	Outpatient	Total
9.	Total Cash Basis Patient Payments from Uninsured (On Exhibit B)			$-
10.	Total Cash Basis Patient Payments from All Other Patients (On Exhibit B)			$-
11.	Total Cash Basis Patient Payments Reported on Exhibit B (Agrees to Column (N) on Exhibit B, 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 hospital (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	$-		

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

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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 (C/R, 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) (WVS 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. Blank Recon Line OR "Decrease worksheet G-3, Line 2 to remove Charity Care Charges related to insured patients INCLUDED on worksheet G-3, Line 2 (impact is an increase in net patient revenue)"					-
36. Adjusted Contractual Adjustments					-
37. Unreconciled Difference	Unreconciled Difference (Should be $0)	$ -	Unreconciled Difference (Should be $0)	$ -	

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G. Cost Report - Cost / Days / Charges

Cost Report Year (-) | SELECT HOSPITAL NAME

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

Line #	Cost Center Description	Total Allowable Cost	Intern & Resident Costs Removed on Cost Report *	RCE and Therapy Add-Back (If Applicable		Provider Tax Assessment	Total Cost	I/P 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. 26	*Cost Report Worksheet B, Part I, Col. 25 (Intern & Resident Offset ONLY*	*Cost Report Worksheet C, Part I, Col. 2 and Col. 4*	*Swing-Bed Carve Out - Cost Report Worksheet D-1, Part I, Line 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. 6 (Informational only unless used in Section L charges allocation)*		*Calculated Per Diem*
	Routine Cost Centers (list below):										
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										$ -

		Hospital Observation Days - Cost Report W/S S-3, Pt. I, Line 28, Col. 8	*Subprovider I Observation Days - Cost Report W/S S-3, Pt. I, Line 28.01, Col. 8*	*Subprovider II Observation Days - Cost Report W/S S-3, Pt. I, Line 28.02, Col. 8*		*Calculated (Per Diems Above Multiplied by Days)*	*Inpatient Charges - Cost Report Worksheet C, Pt. I, Col. 6*	*Outpatient Charges - Cost Report Worksheet C, Pt. I, Col. 7*	*Total Charges - Cost Report Worksheet C, Pt. I, Col. 8*	*Medicaid Calculated Cost-to-Charge Ratio*
	Observation Data (Non-Distinct)									
20	09200 Observation (Non-Distinct)	-	-	-		$ -	$ -	$ -	$ -	-

		Cost Report Worksheet B, Part I, Col. 26	*Cost Report Worksheet B, Part I, Col. 25 (Intern & Resident Offset ONLY*	*Cost Report Worksheet C, Part I, Col. 2 and Col. 4*		*Allocation of Provider Tax from Section L of the Survey Based on Total Cost*	*Calculated*	*Inpatient Charges - Cost Report Worksheet C, Pt. I, Col. 6*	*Outpatient Charges - Cost Report Worksheet C, Pt. I, Col. 7*	*Total Charges - Cost Report Worksheet C, Pt. I, Col. 8*	*Medicaid Calculated Cost-to-Charge Ratio*
	Ancillary Cost Centers (from W/S C excluding Observation) (list below):										
21		$ -	$ -	$ -		$ -	$ -	$ -	$ -	$ -	-
22		$ -	$ -	$ -		$ -	$ -	$ -	$ -	$ -	-
23		$ -	$ -	$ -		$ -	$ -	$ -	$ -	$ -	-
24		$ -	$ -	$ -		$ -	$ -	$ -	$ -	$ -	-
25		$ -	$ -	$ -		$ -	$ -	$ -	$ -	$ -	-
26		$ -	$ -	$ -		$ -	$ -	$ -	$ -	$ -	-
27		$ -	$ -	$ -		$ -	$ -	$ -	$ -	$ -	-
28		$ -	$ -	$ -		$ -	$ -	$ -	$ -	$ -	-
29		$ -	$ -	$ -		$ -	$ -	$ -	$ -	$ -	-
30		$ -	$ -	$ -		$ -	$ -	$ -	$ -	$ -	-
31		$ -	$ -	$ -		$ -	$ -	$ -	$ -	$ -	-

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Disproportionate Share Hospital (DSH) Examination Survey Part II

Version 8.11

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
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			$ -	$ -	$ -		$ -	$ -	$ -	$ -	$ -	-
90			$ -	$ -	$ -		$ -	$ -	$ -	$ -	$ -	-
91			$ -	$ -	$ -		$ -	$ -	$ -	$ -	$ -	-
92			$ -	$ -	$ -		$ -	$ -	$ -	$ -	$ -	-
93			$ -	$ -	$ -		$ -	$ -	$ -	$ -	$ -	-
94			$ -	$ -	$ -		$ -	$ -	$ -	$ -	$ -	-

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

Version 8.11

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
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.

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Disproportionate Share Hospital (DSH) Examination Survey Part II

Version 8.11

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

Cost Report Year (- SELECT HOSPITAL NAME

	Line #	Cost Center Description	Medicaid Per Diem Cost for Routine Cost Centers	Medicaid Cost to Charge Ratio for Ancillary Cost Centers	In-State Medicaid FFS Primary		In-State Medicaid Managed Care Primary		In-State Medicare FFS Cross-Overs (with Medicaid Secondary)		In-State Other Medicaid Eligibles (Not Included Elsewhere)		Uninsured		Total In-State Medicaid		% Survey to Cost Report Totals
					Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient (See Exhibit A)	Outpatient (See Exhibit A)	Inpatient	Outpatient	
			From Section G	From Section G	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From Hospital's Own Internal Analysis	From Hospital's Own Internal Analysis			
		Routine Cost Centers (from Section G):			Days		Days		Days		Days		Days		Days		
1	03000	ADULTS & PEDIATRICS	$ -												-		
2	03100	INTENSIVE CARE UNIT	$ -												-		
3	03200	CORONARY CARE UNIT	$ -												-		
4	03300	BURN INTENSIVE CARE UNIT	$ -												-		
5	03400	SURGICAL INTENSIVE CARE UNIT	$ -												-		
6	03600	OTHER SPECIAL CARE UNIT	$ -												-		
7	04000	SUBPROVIDER I	$ -												-		
8	04100	SUBPROVIDER II	$ -												-		
9	04200	OTHER SUBPROVIDER	$ -												-		
10	04300	NURSERY	$ -												-		
11			$ -												-		
12			$ -												-		
13			$ -												-		
14			$ -												-		
15			$ -												-		
16			$ -												-		
17			$ -												-		
18				Total Days	-	-	-	-	-	-	-	-	-	-	-	-	
19		Total Days per PS&R or Exhibit Detail			-		-		-		-		-				
20		Unreconciled Days (Explain Variance			-		-		-		-		-				
21		Routine Charges			Routine Charges		Routine Charges		Routine Charges		Routine Charges		Routine Charges		Routine Charges		
21.01		Calculated Routine Charge Per Diem			$ -		$ -		$ -		$ -		$ -		$ -		
		Ancillary Cost Centers (from W/S C) (from Section G):			Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	
22	09200	Observation (Non-Distinct)		-											$ -	$ -	
23				-											$ -	$ -	
24				-											$ -	$ -	
25				-											$ -	$ -	
26				-											$ -	$ -	
27				-											$ -	$ -	
28				-											$ -	$ -	
29				-											$ -	$ -	
30				-											$ -	$ -	
31				-											$ -	$ -	
32				-											$ -	$ -	
33				-											$ -	$ -	
34				-											$ -	$ -	
35				-											$ -	$ -	
36				-											$ -	$ -	
37				-											$ -	$ -	
38				-											$ -	$ -	
39				-											$ -	$ -	
40				-											$ -	$ -	
41				-											$ -	$ -	
42				-											$ -	$ -	
43				-											$ -	$ -	
44				-											$ -	$ -	
45				-											$ -	$ -	
46				-											$ -	$ -	
47				-											$ -	$ -	
48				-											$ -	$ -	
49				-											$ -	$ -	
50				-											$ -	$ -	
51				-											$ -	$ -	
52				-											$ -	$ -	
53				-											$ -	$ -	
54				-											$ -	$ -	
55				-											$ -	$ -	
56				-											$ -	$ -	
57				-											$ -	$ -	
58				-											$ -	$ -	
59				-											$ -	$ -	
60				-											$ -	$ -	
61				-											$ -	$ -	

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

Cost Report Year (- | SELECT HOSPITAL NAME

				In-State Medicaid FFS Primary		In-State Medicaid Managed Care Primary		In-State Medicare FFS Cross-Overs (with Medicaid Secondary)		In-State Other Medicaid Eligibles (Not Included Elsewhere)		Uninsured		Total In-State Medicaid		%
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			-											$ -	$ -	
122			-											$ -	$ -	
123			-											$ -	$ -	
124			-											$ -	$ -	
125			-											$ -	$ -	
126			-											$ -	$ -	
127			-											$ -	$ -	
				$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -			

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

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

Cost Report Year (- SELECT HOSPITAL NAME

	Totals / Payments	In-State Medicaid FFS Primary		In-State Medicaid Managed Care Primary		In-State Medicare FFS Cross-Overs (with Medicaid Secondary)		In-State Other Medicaid Eligibles (Not Included Elsewhere)		Uninsured		Total In-State Medicaid		%
128	**Total Charges** *(includes organ acquisition from Section J)*	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ - (Agrees to Exhibit A)	$ - (Agrees to Exhibit A)	$ -	$ -	
129	Total Charges per PS&R or Exhibit Detail	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -			
130	Unreconciled Charges (Explain Variance	-	-	-	-	-	-	-	-	-	-			
131	**Total Calculated Cost (includes organ acquisition from Section J)**	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)											$ -	$ -	
133	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)									(Agrees to Exhibit B and B-1)	(Agrees to Exhibit B and B-1)	$ -	$ -	
143	Payment from Hospital Uninsured During Cost Report Year (Cash Basis)													
144	Section 1011 Payment Related to Inpatient Hospital Services NOT Included in Exhibits B & B-1 (from Section E)									$ -	$ -			
145	**Calculated Payment Shortfall / (Longfall) (PRIOR TO SUPPLEMENTAL PAYMENTS AND DSH)**	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
146	**Calculated Payments as a Percentage of Cost**	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	
147	**Total Medicare Days from W/S S-3 of the Cost Report Excluding Swing-Bed (C/R, W/S S-3, Pt. I, Col. 6, Sum of Lns. 2, 3, 4, 14, 16, 17, 18 less lines 5 & 6)**					-								
148	**Percent of cross-over days to total Medicare days from the cost report**					0%								

ERROR! No other eligibles reported! See certification statement on DSH Survey Part I.

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 t
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 pay
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 payn

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

Version 8.11

I. Out-of-State Medicaid Data:

Cost Report Year (-) | SELECT HOSPITAL NAME

Line #	Cost Center Description	Medicaid Per Diem Cost for Routine Cost Centers	Medicaid Cost to Charge Ratio for Ancillary Cost Centers	Out-of-State Medicaid FFS Primary		Out-of-State Medicaid Managed Care Primary		Out-of-State Medicare FFS Cross-Overs (with Medicaid Secondary)		Out-of-State Other Medicaid Eligibles (Not Included Elsewhere)		Total Out-Of-State Medicaid	
				Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient
		From Section G	From Section G	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)		
	Routine Cost Centers (list below)			Days		Days		Days		Days		Days	
1	03000 ADULTS & PEDIATRICS	$ -										-	
2	03100 INTENSIVE CARE UNIT	$ -										-	
3	03200 CORONARY CARE UNIT	$ -										-	
4	03300 BURN INTENSIVE CARE UNIT	$ -										-	
5	03400 SURGICAL INTENSIVE CARE UNIT	$ -										-	
6	03600 OTHER SPECIAL CARE UNIT	$ -										-	
7	04000 SUBPROVIDER I	$ -										-	
8	04100 SUBPROVIDER II	$ -										-	
9	04200 OTHER SUBPROVIDER	$ -										-	
10	04300 NURSERY	$ -										-	
11		$ -										-	
12		$ -										-	
13		$ -										-	
14		$ -										-	
15		$ -										-	
16		$ -										-	
17		$ -										-	
18			Total Days	-		-		-		-		-	
19	Total Days per PS&R or Exhibit Detail			-		-		-		-			
20	Unreconciled Days (Explain Variance)			-		-		-		-			
				Routine Charges		Routine Charges		Routine Charges		Routine Charges		Routine Charges	
21	Routine Charges											$ -	
21.01	Calculated Routine Charge Per Diem			$ -		$ -		$ -		$ -		$ -	
	Ancillary Cost Centers (from W/S C) (list below):			Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges
22	09200 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			-									$ -	$ -

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

Version 8.11

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	
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			-									$ -	$ -
90			-									$ -	$ -
91			-									$ -	$ -
92			-									$ -	$ -
93			-									$ -	$ -
94			-									$ -	$ -
95			-									$ -	$ -
96			-									$ -	$ -
97			-									$ -	$ -
98			-									$ -	$ -
99			-									$ -	$ -
100			-									$ -	$ -
101			-									$ -	$ -
102			-									$ -	$ -
103			-									$ -	$ -
104			-									$ -	$ -
105			-									$ -	$ -
106			-									$ -	$ -
107			-									$ -	$ -
108			-									$ -	$ -
109			-									$ -	$ -
110			-									$ -	$ -

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

Version 8.11

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	
111										$ -	$ -
112										$ -	$ -
113										$ -	$ -
114										$ -	$ -
115										$ -	$ -
116										$ -	$ -
117										$ -	$ -
118										$ -	$ -
119										$ -	$ -
120										$ -	$ -
121										$ -	$ -
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%

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.

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

Cost Report Year (- SELECT HOSPITAL NAME

		Total Organ Acquisition Cost	Additional Add-In Intern/Resident Cost	Total Adjusted Organ Acquisition Cost	Revenue for Medicaid/ Cross-Over / Uninsured Organs Sold	Total Useable Organs (Count)	In-State Medicaid FFS Primary		In-State Medicaid Managed Care Primary		In-State Medicare FFS Cross-Overs (with Medicaid Secondary)		In-State Other Medicaid Eligibles (Not Include Elsewhere)		Uninsured	
							Charges	Useable Organs (Count)	Charges	Useable Organs (Count)	Charges	Useable Organs (Count)	Charges	Useable Organs (Count)	Charges	Useable Organs (Count)
		Cost Report Worksheet D-4, Pt. III, Col. 1, Ln 61	Add-On Cost Factor on Section G, Line 133 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 WS D-4 Pt. III, Col. 1, Ln 66 (substitute Medicare with Medicaid Cross-Over & uninsured). See Note C below.	Cost Report Worksheet D-4, Pt. III, Line 62	From Paid Claims Data or Provider Logs (Note A)	From Paid Claims Data or Provider Logs (Note A)	From Paid Claims Data or Provider Logs (Note A)	From Paid Claims Data or Provider Logs (Note A)	From Paid Claims Data or Provider Logs (Note A)	From Paid Claims Data or Provider Logs (Note A)	From Paid Claims Data or Provider Logs (Note A)	From Paid Claims Data or Provider Logs (Note A)	From Hospital's Own Internal Analysis	From Hospital's Own Internal Analysis
	Organ Acquisition Cost Centers (list below)															
1	Lung Acquisition	$ -	$ -	$ -		0										
2	Kidney Acquisition	$ -	$ -	$ -		0										
3	Liver Acquisition	$ -	$ -	$ -		0										
4	Heart Acquisition	$ -	$ -	$ -		0										
5	Pancreas Acquisition	$ -	$ -	$ -		0										
6	Intestinal 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 H as part of your In-State Medicaid total payments
Note C: Enter the total revenue applicable to organs furnished to other providers, to organ procurement organizations and others, and for organs transplanted into non-Medicaid / non-Uninsured patients (but where organs were included in the Medicaid and Uninsured organ counts above). Such revenues must be determined under the accrual method of accounting. If organs are transplanted into non-Medicaid/non-Uninsured patients who are not liable for payment on a charge basis, and as such there is no revenue applicable to the related organ acquisitions, the amount entered must also include an amount representing the acquisition cost of the organs transplanted into such patients.

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

Cost Report Year (- SELECT HOSPITAL NAME

		Total Organ Acquisition Cost	Additional Add-In Intern/Resident Cost	Total Adjusted Organ Acquisition Cost	Revenue for Medicaid/ Cross-Over / Uninsured Organs Sold	Total Useable Organs (Count)	Out-of-State Medicaid FFS Primary		Out-of-State Medicaid Managed Care Primar		Out-of-State Medicare FFS Cross-Overs (wit Medicaid Secondary)		Out-of-State Other Medicaid Eligibles (Not Included Elsewhere)	
							Charges	Useable Organs (Count)	Charges	Useable Organs (Count)	Charges	Useable Organs (Count)	Charges	Useable Organs (Count)
		Cost Report Worksheet D-4, Pt. III, Col. 1, Ln 61	Add-On Cost Factor on Section G, Line 133 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 WS D-4 Pt. III, Col. 1, Ln 66 (substitute Medicare with Medicaid Cross-Over & uninsured). See Note C below.	Cost Report Worksheet D-4, Pt. III, Line 62	From Paid Claims Data or Provider Logs (Note A)	From Paid Claims Data or Provider Logs (Note A)	From Paid Claims Data or Provider Logs (Note A)	From Paid Claims Data or Provider Logs (Note A)	From Paid Claims Data or Provider Logs (Note A)	From Paid Claims Data or Provider Logs (Note A)	From Paid Claims Data or Provider Logs (Note A)	From Paid Claims Data or Provider Logs (Note A)
	Organ Acquisition Cost Centers (list below)													
11	Lung Acquisition	$ -	$ -	$ -	$ -	0								
12	Kidney Acquisition	$ -	$ -	$ -	$ -	0								
13	Liver Acquisition	$ -	$ -	$ -	$ -	0								
14	Heart Acquisition	$ -	$ -	$ -	$ -	0								
15	Pancreas Acquisition	$ -	$ -	$ -	$ -	0								
16	Intestinal Acquisition	$ -	$ -	$ -	$ -	0								
17	Islet Acquisition	$ -	$ -	$ -	$ -	0								
18		$ -	$ -	$ -	$ -	0								
19	**Totals**	$ -	$ -	$ -	$ -	-	$ -	-	$ -	-	$ -	-	$ -	-
20	**Total Cost**							-		-		-		-

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

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

Version 8.11

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.*

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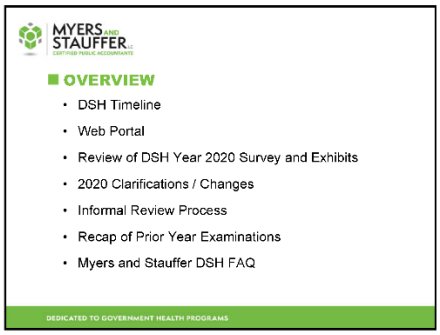
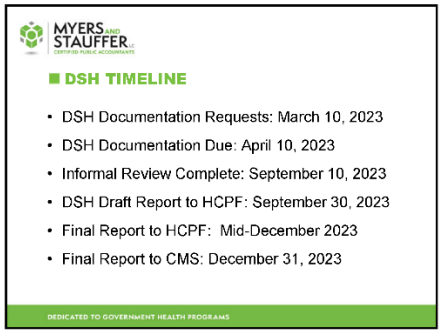
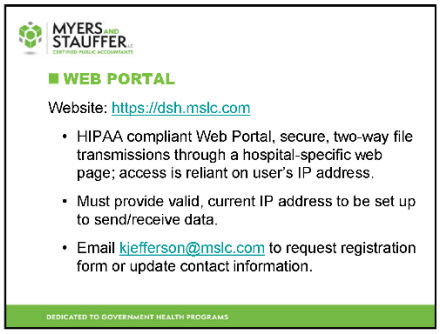
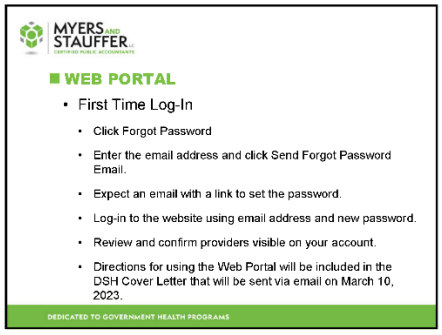
Appendix E: Sample Training Materials

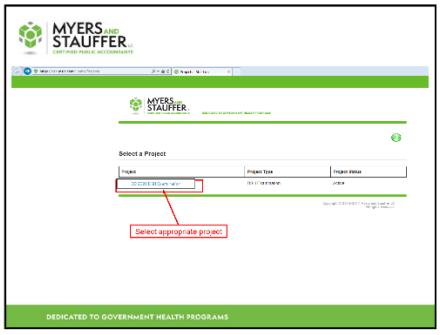
Sample DSH Update Training



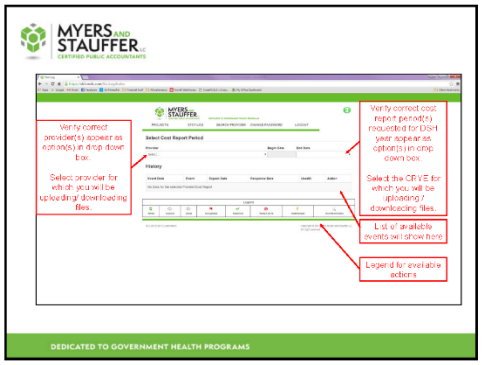


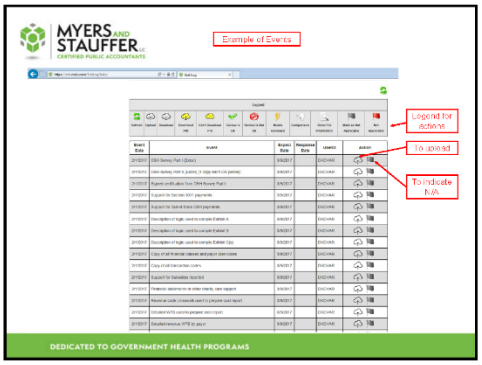


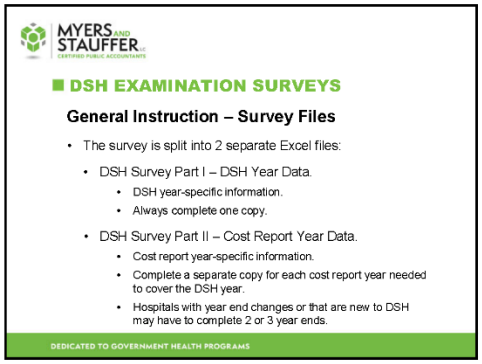


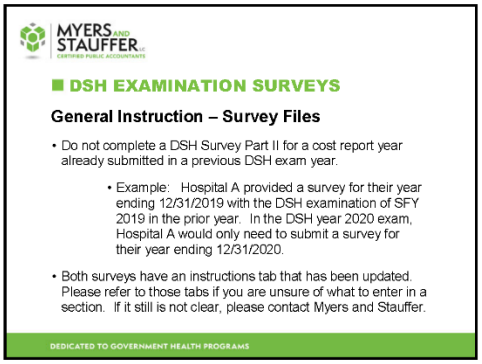


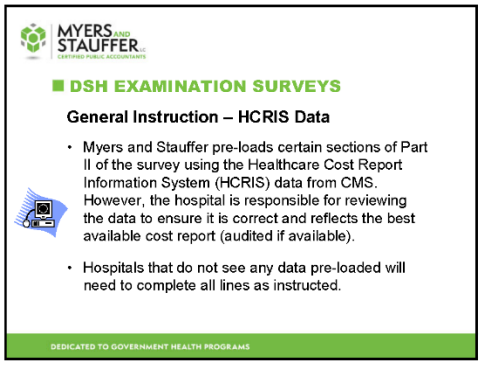
1

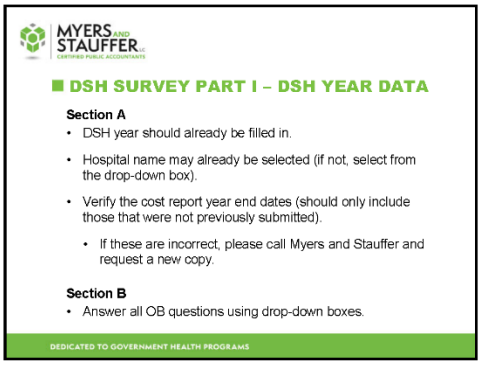

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS
Verify correct provider(s) appear as option(s) in drop down box.
Select provider for which you will be uploading/ downloading files.
Verify correct cost report period(s) requested for DSH year appear as option(s) in drop down box.
Select the CR YE for 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
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 12/31/2019 with the DSH examination of SFY 2019 in the prior year. In the DSH year 2020 exam, Hospital A would only need to submit a survey for their year ending 12/31/2020.
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 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 see any data pre-loaded 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 were not 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

DSH SURVEY PART I – DSH YEAR DATA

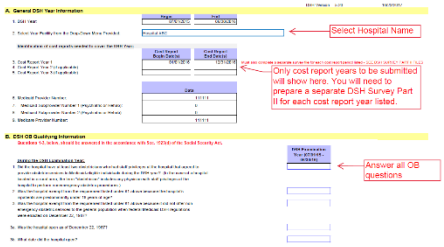
Section C

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

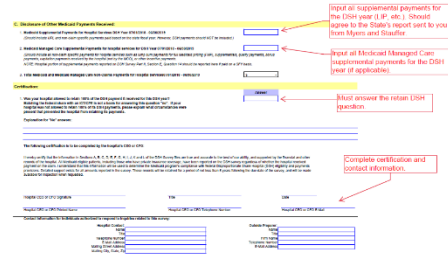
Certification

- 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



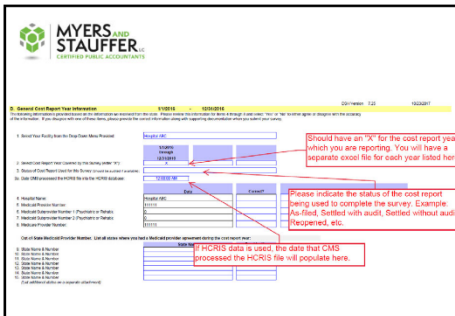
DEDICATED TO GOVERNMENT HEALTH PROGRAMS

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 –Will 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



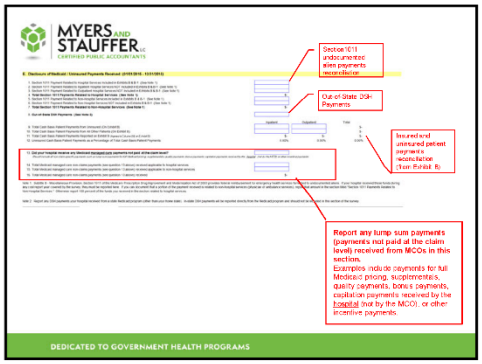
DEDICATED TO GOVERNMENT HEALTH PROGRAMS

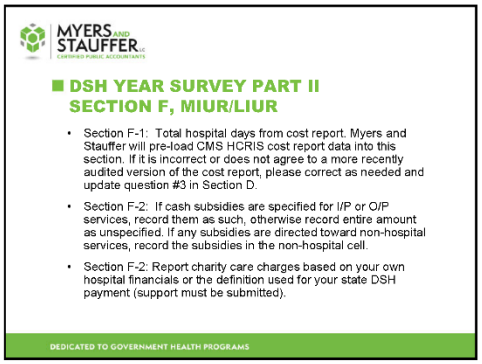
DSH YEAR SURVEY PART II SECTION E, MISC. PAYMENT INFO.

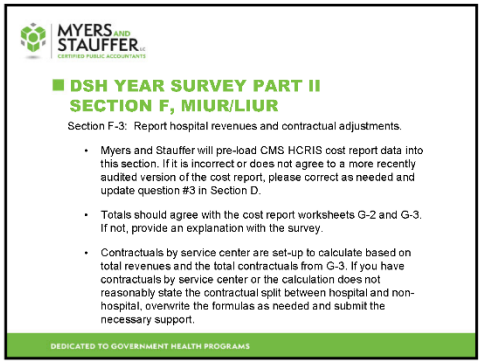
- 1011 Payments - You must report your Section 1011 payments included in payments on Exhibit B (posted at the patient level), and payments received but not included in Exhibit B (not posted at the patient level), and separate the 1011 payments between hospital services and non-hospital services (non-hospital 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.

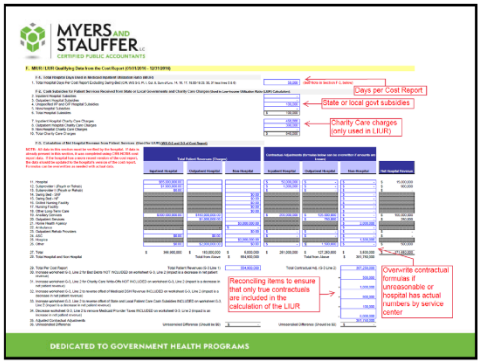
DEDICATED TO GOVERNMENT HEALTH PROGRAMS

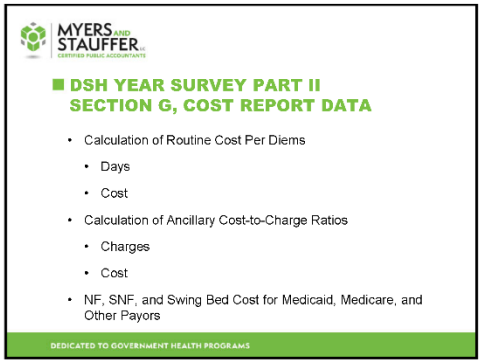
3

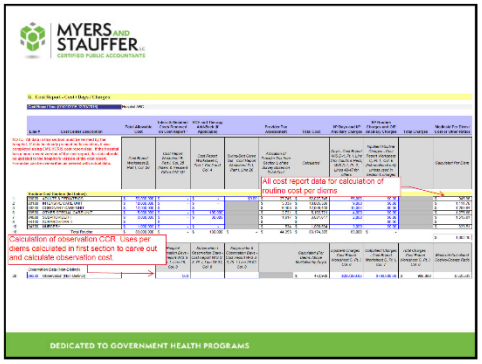

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS
Section 1011 undocumented alien payments reconciliation
Out-of-State DSH Payments
Insured and uninsured patient segments reconciliation (Item Points 8)
Report any lump sum payments (payments not paid at the claim level) received from MCOs in this section.
Examples include payments for full Medicaid pricing, supplements, quality payments, bonus payments, capitation payments received by the hospital (not by the MCO), or other incentive payments.
DEDICATED TO GOVERNMENT HEALTH PROGRAMS


MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS
DSH YEAR SURVEY PART II
SECTION F, 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 does not 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

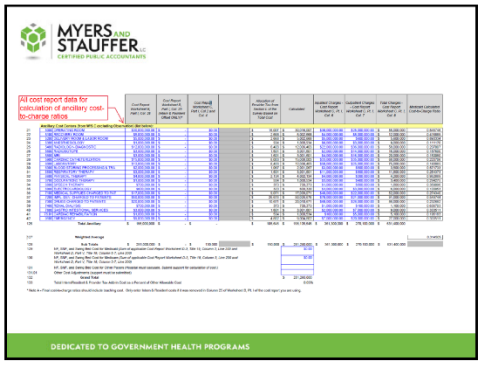

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS
DSH YEAR SURVEY PART II
SECTION F, MIUR/LIUR
Section F-3: Report hospital revenues and contractual adjustments.
Myers and Stauffer will pre-load CMS HCRIS cost report data into this section. If it is incorrect or does not agree to a more recently audited 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

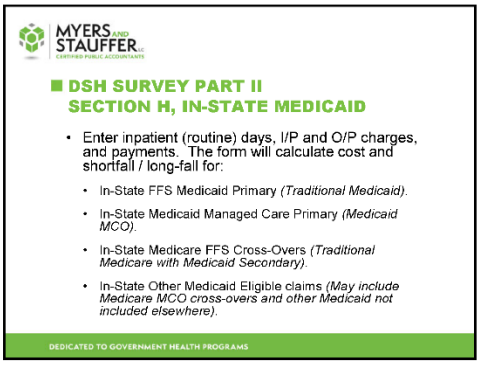

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS
Days per Cost Report
State or local govt subsidies
Charity Care charges (only used in LIUR)
Reconciling items to ensure that only true contractuals are included in the calculation of the LIUR
Overwrite contractual formulas if unreasonable or hospital has actual numbers by service center
DEDICATED TO GOVERNMENT HEALTH PROGRAMS

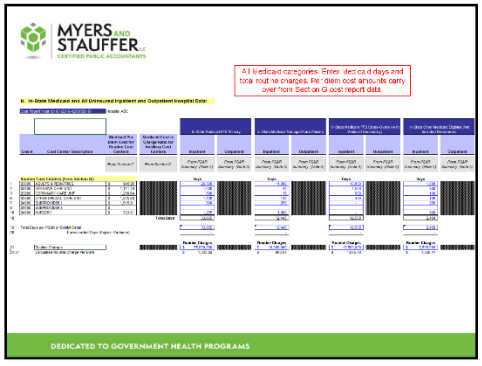

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS
DSH YEAR SURVEY PART II
SECTION G, COST REPORT DATA
Calculation of Routine Cost Per Diems
Days
Cost
Calculation of Ancillary Cost-to-Charge Ratios
Charges
Cost
NF, SNF, and Swing Bed Cost for Medicaid, Medicare, and Other Payors
DEDICATED TO GOVERNMENT HEALTH PROGRAMS

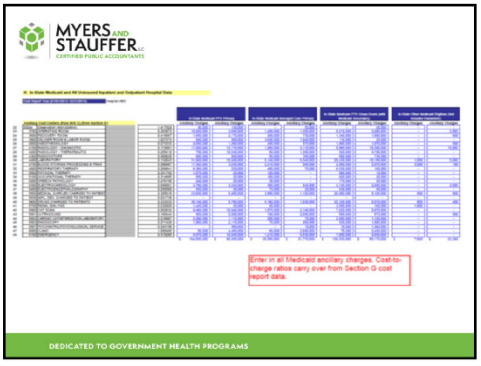

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS
All cost report data for calculation of routine cost per diems
Calculation of observation CCR. Loads part diems calculated in first section to carve out and calculate observation cost.
DEDICATED TO GOVERNMENT HEALTH PROGRAMS

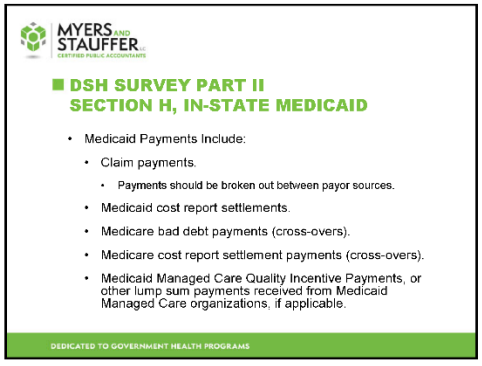
4

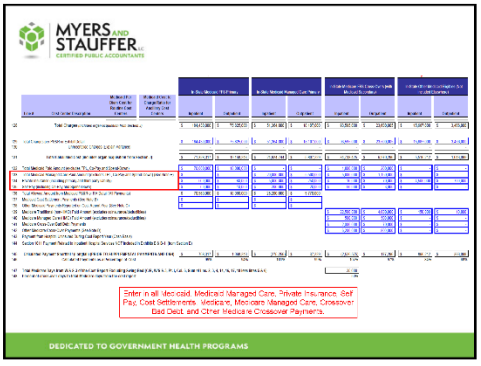

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS
All cost report data for calculation of ancillary cost-to-charge ratios
DEDICATED TO GOVERNMENT HEALTH PROGRAMS


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 Secondary).
In-State Other Medicaid Eligible claims (May include Medicare MCO 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 Sect on 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, if applicable.
DEDICATED TO GOVERNMENT HEALTH PROGRAMS

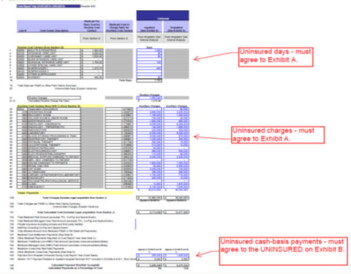

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS
Enter in all Medicaid, Medicaid Managed Care, Private Insurance, Self-Pay, Cost Settlements, Medicare, Medicare Managed Care, Crossover Bad Debt, and Other Medicare Crossover Payments.
DEDICATED TO GOVERNMENT HEALTH PROGRAMS

5

DSH SURVEY PART II SECTION H, UNINSURED

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

DEDICATED TO GOVERNMENT HEALTH PROGRAMS



DEDICATED TO GOVERNMENT HEALTH PROGRAMS

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

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

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 for reasonableness and correct any issues 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

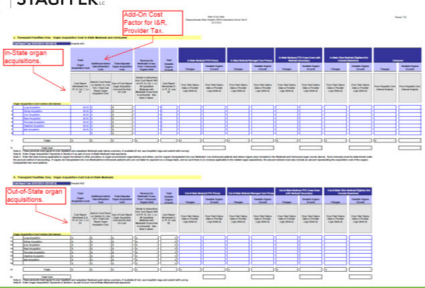
- Total organ acquisition cost and total useable organs may be pre-loaded from HCRIS data. If it is incorrect or does not agree to a more recently audited version of the cost report, please correct as needed and update question #3 in Section D.
- These schedules should be used to calculate organ acquisition cost for Medicaid (in-state and out-of-state) and uninsured for transplants occurring at the hospital.
- 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

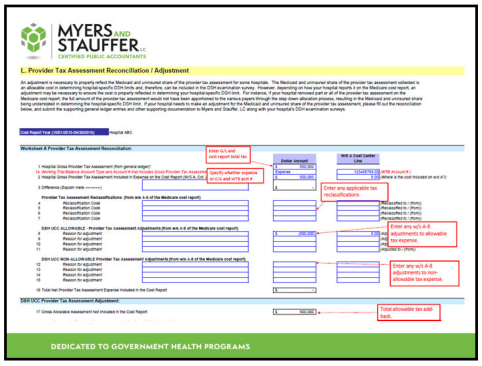


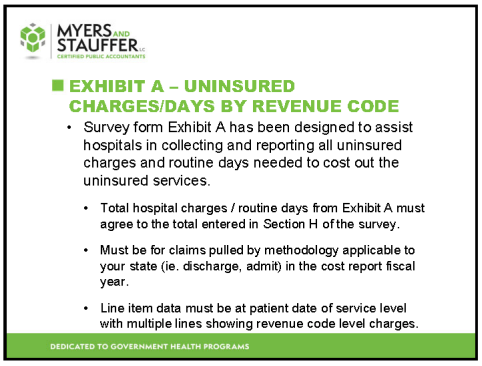
DEDICATED TO GOVERNMENT HEALTH PROGRAMS

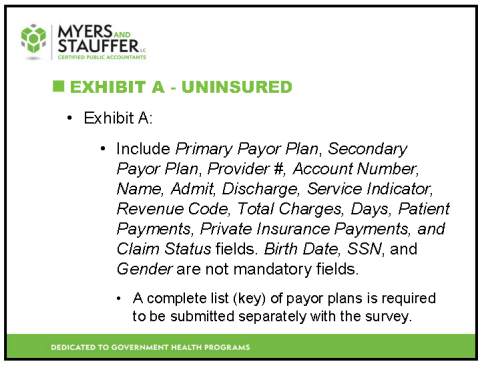
DSH SURVEY PART II SECTION L, PROVIDER TAXES

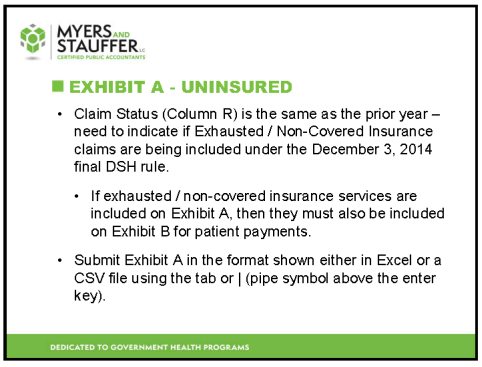
- The Medicaid DSH audit rule clearly indicates that the portion of permissible provider taxes applicable to Medicaid and uninsured is an allowable cost for the Medicaid DSH UCC. (FR Vol. 73, No. 245, Friday, Dec. 19, 2008, page 77923)
- All permissible provider tax not included in allowable cost on the cost report will be added back and allocated to the Medicaid and uninsured UCC on a reasonable basis (e.g., charges).
- Complete the section using cost report data and hospital's own general ledger.

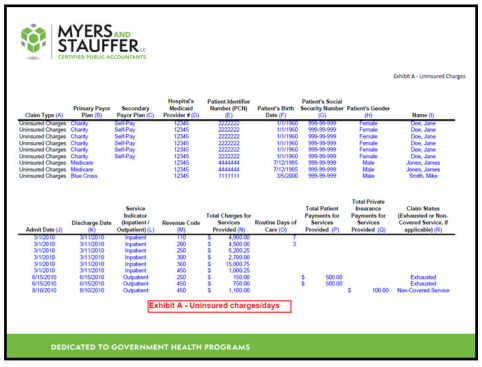
DEDICATED TO GOVERNMENT HEALTH PROGRAMS


MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS
I. Provider Tax Assessment Reconciliation / Adjustment
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 claims pulled by methodology applicable to your state (ie. discharge, admit) 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 Number, Name, Admit, Discharge, Service Indicator, Revenue Code, Total Charges, Days, Patient Payments, Private Insurance Payments, and Claim Status fields. Birth Date, SSN, and Gender are not mandatory 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).
DEDICATED TO GOVERNMENT HEALTH PROGRAMS


MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS
Exhibit A - Uninsured Charges
Exhibit A - Uninsured charges/days
DEDICATED TO GOVERNMENT HEALTH PROGRAMS

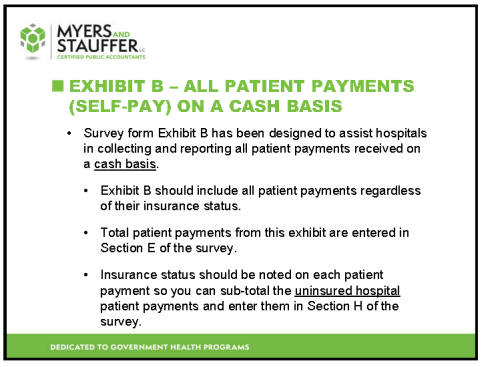

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS
EXHIBIT B – ALL PATIENT PAYMENTS (SELF-PAY) ON A CASH BASIS
Survey form Exhibit B has been designed to assist hospitals in collecting and reporting all patient payments received on a cash basis.
Exhibit B should include all patient payments regardless 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

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 2020 cost report year that relates to a service provided in the 2006 cost report year, must be used to reduce uninsured cost for the 2020 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 #, PCN, 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. *Birth Date, SSN,* and *Gender* may also be requested.
    - A separate "key" for all payment transaction codes should be submitted with the survey.
  - Submit Exhibit B in the format shown using Excel or a CSV file using the tab or | (pipe symbol above the enter key).

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Exhibit B - Self-Pay Payments

Claim Type (A)	Primary Payor Plan (B)	Secondary Payor Plan (C)	Transaction Code (D)	Hospital's Medicaid Provider # (E)	Patient Identifier Number (PCN) (F)	Patient's Birth Date (G)	Patient's Social Security Number (H)	Patient's Gender (I)	Name (J)
Self-Pay Payments	Medicare	Medicaid	500	12345	3333333	2/7/2025	999-99-999	Male	Jones, Anthony
Self-Pay Payments	Medicare	Medicaid	500	12345	3333333	2/7/2025	999-99-999	Male	Jones, Anthony
Self-Pay Payments	Medicare	Medicaid	500	12345	3333333	2/7/2025	999-99-999	Male	Jones, Anthony
Self-Pay Payments	Blue Cross		150	12345	9999999	9/25/1975	999-99-999	Male	Smith, John
Self-Pay Payments	Blue Cross		150	12345	9999999	9/25/1975	999-99-999	Male	Smith, John
Self-Pay Payments	Blue Cross		150	12345	9999999	9/25/1975	999-99-999	Male	Smith, John
Self-Pay Payments	Self-Pay		500	12345	7777777	7/6/2000	999-99-999	Male	Cliff, Heath
Self-Pay Payments	Self-Pay		500	12345	7777777	7/6/2000	999-99-999	Male	Cliff, Heath
Self-Pay Payments	United Healthcare		500	12345	5555555	2/15/1960	999-99-999	Male	Johnson, Joe

Admit Date (K)	Discharge Date (L)	Date of Cash Collection (M)	Amount of Cash Collections (N)	Indicate if Collection is a 1011 Payment (O)	Service Indicator (Inpatient / Outpatient)	Total Hospital Charges for Services Provided (P)	Total Physician Charges for Services Provided (Q)	Total Other Non-Hospital Charges for Services Provided (S)	Insurance Status When Services Were Provided (Insured or Uninsured) (T)	Claim Status (Exhausted or Non-Covered Service, if applicable) (U)
7/12/1995	7/14/1995	7/15/2010	$ 50	No	Inpatient	$ 10,000	$ 900	$ -	Insured	
7/12/1995	7/14/1995	3/1/2010	$ 50	No	Inpatient	$ 10,000	$ 900	$ -	Insured	
7/12/1995	7/14/1995	4/1/2010	$ 50	No	Inpatient	$ 10,000	$ 900	$ -	Insured	
9/21/2000	9/21/2000	9/30/2009	$ 150	No	Outpatient	$ 2,000	$ -	$ 50	Insured	Exhausted
9/21/2000	9/21/2000	10/31/2009	$ 150	No	Outpatient	$ 2,000	$ -	$ 50	Insured	Exhausted
9/21/2000	9/21/2000	11/30/2009	$ 150	No	Outpatient	$ 2,000	$ -	$ 50	Insured	Exhausted
12/31/2009	1/1/2010	5/15/2010	$ 90	No	Inpatient	$ 15,000	$ 1,000	$ -	Uninsured	
12/31/2009	1/1/2010	5/31/2010	$ 90	No	Inpatient	$ 15,000	$ 1,000	$ -	Uninsured	
9/1/2005	9/3/2005	11/12/2010	$ 100	No	Inpatient	$ 14,000	$ 400	$ 50	Insured	Non-Covered Service

Exhibit B - Cash Basis Patient Payments

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EXHIBIT C – HOSPITAL-PROVIDED MEDICAID DATA

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

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

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 eligible data (Section H).
  - All self-reported Out-of-State Medicaid categories (Section I).

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EXHIBIT C – HOSPITAL-PROVIDED MEDICAID DATA

- Exhibit C
  - Include *Primary Payor Plan, Secondary Payor Plan, Hospital MCD #, 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. *DOB, Social,* and *Gender* may also be requested.
    - A complete list (key) of payor plans is required to be submitted separately with the survey.
  - Submit Exhibit C in the format shown using Excel or a CSV file using the tab or | (pipe symbol above the enter key).

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EXHIBIT C – HOSPITAL-PROVIDED MEDICAID DATA

- Exhibit C
  - In preparation for future year's DSH Examinations that will be impacted by the Consolidated Appropriations Act (CAA), two columns have been added to the Exhibit C example template.
    - "Does claim have any coverage other than Medicaid FFS/Medicaid Managed Care? (Y/N)
    - "Comments"

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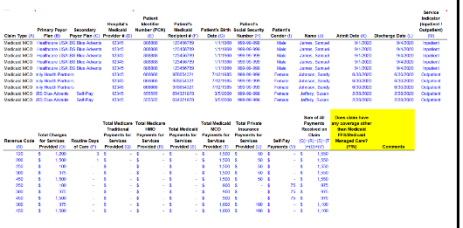

In State MCO

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EXHIBITS COMMON ISSUES

- Submitted Exhibit columns and/or headers have been modified
- Service Indicator other than Inpatient/Outpatient (IP, OP , I and O)
- #N/A or "VALUE" errors
- Discharge date is before admit date
- Exhibits do not agree with DSH Survey II
- No revenue codes

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DSH SURVEY PART I – DSH YEAR DATA

Checklist

- Separate tab in Part I of the survey.
- Includes list of all supporting documentation that needs to be submitted with the survey for examination.
- Includes Myers and Stauffer address and phone numbers.

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2020 CLARIFICATIONS/CHANGES

- *DSH Allotments*
  - Allotment reduction delayed even further through the Medicare Access and CHIP Reauthorization Act of 2016
  - 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
  - CARES Act§ 3813 delayed until December 1, 2020
  - Consolidated Appropriations Act for 2021 delayed DSH reductions until FY 2024

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INFORMAL REVIEW

- Receipt of the DSH Results Letter begins informal review process.
- Provider given 10 days to respond with questions and requests for workpapers supporting adjustments.
- Provider opportunity to challenge the results.

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INFORMAL REVIEW

DSH Results Letter Includes:

- State DSH Year Adjusted Uncompensated Care Calculation (UCC)
- In-State DSH Payments in Excess of State DSH Year Adjusted UCC
- Findings/Observations Noted During Examination Procedures
- MIUR/LIUR

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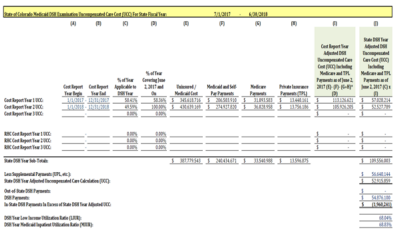
INFORMAL REVIEW



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PRIOR YEAR DSH EXAMINATION

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.

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PRIOR YEAR DSH EXAMINATION

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.

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PRIOR YEAR DSH EXAMINATION

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.
- Some hospitals did not include their charity care patients in the uninsured even though they had no third party coverage.
- 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.

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PRIOR YEAR DSH EXAMINATION

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.
- Exhibit B – Patient payments did not always include all patient payments – some hospitals incorrectly limited their data to uninsured patient payments.

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PRIOR YEAR DSH EXAMINATION

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.
- Liability insurance claims were incorrectly included in uninsured even when the insurance (e.g., auto policy) made a payment on the claim.

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FAQ

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

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

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

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FAQ

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

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

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

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FAQ

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

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

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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 would not cover beneficiaries over 18.

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FAQ

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

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

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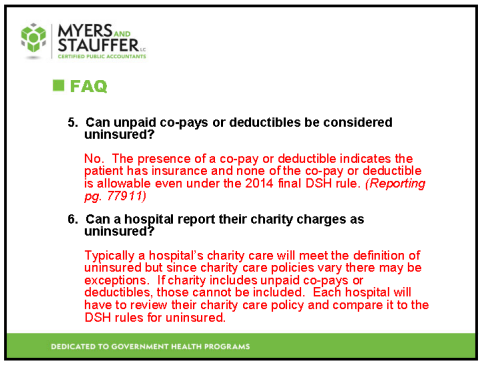
MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS
FAQ
5. Can unpaid co-pays or deductibles be considered uninsured?
No. The presence of a co-pay or deductible indicates the patient has insurance and none of the co-pay or deductible is allowable even under the 2014 final DSH rule. (Reporting pg. 77911)
6. Can a hospital report their charity charges as uninsured?
Typically a hospital's charity care will meet the definition of uninsured but since charity care policies vary there may be exceptions. If charity includes unpaid co-pays or deductibles, those cannot be included. Each hospital will have to review their charity care policy and compare it to the DSH rules for uninsured.
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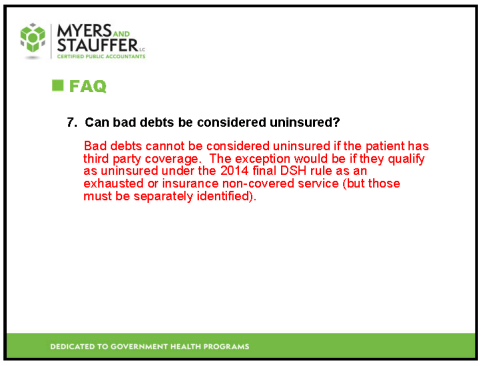
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FAQ
7. Can bad debts be considered uninsured?
Bad debts cannot be considered uninsured if the patient has third party coverage. The exception would be if they qualify as uninsured under the 2014 final DSH rule as an exhausted or insurance non-covered service (but those must be separately identified).
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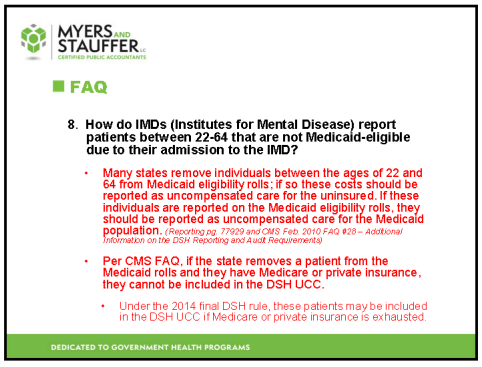
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FAQ
8. How do IMDs (Institutes for Mental Disease) report patients between 22-64 that are not Medicaid-eligible due to their admission to the IMD?
Many states remove individuals between the ages of 22 and 64 from Medicaid eligibility rolls; if so these costs should be reported as uncompensated care for the uninsured. If these individuals are reported on the Medicaid eligibility rolls, they should be reported as uncompensated care for the Medicaid population. (Reporting pg. 77929 and CMS Feb. 2010 FAQ #28 – Additional Information on the DSH Reporting and Audit Requirements)
Per CMS FAQ, if the state removes a patient from the Medicaid rolls and they have Medicare or private insurance, 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 or private insurance is exhausted.
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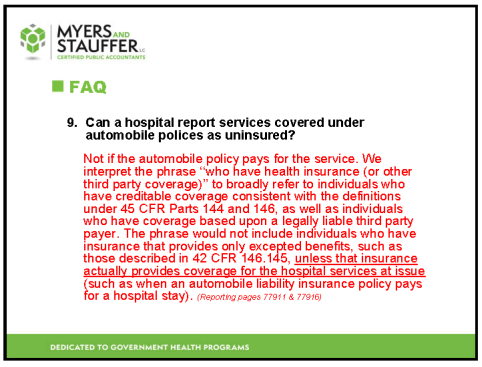
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FAQ
9. Can a hospital report services covered under automobile polices as uninsured?
Not if the automobile policy pays for the service. We interpret the phrase "who have health insurance (or other third party coverage)" to broadly refer to individuals who have creditable coverage consistent with the definitions under 45 CFR Parts 144 and 146, as well as individuals who have coverage based upon a legally liable third party payer. The phrase would not include individuals who have insurance that provides only excepted benefits, such as those described in 42 CFR 146.145, unless that insurance actually provides coverage for the hospital services at issue (such as when an automobile liability insurance policy pays for a hospital stay). (Reporting pages 77911 & 77916)
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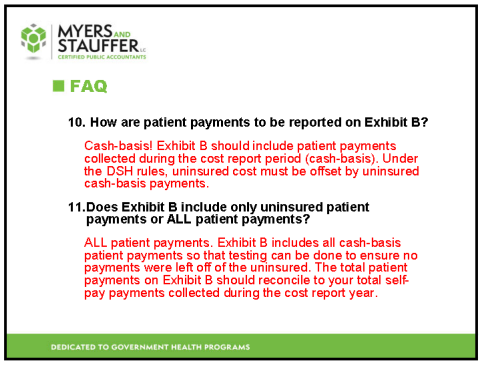
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FAQ
10. How are patient payments to be reported on Exhibit B?
Cash-basis! Exhibit B should include patient payments collected during the cost report period (cash-basis). Under the DSH rules, uninsured cost must be offset by uninsured cash-basis payments.
11. Does Exhibit B include only uninsured patient payments or ALL patient payments?
ALL patient payments. Exhibit B includes all cash-basis patient payments so that testing can be done to ensure no payments were left off of the uninsured. The total patient payments on Exhibit B should reconcile to your total self-pay payments collected during the cost report year.
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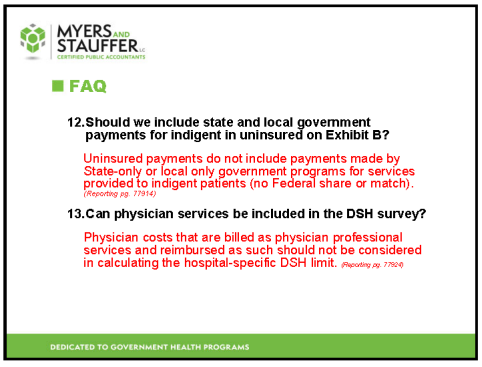
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FAQ
12. Should we include state and local government payments for indigent in uninsured on Exhibit B?
Uninsured payments do not include payments made by State-only or local only government programs for services provided to indigent patients (no Federal share or match). (Reporting pg. 77914)
13. Can physician services be included in the DSH survey?
Physician costs that are billed as physician professional services and reimbursed as such should not be considered in calculating the hospital-specific DSH limit. (Reporting pg. 77924)
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13

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FAQ

14. **Do dual eligible patients (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. *(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 77920 & 77926)*

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FAQ

16. **Do other Medicaid eligible claims (private insurance/Medicaid) have to be included in the Medicaid UCC?**

Yes. Since Section 1923(g)(1) does not contain an exclusion for dually eligible individuals, CMS believes the costs attributable to dual eligibles should be included in the calculation of the uncompensated costs of serving Medicaid eligible individuals. *(Reporting pages 77912)*

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OTHER INFORMATION

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

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

Reach out to the Myers & Stauffer contact for your state for additional state specific information or with any questions or concerns.

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www.myersandstauffer.com

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DSH Payment Examination and Certified Public Expenditures Reconciliation Training

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DISPROPORTIONATE SHARE HOSPITAL (DSH) PAYMENT EXAMINATION AND CERTIFIED PUBLIC EXPENDITURES (CPE) RECONCILIATION UPDATE STATE FISCAL YEAR 2020

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OVERVIEW

- DSH & CPE Timeline
- Web Portal
- Review of DSH Year 2020 Survey and Exhibits
- 2020 Clarifications / Changes
- Review of DSH Results
- Recap of Prior Year Examinations
- Myers and Stauffer DSH FAQs
- CPE Reconciliation Procedures and Requests

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DSH TIMELINE

- Note: Consistent with 2019, the 2020 DSH requests are for hospitals that received Statutory and/or Virtual DSH payments.
- DSH and CPE Documentation Due: May 26, 2023
- DSH Results to Hospitals (Tentative): November, 2023
- Final DSH Report to TennCare: Mid-December 2023
- Final DSH Report due to CMS: December 31, 2023
- CPE Reconciliation to TennCare: January - February 2024

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WEB PORTAL

Website: https://dsh.mslc.com

- HIPAA compliant Web Portal, secure, two-way file transmissions through a hospital-specific web page; access is reliant on user's IP address.
- Must provide valid, current IP address to be set up to send/receive data.
- Email bfraney@mslc.com to request registration form or update contact information.

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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.
  - Directions for using the Web Portal were included in the Cover Letters that were sent with the DSH and CPE requests.

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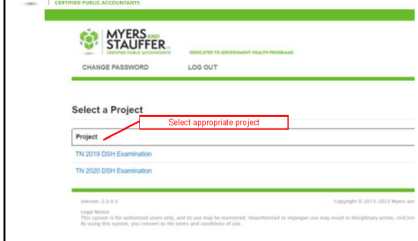

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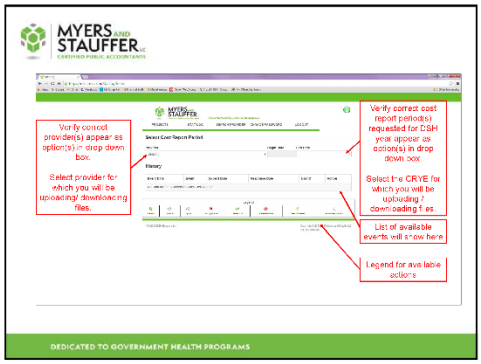
Verify correct provider(s) appear as option(s) in drop down box.
Select provider for which you will be uploading/ downloading files.
Verify correct cost report period(s) requested for DSH year appear as option(s) in drop down box.
Select the CRYE for which you will be uploading / downloading files.
List of available events will show here.
Legend for available actions
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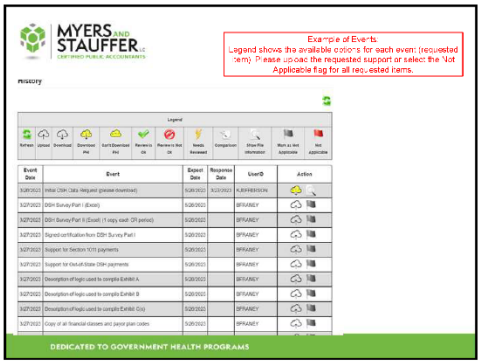
Example of Events:
Legend shows the available actions for each event (requested item). Please upload the requested support or select the 'Not Applicable' flag for all requested items.
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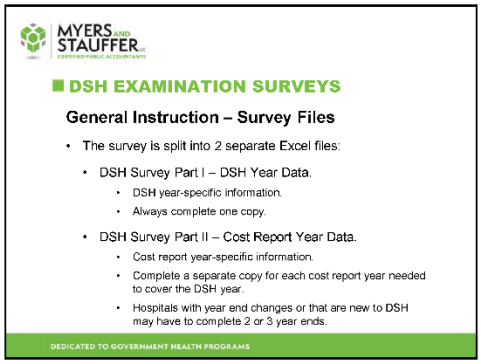
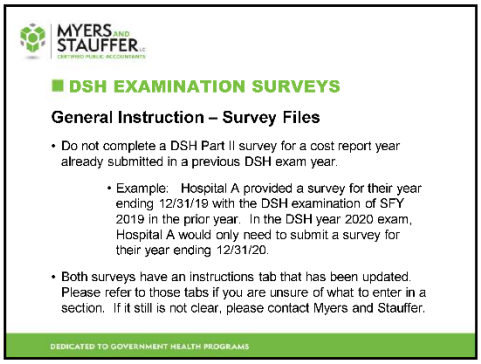
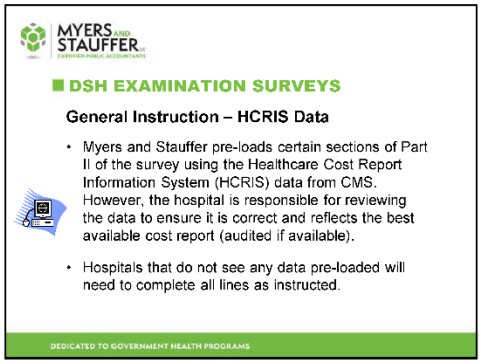
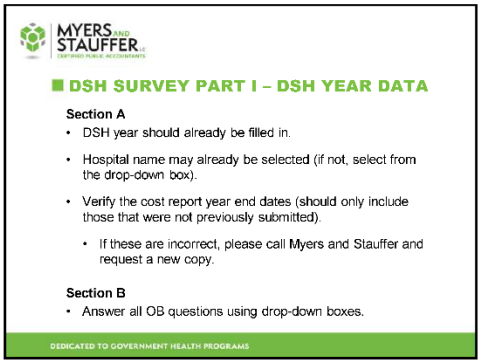
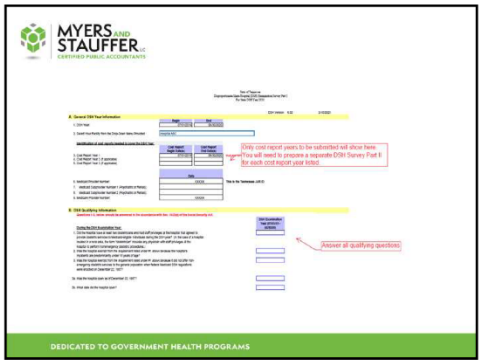
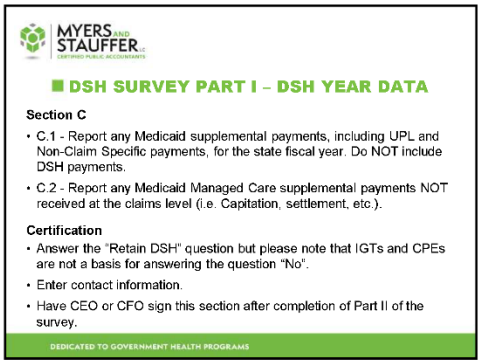

DSH EXAMINATION SURVEYS
General Instruction – Survey Files
The survey is split into 2 separate Excel files:
DSH Survey Part I – DSH Year Data.
DSH year-specific information.
Always complete one copy.
DSH Survey Part II – Cost Report Year Data.
Cost report year-specific information.
Complete a separate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

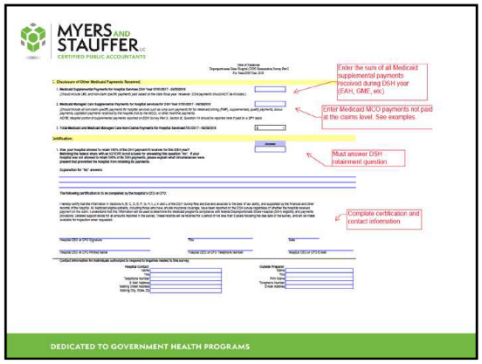

DSH EXAMINATION SURVEYS
General Instruction – Survey Files
Do not complete a DSH Part II survey for a cost report year already submitted in a previous DSH exam year.
Example: Hospital A provided a survey for their year ending 12/31/19 with the DSH examination of SFY 2019 in the prior year. In the DSH year 2020 exam, Hospital A would only need to submit a survey for their year ending 12/31/20.
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

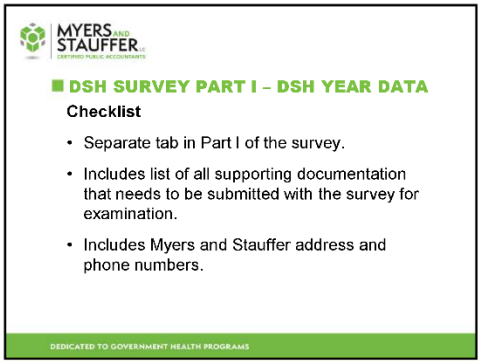

DSH EXAMINATION SURVEYS
General Instruction – HCRIS Data
Myers and Stauffer pre-loads certain sections of Part II of the survey using the Healthcare Cost Report Information System (HCRIS) data from CMS. However, the hospital is responsible for reviewing the data to ensure it is correct and reflects the best available cost report (audited if available).
Hospitals that do not see any data pre-loaded will need to complete all lines as instructed.
DEDICATED TO GOVERNMENT HEALTH PROGRAMS

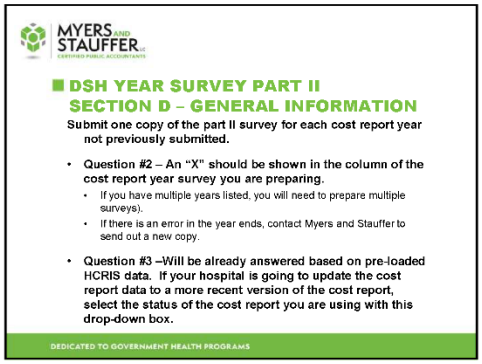

DSH SURVEY PART I – DSH YEAR DATA
Section A
DSH year should already be filled in.
Hospital name may already be selected (if not, select from the drop-down box).
Verify the cost report year end dates (should only include those that were not previously submitted).
If these are incorrect, please call Myers and Stauffer and request a new copy.
Section B
Answer all OB questions using drop-down boxes.
DEDICATED TO GOVERNMENT HEALTH PROGRAMS

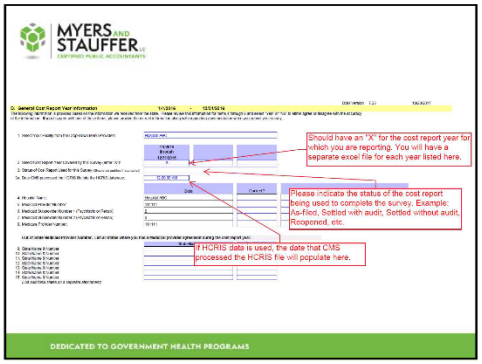

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS
Only cost report years to be submitted will show here. You will need to prepare a separate DSH Survey Part II for each cost report year listed.
Answer all qualifying questions
DEDICATED TO GOVERNMENT HEALTH PROGRAMS


MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS
DSH SURVEY PART I – DSH YEAR DATA
Section C
• C.1 - Report any Medicaid supplemental payments, including UPL and Non-Claim Specific payments, for the state fiscal year. Do NOT include DSH payments.
• C.2 - Report any Medicaid Managed Care supplemental payments NOT received at the claims level (i.e. Capitation, settlement, etc.).
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


MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS
Enter the sum of all Medicaid supplemental payments received during DSH year (IGAH, GME, etc)
Enter Medicaid MCO payments not paid at the claims level. See examples.
Must answer DSH Inherent question
Complete certification and contact information
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.
• 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


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 –Will 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

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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
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DSH YEAR SURVEY PART II SECTION F, 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 does not 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

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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 does not 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

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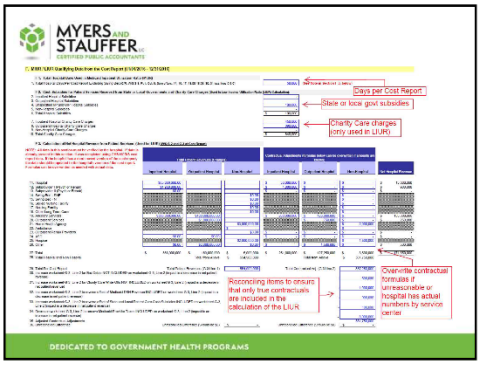
CERTIFIED PUBLIC ACCOUNTANTS



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CERTIFIED PUBLIC ACCOUNTANTS

DSH YEAR SURVEY PART II SECTION G, COST REPORT DATA

- Calculation of Routine Cost Per Diems
  - Days
  - Cost
- Calculation of Ancillary Cost-to-Charge Ratios
  - Charges
  - Cost
- NF, SNF, and Swing Bed Cost for Medicaid, Medicare, and Other Payors

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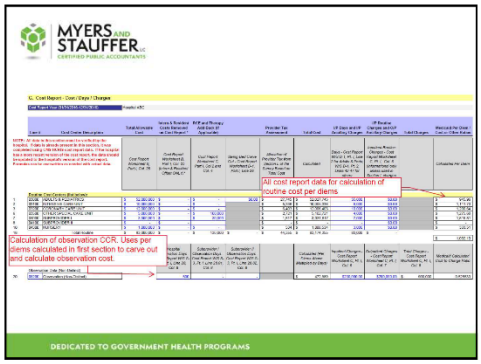
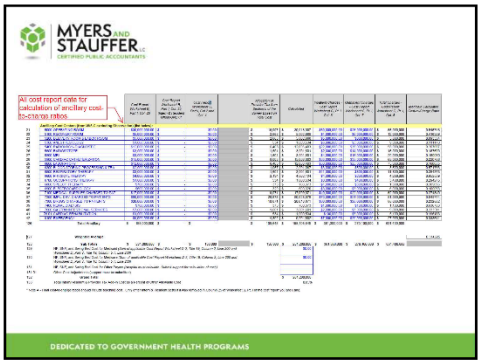
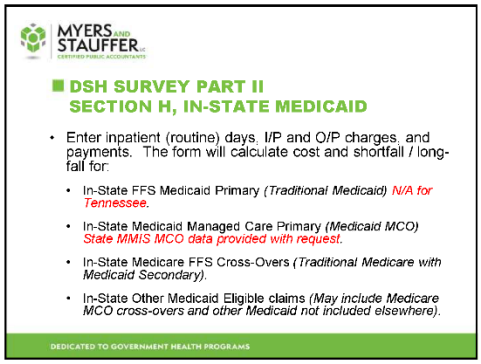
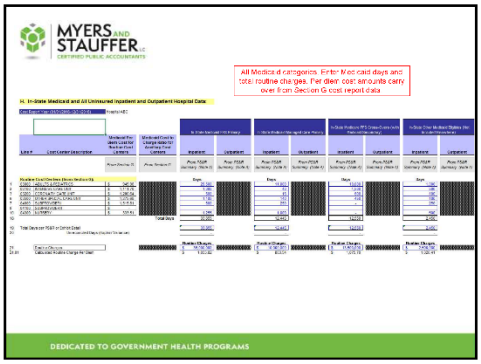
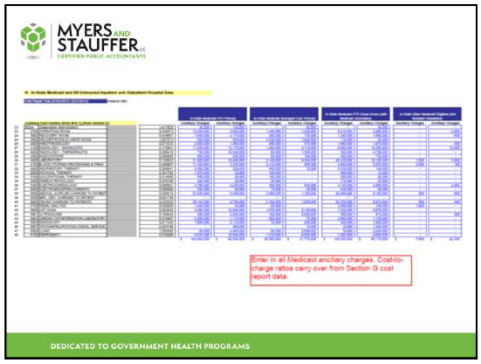
4

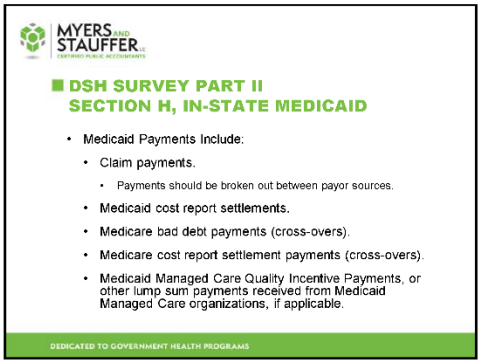

All cost report data for calculation of routine cost per diems
Calculation of observation CCR. Uses per diems calculated in first section to carve out and calculate observation cost.
DEDICATED TO GOVERNMENT HEALTH PROGRAMS


All cost report data for calculation of ancillary cost-to-charge ratios
DEDICATED TO GOVERNMENT HEALTH PROGRAMS

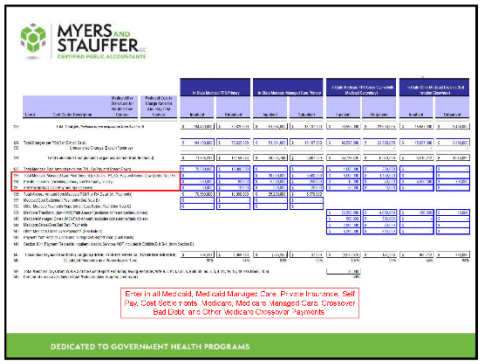

DSH SURVEY PART II
SECTION H, IN-STATE MEDICAID
Enter inpatient (routine) days, I/P and O/P charges, and payments. The form will calculate cost and shortfall / long-fall for:
In-State FFS Medicaid Primary (Traditional Medicaid) N/A for Tennessee.
In-State Medicaid Managed Care Primary (Medicaid MCO) State MMIS MCO data provided with request.
In-State Medicare FFS Cross-Overs (Traditional Medicare with Medicaid Secondary).
In-State Other Medicaid Eligible claims (May include Medicare MCO cross-overs and other Medicaid not included elsewhere).
DEDICATED TO GOVERNMENT HEALTH PROGRAMS

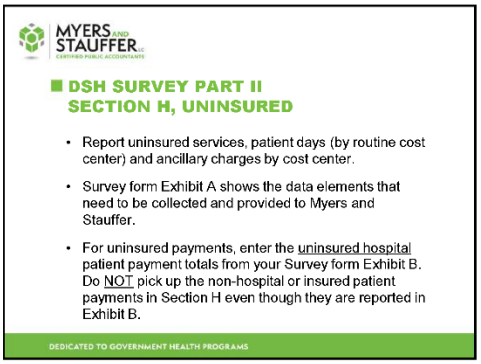

All Medicaid categories. Enter Medicaid days and total routine charges. Per diem cost amounts carry over from Section G cost report data
DEDICATED TO GOVERNMENT HEALTH PROGRAMS

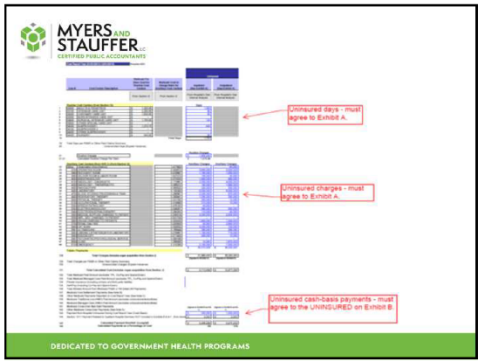

Enter in all Medicaid ancillary charges. Cost-to-charge ratios carry over from Section G cost report data.
DEDICATED TO GOVERNMENT HEALTH PROGRAMS

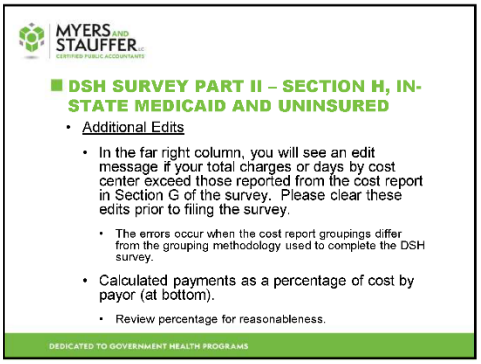

DSH SURVEY PART II
SECTION H, IN-STATE MEDICAID
Medicaid Payments Include:
Claim payments.
Payments should be broken out between payor sources.
Medicaid cost report settlements.
Medicare bad debt payments (cross-overs).
Medicare cost report settlement payments (cross-overs).
Medicaid Managed Care Quality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

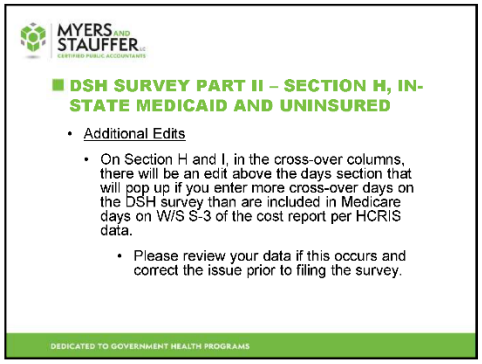
5

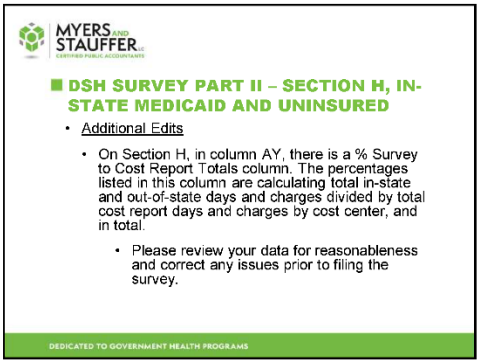

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS
Enter in all Medicaid, Medicaid Managed Care, Private Insurance, Self Pay, Cost Settlements, Medicare, Medicare Managed Care, Crossover Bad Debt, and Other Medicare Crossover Payments
DEDICATED TO GOVERNMENT HEALTH PROGRAMS


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 - must agree to Exhibit A.
Uninsured charges - must agree to Exhibit A.
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.
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
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 for reasonableness and correct any issues prior to filing the survey.
DEDICATED TO GOVERNMENT HEALTH PROGRAMS

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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

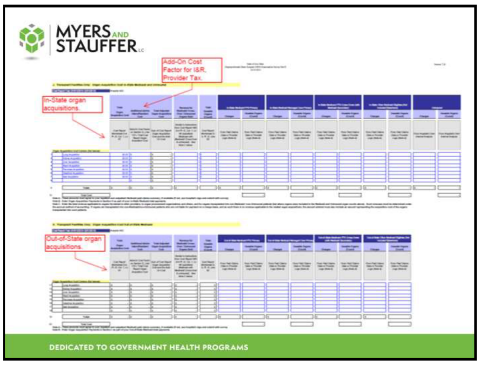
- Total organ acquisition cost and total useable organs may be pre-loaded from HCRIS data. If it is incorrect or does not agree to a more recently audited version of the cost report, please correct as needed and update question #3 in Section D.
- These schedules should be used to calculate organ acquisition cost for Medicaid (in-state and out-of-state) and uninsured for transplants occurring at the hospital.
- 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

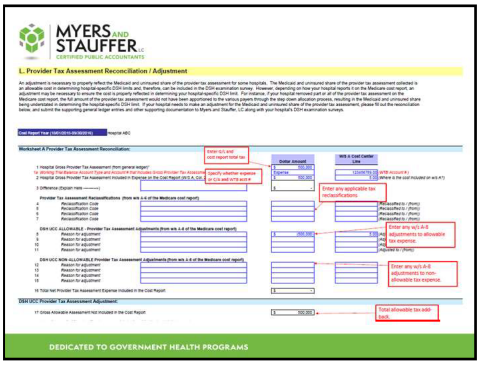


DEDICATED TO GOVERNMENT HEALTH PROGRAMS

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 on a reasonable basis (e.g., charges).
- Complete the section using cost report data and hospital's own general ledger.

DEDICATED TO GOVERNMENT HEALTH PROGRAMS



DEDICATED TO GOVERNMENT HEALTH PROGRAMS

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 claims pulled by methodology applicable to your state (ie. discharge, admit) 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

EXHIBIT A - UNINSURED

- Exhibit A:
  - Include *Primary Payor Plan, Secondary Payor Plan, Provider #, Account Number, Name, Admit, Discharge, Service Indicator, Revenue Code, Total Charges, Days, Patient Payments, Private Insurance Payments,* and *Claim Status* fields. *Birth Date, SSN*, and *Gender* are not mandatory fields.
    - A complete list (key) of payor plans is required to be submitted separately with the survey.

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

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

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

Admit Date (J)	Discharge Date (K)	Service Indicator (Inpatient / Outpatient) (L)	Revenue Code (M)	Total Charges for Services Provided (N)	Routine Days of Care (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)
3/1/2010	3/11/2010	Inpatient	110	$ 4,000.00	7			
3/1/2010	3/11/2010	Inpatient	200	$ 4,500.00	3			
3/1/2010	3/11/2010	Inpatient	250	$ 5,200.25				
3/1/2010	3/11/2010	Inpatient	300	$ 2,700.00				
3/1/2010	3/11/2010	Inpatient	360	$ 15,000.75				
3/1/2010	3/11/2010	Inpatient	450	$ 1,000.25				
6/15/2010	6/15/2010	Outpatient	250	$ 150.00		$ 500.00		Exhausted
6/15/2010	6/15/2010	Outpatient	450	$ 750.00		$ 500.00		Exhausted
8/10/2010	8/10/2010	Outpatient	450	$ 1,100.00			$ 100.00	Non-Covered Service

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.

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

- Patient payments received for uninsured services need to be reported on a cash basis.
  - For example, a cash payment received during the 2020 cost report year that relates to a service provided in the 2006 cost report year, must be used to reduce uninsured cost for the 2020 cost report year.

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

8

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*, *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. *Birth Date*, *SSN*, and *Gender* may also be requested.
    - A separate "key" for all payment transaction codes should be submitted with the survey.
- Submit Exhibit B in the format shown using Excel or a CSV file using the tab or | (pipe symbol above the enter key).

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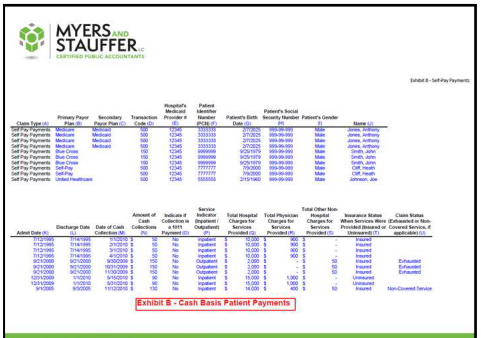

Exhibit B - Cash Basis Patient Payments

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

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

EXHIBIT C – HOSPITAL-PROVIDED MEDICAID DATA

- Types of data that may require an Exhibit C are as follows:
  - Self-reported Medicaid/Medicare cross-over data (Section H).
  - Self-reported "Other" Medicaid eligible data (Section H).
  - All self-reported Out-of-State Medicaid categories (Section I).

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EXHIBIT C – HOSPITAL-PROVIDED MEDICAID DATA

- Exhibit C
  - Include *Primary Payor Plan*, *Secondary Payor Plan*, *Hospital MCD #*, *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. *DOB*, *Social*, and *Gender* may also be requested.
    - A complete list (key) of payor plans is required to be submitted separately with the survey.
  - Submit Exhibit C in the format shown using Excel or a CSV file using the tab or | (pipe symbol above the enter key).

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EXHIBIT C – HOSPITAL-PROVIDED MEDICAID DATA

- Exhibit C
  - **In preparation for future year's DSH Examinations that will be impacted by the Consolidated Appropriations Act (CAA), two columns have been added to the Exhibit C example template.**
    - "Does claim have any coverage other than Medicaid FFS/Medicaid Managed Care? (Y/N)
    - "Comments"

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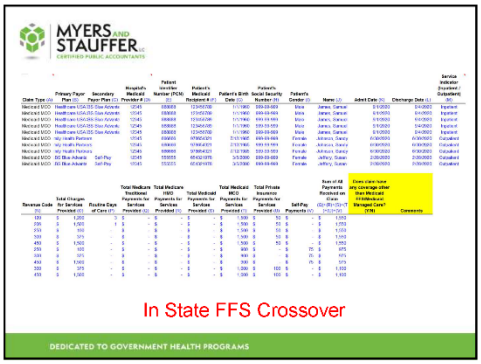
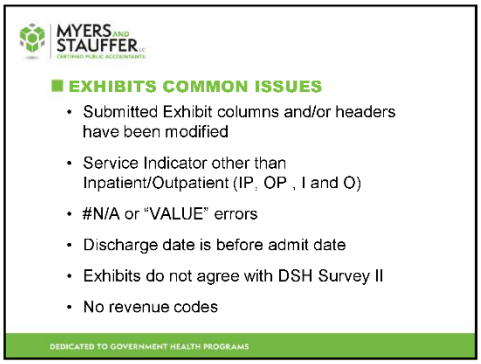
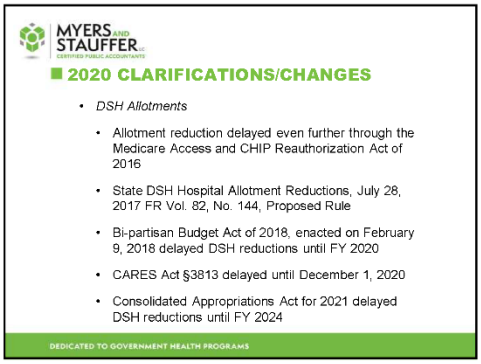
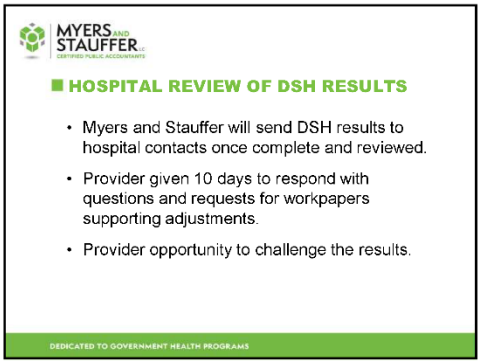
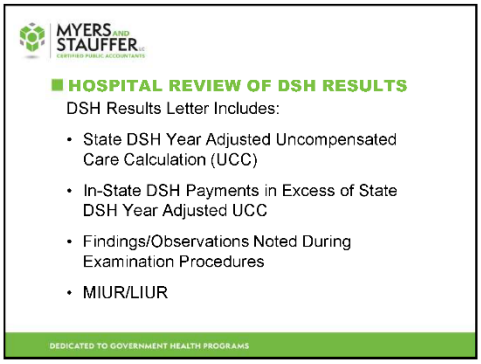
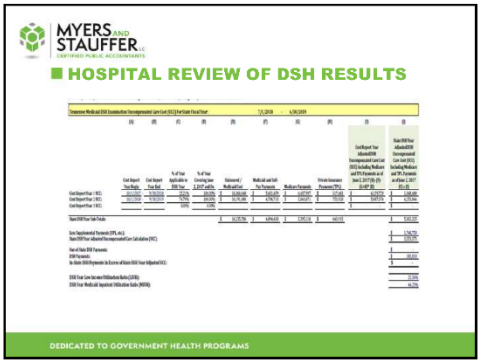

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS
In State FFS Crossover
DEDICATED TO GOVERNMENT HEALTH PROGRAMS


MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS
EXHIBITS COMMON ISSUES
Submitted Exhibit columns and/or headers have been modified
Service Indicator other than Inpatient/Outpatient (IP, OP , I and O)
#N/A or "VALUE" errors
Discharge date is before admit date
Exhibits do not agree with DSH Survey II
No revenue codes
DEDICATED TO GOVERNMENT HEALTH PROGRAMS


MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS
2020 CLARIFICATIONS/CHANGES
DSH Allotments
Allotment reduction delayed even further through the Medicare Access and CHIP Reauthorization Act of 2016
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
CARES Act §3813 delayed until December 1, 2020
Consolidated Appropriations Act for 2021 delayed DSH reductions until FY 2024
DEDICATED TO GOVERNMENT HEALTH PROGRAMS


MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS
HOSPITAL REVIEW OF DSH RESULTS
Myers and Stauffer will send DSH results to hospital contacts once complete and reviewed.
Provider given 10 days to respond with questions and requests for workpapers supporting adjustments.
Provider opportunity to challenge the results.
DEDICATED TO GOVERNMENT HEALTH PROGRAMS


MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS
HOSPITAL REVIEW OF DSH RESULTS
DSH Results Letter Includes:
State DSH Year Adjusted Uncompensated Care Calculation (UCC)
In-State DSH Payments in Excess of State DSH Year Adjusted UCC
Findings/Observations Noted During Examination Procedures
MIUR/LIUR
DEDICATED TO GOVERNMENT HEALTH PROGRAMS


MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS
HOSPITAL REVIEW OF DSH RESULTS
DEDICATED TO GOVERNMENT HEALTH PROGRAMS

PRIOR YEAR DSH EXAMINATION

Common Issues Noted During Examination

- Hospitals had duplicate patient claims in the uninsured, cross-over, and state's Medicaid MCO 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

PRIOR YEAR DSH EXAMINATION

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

PRIOR YEAR DSH EXAMINATION

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.
- Some hospitals did not include their charity care patients in the uninsured even though they had no third party coverage.
- 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.

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PRIOR YEAR DSH EXAMINATION

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.
- Exhibit B – Patient payments did not always include all patient payments – some hospitals incorrectly limited their data to uninsured patient payments.

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PRIOR YEAR DSH EXAMINATION

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.
- Liability insurance claims were incorrectly included in uninsured even when the insurance (e.g., auto policy) made a payment on the claim.

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FAQ

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

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

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

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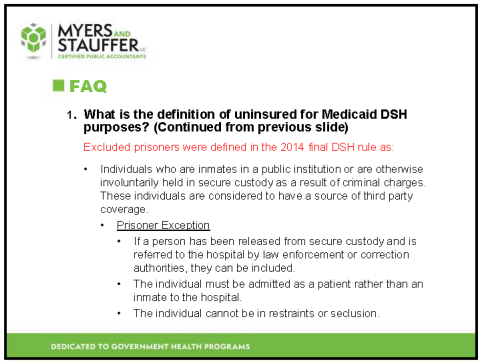
11


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.
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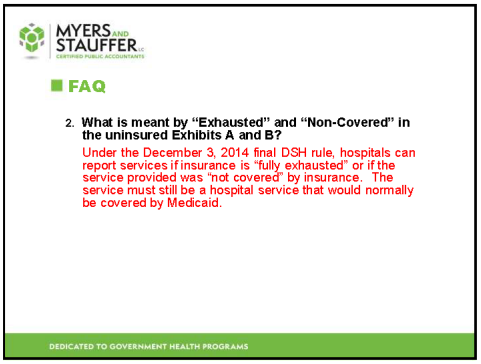
MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS
FAQ
2. What is meant by "Exhausted" and "Non-Covered" in the uninsured Exhibits A and B?
Under the December 3, 2014 final DSH rule, hospitals can report services if insurance is "fully exhausted" or if the service provided was "not covered" by insurance. The service must still be a hospital service that would normally be covered by Medicaid.
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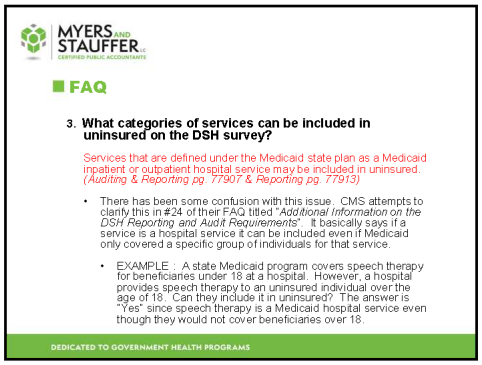
MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS
FAQ
3. What categories of services can be included in uninsured on the DSH survey?
Services that are defined under the Medicaid state plan as a Medicaid inpatient or outpatient hospital service may be included in uninsured. (Auditing & Reporting pg. 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 would not cover beneficiaries over 18.
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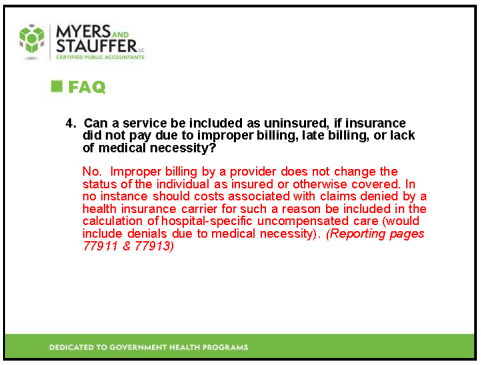
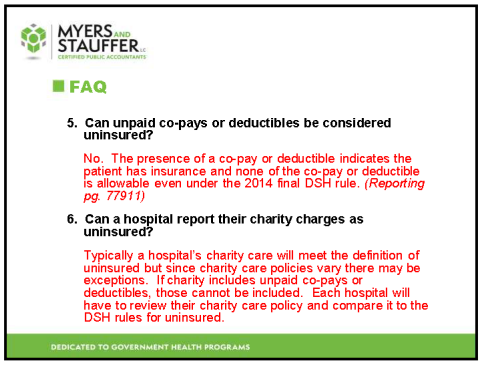

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS
FAQ
4. Can a service be included as uninsured, if insurance did not pay due to improper billing, late billing, or lack of medical necessity?
No. Improper billing by a provider does not change the status of the individual as insured or otherwise covered. In no instance should costs associated with claims denied by a health insurance carrier for such a reason be included in the calculation of hospital-specific uncompensated care (would include denials due to medical necessity). (Reporting pages 77911 & 77913)
DEDICATED TO GOVERNMENT HEALTH PROGRAMS


MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS
FAQ
5. Can unpaid co-pays or deductibles be considered uninsured?
No. The presence of a co-pay or deductible indicates the patient has insurance and none of the co-pay or deductible is allowable even under the 2014 final DSH rule. (Reporting pg. 77911)
6. Can a hospital report their charity charges as uninsured?
Typically a hospital's charity care will meet the definition of uninsured but since charity care policies vary there may be exceptions. If charity includes unpaid co-pays or deductibles, those cannot be included. Each hospital will have to review their charity care policy and compare it to the DSH rules for uninsured.
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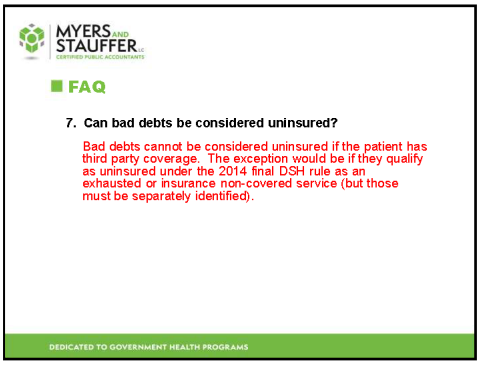
MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS
FAQ
7. Can bad debts be considered uninsured?
Bad debts cannot be considered uninsured if the patient has third party coverage. The exception would be if they qualify as uninsured under the 2014 final DSH rule as an exhausted or insurance non-covered service (but those must be separately identified).
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FAQ

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

- Many states remove individuals between the ages of 22 and 64 from Medicaid eligibility rolls; if so these costs should be reported as uncompensated care for the uninsured. If these individuals are reported on the Medicaid eligibility rolls, they should be reported as uncompensated care for the Medicaid population. *(Reporting pg. 77929 and CMS Feb. 2010 FAQ #28 – Additional Information on the DSH Reporting and Audit Requirements)*
- Per CMS FAQ, if the state removes a patient from the Medicaid rolls and they have Medicare or private insurance, 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 or private insurance is exhausted.

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FAQ

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

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

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FAQ

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

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

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

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

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FAQ

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

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

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

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

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FAQ

14. **Do dual eligible patients (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. *(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 77920 & 77926)*

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FAQ

16. **Do other Medicaid eligible claims (private insurance/Medicaid) have to be included in the Medicaid UCC?**

Yes. Since Section 1923(g)(1) does not contain an exclusion for dually eligible individuals, CMS believes the costs attributable to dual eligibles should be included in the calculation of the uncompensated costs of serving Medicaid eligible individuals. *(Reporting pages 77912)*

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CERTIFIED PUBLIC EXPENDITURES (CPE) RECONCILIATIONS

- TennCare's CMS approved CPE protocol requires a reconciliation of CPE's claimed by the state for public designated hospitals.
- DSH results are used to perform the reconciliations and typically no separate CPE request is necessary for any public hospital that also received a DSH payment.
- Any public hospital that did *not* receive a DSH payment should have received an Uncompensated Care Cost (UCC) Hospital Documentation Request.

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CERTIFIED PUBLIC EXPENDITURES (CPE) RECONCILIATIONS

- Non-DSH public hospitals should complete the UCC request and provide all requested information.
- The CPE UCC form is much more condensed than the DSH surveys, based on the state's CPE protocol.
- Reconciliation of CPE's are based on Medicaid shortfall and uninsured uncompensated care costs only.

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CERTIFIED PUBLIC EXPENDITURES (CPE) RECONCILIATIONS

- The CPE survey form only includes a request for uninsured charge and self pay payment data, a revenue code crosswalk and a signed certification form.
- Medicaid shortfall is calculated based on state provided Medicaid MCO MMIS data. Hospitals do not need to submit this data.
- DSH and other Medicaid supplemental payments are offset in the CPE reconciliations.

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CERTIFIED PUBLIC EXPENDITURES (CPE) RECONCILIATIONS

- Interim and final CPE reconciliation schedules are prepared for the State after all applicable hospitals DSH and/or CPE/UCC survey procedures are complete.

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OTHER DSH & CPE INFORMATION

Please use the DSH Part I Survey Submission Checklist and the DSH or CPE web portal events when preparing to submit your surveys and supporting documentation.

Note: Exhibits A-C (used for DSH) and UCC Hospital Documentation Requests (used for CPE) include protected health information and must be sent using the Myers and Stauffer secure web portal (no e-mail).

Reach out to the Myers & Stauffer contact for your state for additional state specific information or with any questions or concerns.

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MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

CONTACT INFORMATION

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800-505-1698
www.myersandstauffer.com

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DSH Payment Examination Training

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

DISPROPORTIONATE SHARE HOSPITAL (DSH) PAYMENT EXAMINATION UPDATE
DSH YEAR 2019
PLEASE STAY MUTED DURING THE PRESENTATION
TODAY'S PRESENTATION IS BEING RECORDED
DEDICATED TO GOVERNMENT HEALTH PROGRAMS

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OVERVIEW

- DSH Examination Policy
- DSH Year 2019 Examination Timeline
- DSH Year 2019 Examination Impact
- Paid Claims Data Review
- Review of DSH Year 2019 Survey and Exhibits
- 2019 Clarifications / Changes
- Recap of Prior Year Examinations (2018)
- Myers and Stauffer Q&A (via the chat option in Microsoft Teams)

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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*"

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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.

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RELEVANT DSH POLICY (CONT.)

- Audit/Reporting implemented in FR Vol. 79, No. 232, Wednesday, Dec. 03, 2014, Final Rule
- "Medicare Access and CHIP Reauthorization Act" - Public Law, April 16, 2015, Sec. 412 delayed DSH reductions until FY 2018
- 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
- CARES Act § 3813 delayed the DSH reductions until December 1, 2020
- Consolidated Appropriations Act for 2021 delayed DSH reductions until FY 2024

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WHO IS SUBJECT TO DSH EXAMINATION

- State of Washington has multiple DSH program payments
- In 2019, DSH payments were made for Low Income DSH (LIDSH), Small Rural DSH (SRDSH), Public Hospital DSH (PHDSH), Medical Care Services DSH (MCSDSH), and Children's Health Program DSH (CHPDSH)
- LIDSH, SRDSH, and PHDSH are lump sum payments
- MCSDSH and CHPDSH are claims based payments
- Hospitals that applied for DSH and received a DSH payment are subject to the DSH Examination

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DSH YEAR 2019 EXAMINATION TIMELINE

- Survey files and data request uploaded to web portal on March 15th
- MMIS Data will be uploaded to web portal
- Survey's returned by April 29, 2022
- Draft report to the state by September 30, 2022
- Final report to CMS by December 31, 2022

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DSH YEAR 2019 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 2019 examination report is a recoupment year.

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PAID CLAIMS DATA UPDATE FOR 2019

- Medicaid fee-for-service paid claims data
  - Will be uploaded to web portal.
  - Same format as last year.
  - Reported based on cost report year (using discharge date).
  - At revenue code level.
  - Will exclude non-Title 19 services (such as CHIP).

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PAID CLAIMS DATA UPDATE FOR 2019

- Medicare/Medicaid cross-over paid claims data
  - Will be uploaded to web portal.
  - Same format as last year.
  - Reported based on cost report year (using discharge date).
  - At revenue code level.
  - Will exclude non-Title 19 services (such as CHIP).

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PAID CLAIMS DATA UPDATE FOR 2019

- Medicare/Medicaid cross-over paid claims data (cont.)
- Hospital is responsible for ensuring all Medicare payments are included in the final survey even if the payments are not reflected in the paid claim totals. Non-claims based Medicare payments can include:

Medicare Cost Report settlement	Bad Debt reimbursement
Direct GME payments	IME payments
Medicare DSH adjustments	Inpatient capital payments
Organ Acquisition payments	Intern and resident payments
Pass-through cost payments	Transitional corridor payments

- Note: The expectation is that Critical Access Hospitals are reimbursed at cost after sequestration.

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PAID CLAIMS DATA UPDATE FOR 2019

- Medicaid managed care paid claims data is not available
  - This data was <u>not</u> provided last year.
  - 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).

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PAID CLAIMS DATA UPDATE FOR 2019

- 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.

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PAID CLAIMS DATA UPDATE FOR 2019

- "Other" Medicaid Eligibles
  - **Definition:** Medicaid-eligible patient services where Medicaid did not receive the claim or have any cost-sharing and, as a result, 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).

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PAID CLAIMS DATA UPDATE FOR 2019

- "Other" Medicaid Eligibles (cont.)
  - 2008 DSH Rule 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 or a signed statement verifying there are none to report, we may have to list the hospital as non-compliant in the 2019 DSH examination report.
  - Ensure that you ***separately report*** Medicaid, Medicaid MCO, Medicare, Medicare HMO, private insurance, and self-pay payments in Exhibit C.

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PAID CLAIMS DATA UPDATE FOR 2019

Additional Clarification on Crossover and Other Medicaid Eligible Claims:

In-State Medicare FFS Cross-Over Column	In-State Other Medicaid Eligible Column
Medicare FFS primary with Medicaid FFS secondary	Private Insurance primary with Medicaid FFS secondary
Medicare FFS primary with Medicaid HMO secondary	Private Insurance primary with Medicaid HMO secondary
Medicare HMO primary with Medicaid FFS secondary	Medicaid FFS no-pays (as long as service provided is Medicaid covered hospital service)
Medicare HMO primary with Medicaid HMO secondary	

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PAID CLAIMS DATA UPDATE FOR 2019

- Uninsured Services
  - Uninsured charges/days will be reported on Exhibit A and patient payments will be reported on Exhibit B.
  - Exhibit A charges 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).

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FILES EACH HOSPITAL RECEIVED

- DSH data request documents:
  - Notice of the 2019 DSH Procedures
  - DSH Survey Part I – DSH year data
  - DSH Survey Part II – cost report year data
  - Exhibit A-C Hospital Provided Claims Data Template
  - DSH Survey - Revenue Code Crosswalk Template

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FILES EACH HOSPITAL WILL RECEIVE

- Data received from the State to be provided to the hospitals:
  - Traditional FFS MMIS data (includes state-only program data)
  - Crossover data
  - Supplemental/Enhanced payments

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DSH EXAMINATION SURVEYS

General Instruction – Survey Files

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

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DSH EXAMINATION SURVEYS

General Instruction – Survey Files

- Do not 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 12/31/18 with the DSH examination of SFY 2018 in the prior year. In the DSH year 2019 exam, Hospital A would only need to submit a survey for their year ending 12/31/19.
- 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.

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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.

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DSH SURVEY PART I – DSH YEAR DATA

Section A

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

Section B

- Answer all DSH Qualifying questions using drop-down boxes.

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DSH SURVEY PART I – DSH YEAR DATA

Section C

- Item 1: Report any Medicaid supplemental payments, including UPL and Non-Claim Specific payments, for the state fiscal year. Do NOT include DSH payments.
- Item 2: Report any Medicaid Managed Care supplemental payments, including all Non-Claim Specific payments for hospital services such as lump sum payments for full Medicaid pricing (FMP), supplementals, quality payments, bonus payments, capitation payments received by the hospital (not by the MCO), or other incentive payments.
  - Hospital portion of supplemental payments reported on DSH Survey Part II, Section E, Question 14 should be reported here if paid on SFY basis.

Certification

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

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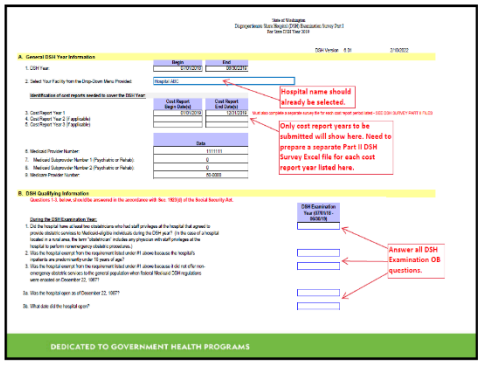
Hospital name should already be selected.
Only cost report years to be submitted will show here. Need to prepare a separate Part II DSH Survey Excel file for each cost report year listed here.
Answer all DSH Examination OB questions.
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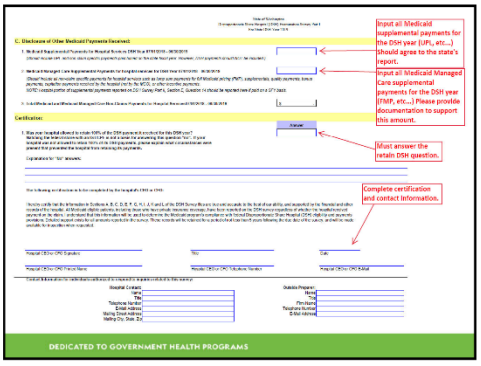
Input all Medicaid supplemental payments for the DSH year (UPL, etc...) Should agree to the state's report.
Input all Medicaid Managed Care supplemental payments for the DSH year (FMP, etc...) Please provide documentation to support this amount.
Must answer the retain DSH question.
Complete certification and contact information.
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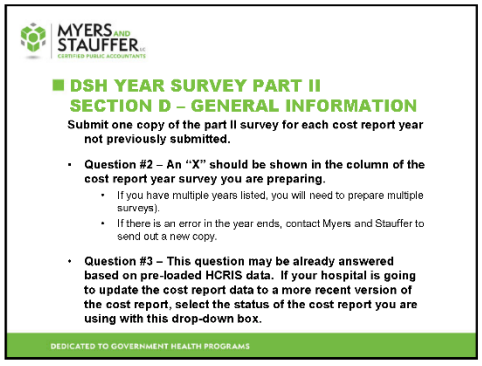
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CERTIFIED PUBLIC ACCOUNTANTS
DSH YEAR SURVEY PART II
SECTION D – GENERAL INFORMATION
Submit one copy of the part II survey for each cost report year not previously submitted.
Question #2 – An "X" should be shown in the column of the cost report year 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.
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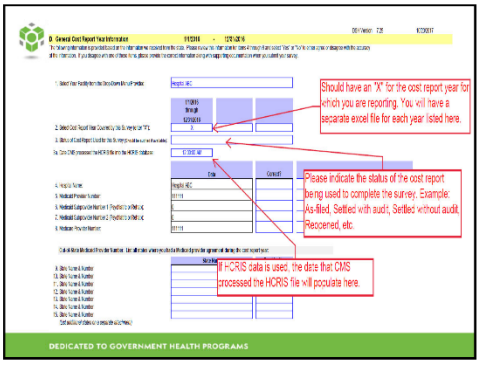
Should have an "X" for the cost report year for which you are reporting. You will have a separate excel file for each year listed here.
Please indicate the status of the cost report being used to complete the survey. Example: As-filed, Settled with audit, Settled without audit, Reopened, etc.
If HCRIS data is used, the date that CMS processed the HCRIS file will populate here.
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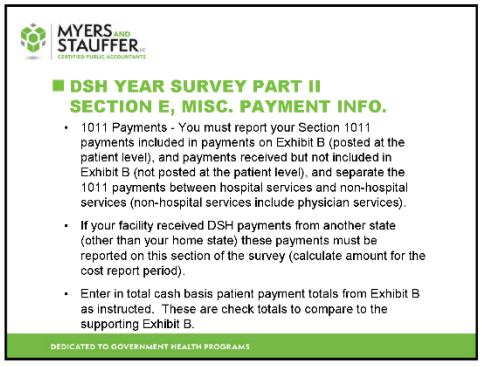
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DSH YEAR SURVEY PART II
SECTION E, MISC. PAYMENT INFO.
1011 Payments - You must report your Section 1011 payments included in payments on Exhibit B (posted at the patient level), and payments received but not included in Exhibit B (not posted at the patient level), and separate the 1011 payments between hospital services and non-hospital services (non-hospital services include physician services).
If your facility received DSH payments from another state (other than your home state) these payments must be reported on this section of the survey (calculate amount for the cost report period).
Enter in total cash basis patient payment totals from Exhibit B as instructed. These are check totals to compare to the supporting Exhibit B.
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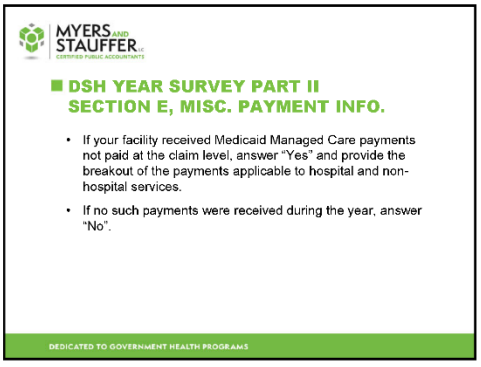
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DSH YEAR SURVEY PART II
SECTION E, MISC. PAYMENT INFO.
If your facility received Medicaid Managed Care payments not paid at the claim level, answer "Yes" and provide the breakout of the payments applicable to hospital and non-hospital services.
If no such payments were received during the year, answer "No".
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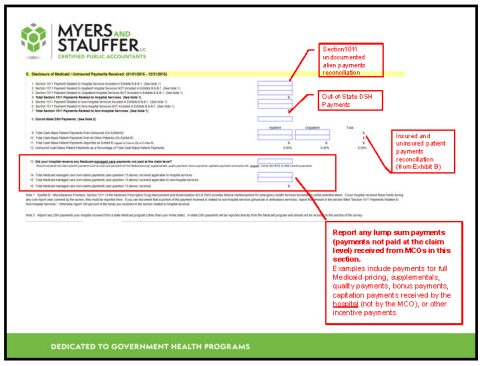
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Section1011 un-documented alien payments reconciliation
Out-of-State DSH Payments
Insured and uninsured patient payments reconciliation (from Exhibit B)
Report any lump sum payments (payments not paid at the claim level) received from MCOs in this section.
Examples include payments for full Medicaid pricing, supplementals, quality payments, bonus payments, capitation payments received by the hospital (not by the MCO), or other incentive payments.
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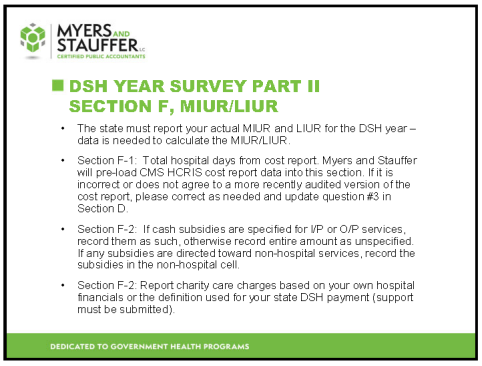
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DSH YEAR SURVEY PART II
SECTION F, MIUR/LIUR
The state must report your actual MIUR and LIUR for the DSH year – data is needed to calculate the MIUR/LIUR.
Section F-1: Total hospital days from cost report. Myers and Stauffer will pre-load CMS HCRIS cost report data into this section. If it is incorrect or does not 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).
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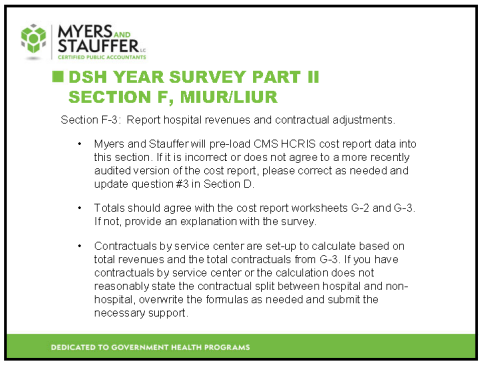
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DSH YEAR SURVEY PART II
SECTION F, MIUR/LIUR
Section F-3: Report hospital revenues and contractual adjustments.
Myers and Stauffer will pre-load CMS HCRIS cost report data into this section. If it is incorrect or does not agree to a more recently audited version of the cost report, please correct as needed and update question #3 in Section D.
Totals should agree with the cost report worksheets G-2 and G-3. If not, provide an explanation with the survey.
Contractuals by service center are set-up to calculate based on total revenues and the total contractuals from G-3. If you have contractuals by service center or the calculation does not reasonably state the contractual split between hospital and non-hospital, overwrite the formulas as needed and submit the necessary support.
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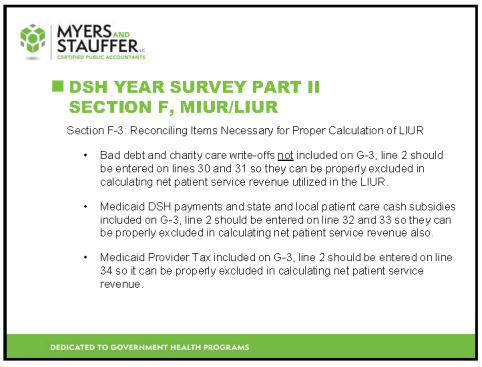
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DSH YEAR SURVEY PART II
SECTION F, MIUR/LIUR
Section F-3: Reconciling Items Necessary for Proper Calculation of LIUR
Bad debt and charity care write-offs not included on G-3, line 2 should be entered on lines 30 and 31 so they can be properly excluded 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.
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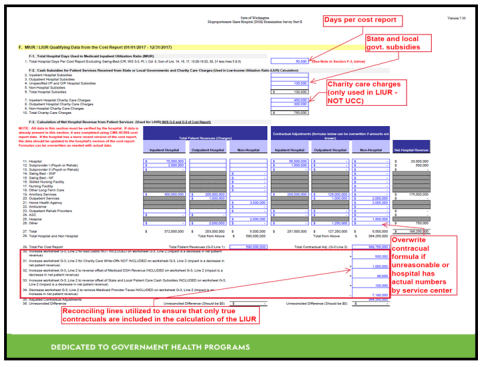
Days per cost report
State and local govt. subsidies
Charity care charges (only used in LIUR - NOT UCC)
Overwrite contracual formula if unreasonable or hospital has actual numbers by service center
Reconciling lines utilized to ensure that only true contractuals are included in the calculation of the LIUR
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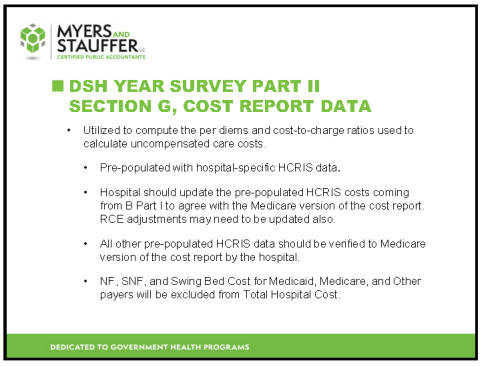
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DSH YEAR SURVEY PART II
SECTION G, COST REPORT DATA
Utilized to compute the per diems and cost-to-charge ratios used to calculate uncompensated care costs.
Pre-populated with hospital-specific HCRIS data.
Hospital should update the pre-populated HCRIS costs coming from B Part I to agree with the Medicare version of the cost report. RCE adjustments may need to be updated also.
All other pre-populated HCRIS data should be verified to Medicare version of the cost report by the hospital.
NF, SNF, and Swing Bed Cost for Medicaid, Medicare, and Other payers will be excluded from Total Hospital Cost.
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DSH YEAR SURVEY PART II SECTION G, COST REPORT DATA

- Calculation of Routine Cost Per Diems
  - Days
  - Cost
- Calculation of Ancillary Cost-to-Charge Ratios
  - Charges
  - Cost
- NF, SNF, and Swing Bed Cost for Medicaid, Medicare, and Other Payors

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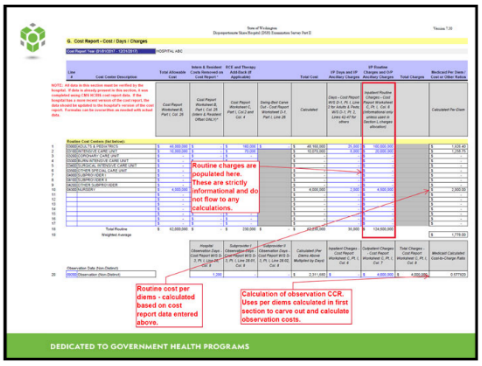

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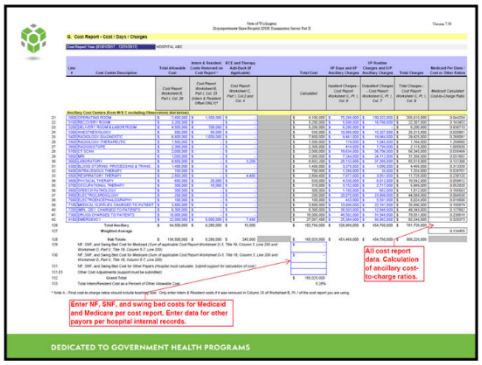

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DSH SURVEY PART II SECTION H, IN-STATE MEDICAID

- Enter inpatient (routine) days, I/P and O/P charges, and payments. The form will calculate cost and shortfall / long-fall for:
  - In-State FFS Medicaid Primary *(Traditional Medicaid) from state's paid claims summaries.*
  - In-State Medicaid Managed Care Primary *(Medicaid MCO) from submitted Exhibit C.*
  - In-State Medicare FFS Cross-Overs *(Traditional Medicare with Medicaid Secondary) from state's paid claims summaries.*
  - In-State Other Medicaid Eligible claims *(May include Medicare MCO cross-overs and other Medicaid not included elsewhere) from submitted Exhibit C.*

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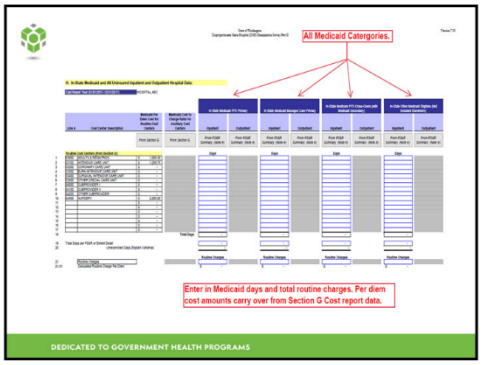

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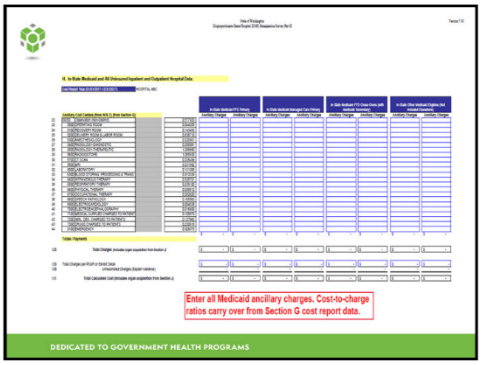

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DSH SURVEY PART II
SECTION H, IN-STATE MEDICAID

- 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).
  - Other third party payments (TPL).
  - Medicaid Managed Care Quality Incentive Payments, or other lump sum payments received from Medicaid Managed Care organizations, if applicable.

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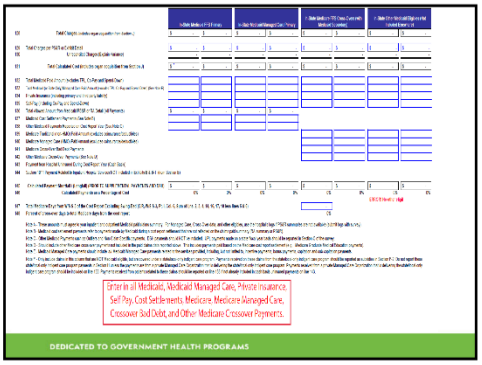

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DSH SURVEY PART II
SECTION H, UNINSURED

- Report uninsured services, patient days (by routine cost center) and ancillary charges by cost center.
- Survey form Exhibit A shows the data elements that need to be collected and provided to Myers and Stauffer.
- For uninsured payments, enter the uninsured hospital patient payment totals from your Survey form Exhibit B. Do NOT pick up the non-hospital or insured patient payments in Section H even though they are reported in Exhibit B.
- State Program data (*MCS – provided by the State summarized by revenue code. Incorporate this data in the State/Local-Only Indigent Care Program section.*)

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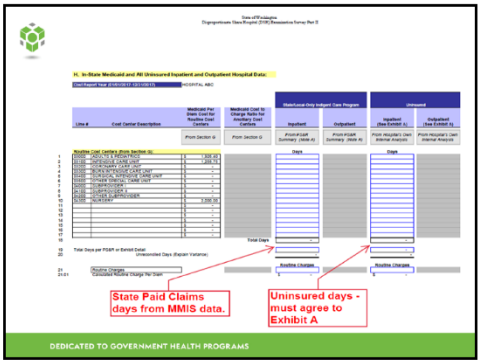

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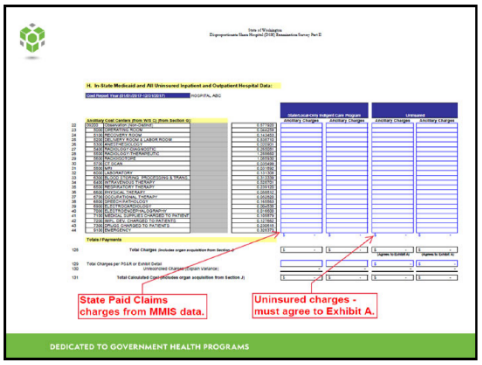

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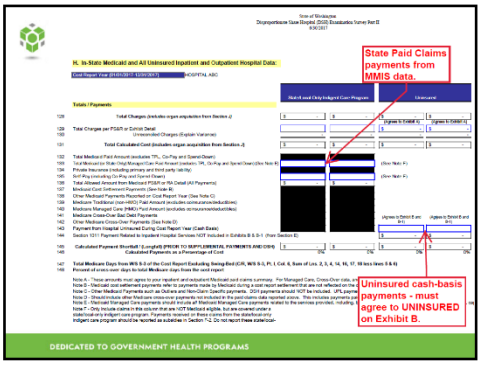

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DSH SURVEY PART II SECTION H, UNINSURED

- 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.

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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.

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

- Additional Edits
  - In the far right column, you will see an edit message if your total charges or days by cost center exceed those reported from the cost report in Section G of the survey. Please clear these edits prior to filing the survey.
    - 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.

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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.

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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 for reasonableness and correct any issues prior to filing the survey.

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DSH SURVEY PART II SECTION I, OUT OF STATE MEDICAID

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

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

- Total organ acquisition cost and total useable organs may be pre-loaded from HCRIS data. If it is incorrect or does not 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 for transplants occurring at the hospital.
- Summary claims data (PS&R) or similar documents and provider records (organ counts) must be provided to support the charges and useable organ counts reported on the survey. The data for uninsured organ acquisitions should be reported separately from the Exhibit A.

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

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

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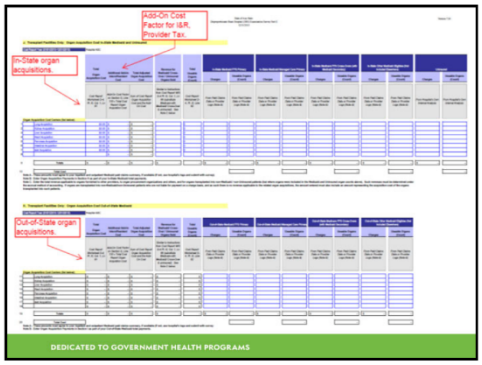

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DSH SURVEY PART II SECTION L, PROVIDER TAXES

TAX

- 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.
- The Medicaid and uninsured share of the provider tax assessment is an allowable cost for Medicaid DSH even if Medicare offsets some of the tax.

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DSH SURVEY PART II SECTION L, PROVIDER TAXES

TAX

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

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DSH SURVEY PART II SECTION L, PROVIDER TAXES

TAX

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

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DSH SURVEY PART II SECTION L, PROVIDER TAXES

TAX

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

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DSH SURVEY PART II SECTION L, PROVIDER TAXES

TAX

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

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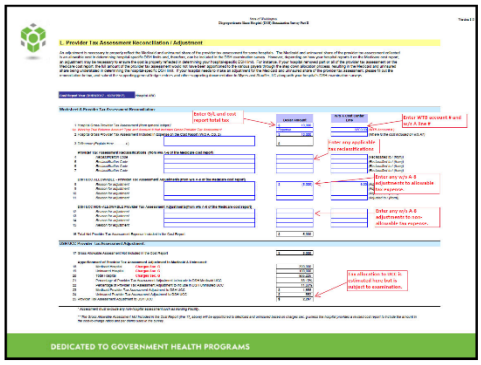

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EXHIBIT A - UNINSURED CHARGES/DAYS BY REVENUE CODE

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

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EXHIBIT A - UNINSURED

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

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EXHIBIT A - UNINSURED

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

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Exhibit A - Uninsured Charges

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

Admit Date (J)	Discharge Date (K)	Service Indicator (Inpatient / Outpatient) (L)	Revenue Code (M)	Total Charges for Services Provided (N)	Routine Days of Care (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)
3/1/2010	3/11/2010	Inpatient	110	$ 4,000.00	7			
3/1/2010	3/11/2010	Inpatient	200	$ 4,500.00	3			
3/1/2010	3/11/2010	Inpatient	250	$ 5,200.25				
3/1/2010	3/11/2010	Inpatient	300	$ 2,700.00				
3/1/2010	3/11/2010	Inpatient	360	$ 15,000.75				
3/1/2010	3/11/2010	Inpatient	450	$ 1,000.25				
6/15/2010	6/15/2010	Outpatient	250	$ 150.00		$ 500.00		Exhausted
6/15/2010	6/15/2010	Outpatient	450	$ 750.00		$ 500.00		Exhausted
8/10/2010	8/10/2010	Outpatient	450	$ 1,100.00			$ 100.00	Non-Covered Service

Exhibit A - Uninsured charges/days

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

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

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

- Patient payments received for uninsured services need to be reported on a cash basis.
  - For example, a cash payment received during the 2019 cost report year that relates to a service provided in the 2013 cost report year, must be used to reduce uninsured cost for the 2019 cost report year.

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

- Exhibit B
  - Include *Primary Payor Plan, Secondary Payor Plan, Payment Transaction Code, Provider #, PCN, 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 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.

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Exhibit B - Self-Pay Payments

Claim Type (A)	Primary Payor Plan (B)	Secondary Payor Plan (C)	Transaction Code (D)	Hospital's Medicaid Provider # (E)	Patient Identifier Number (PCN) (F)	Patient's Birth Date (G)	Patient's Social Security Number (H)	Patient's Gender (I)	Name (J)
Self Pay Payments	Medicare	Medicaid	500	12345	3333333	2/7/2025	999-99-999	Male	Jones, Anthony
Self Pay Payments	Medicare	Medicaid	500	12345	3333333	2/7/2025	999-99-999	Male	Jones, Anthony
Self Pay Payments	Medicare	Medicaid	500	12345	3333333	2/7/2025	999-99-999	Male	Jones, Anthony
Self Pay Payments	Medicare	Medicaid	500	12345	3333333	2/7/2025	999-99-999	Male	Jones, Anthony
Self Pay Payments	Blue Cross		150	12345	9999999	9/25/1979	999-99-999	Male	Smith, John
Self Pay Payments	Blue Cross		150	12345	9999999	9/25/1979	999-99-999	Male	Smith, John
Self Pay Payments	Blue Cross		150	12345	9999999	9/25/1979	999-99-999	Male	Smith, John
Self Pay Payments	Self-Pay		500	12345	7777777	7/9/2000	999-99-999	Male	Cliff, Heath
Self Pay Payments	Self-Pay		500	12345	7777777	7/9/2000	999-99-999	Male	Cliff, Heath
Self Pay Payments	United Healthcare		500	12345	5555555	2/15/1960	999-99-999	Male	Johnson, Joe

Admit Date (K)	Discharge Date (L)	Date of Cash Collection (M)	Amount of Cash Collections (N)	Indicate if Collection is a 1011 Payment (O)	Service Indicator (Inpatient / Outpatient) (P)	Total Hospital Charges for Services Provided (Q)	Total Physician Charges for Services Provided (R)	Total Other Non-Hospital Charges for Services Provided (S)	Insurance Status When Services Were Provided (Insured or Uninsured) (T)	Claim Status (Exhausted or Non-Covered Service, if applicable) (U)
7/12/1995	7/14/1995	1/1/2010	$ 50	No	Inpatient	$ 10,000	$ 900	$ -	Insured	
7/12/1995	7/14/1995	2/1/2010	$ 50	No	Inpatient	$ 10,000	$ 900	$ -	Insured	
7/12/1995	7/14/1995	3/1/2010	$ 50	No	Inpatient	$ 10,000	$ 900	$ -	Insured	
7/12/1995	7/14/1995	4/1/2010	$ 50	No	Inpatient	$ 10,000	$ 900	$ -	Insured	
9/21/2000	9/21/2000	9/30/2009	$ 150	No	Outpatient	$ 2,000	$ -	$ 50	Insured	Exhausted
9/21/2000	9/21/2000	10/31/2009	$ 150	No	Outpatient	$ 2,000	$ -	$ 50	Insured	Exhausted
9/21/2000	9/21/2000	11/30/2009	$ 150	No	Outpatient	$ 2,000	$ -	$ 50	Insured	Exhausted
12/31/2009	1/1/2010	5/15/2010	$ 90	No	Inpatient	$ 15,000	$ 1,000	$ -	Uninsured	
12/31/2009	1/1/2010	5/31/2010	$ 90	No	Inpatient	$ 15,000	$ 1,000	$ -	Uninsured	
9/1/2005	9/3/2005	11/12/2010	$ 130	No	Inpatient	$ 14,000	$ 400	$ 50	Insured	Non-Covered Service

Exhibit B - Cash Basis Patient Payments

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EXHIBIT C - HOSPITAL-PROVIDED MEDICAID DATA

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

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EXHIBIT C - HOSPITAL-PROVIDED MEDICAID DATA

- Types of data that may require an Exhibit C are as follows:
  - Self-reported Medicaid MCO data (Section H).
  - Self-reported "Other" Medicaid eligibles (Section H).
  - All self-reported Out-of-State Medicaid categories (Section I).
  - Additional or adjusted Medicaid FFS/Crossover claims noted during reconciliation of state and internal hospital data (Section H).

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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. *DOB*, *Social*, and *Gender* may also be requested.
    - A complete list (key) of payor plans is required to be submitted separately with the survey.
  - Submit Exhibit C in the format shown using Excel or a CSV file using the tab or | (pipe symbol above the enter key).

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EXHIBIT C - 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 rather than combined into one Exhibit document 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.

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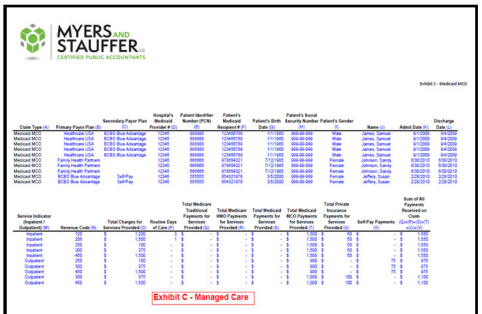

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DSH SURVEY PART I – DSH YEAR DATA

Checklist

- Separate tab in Part I of the survey.
- Should be completed after Part I and Part II surveys are prepared.
- Includes list of all supporting documentation that needs to be submitted with the survey for examination.
- Includes our email addresses and phone numbers.
- Include Item # in file name (e.g. 5(b)_Exh A Logic)

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DSH SURVEY PART I – DSH YEAR DATA

Submission Checklist

1. Electronic copy of the DSH Survey Part I – DSH Year Data.
2. Signed copy of the DSH Survey Part I – Cost Report Year Data.
3. Electronic copy of the DSH Survey Part II – Cost Report Year Data.
4. N/A

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DSH SURVEY PART I – DSH YEAR DATA

Submission Checklist (cont.)

5. (a). Electronic Copy of Exhibit A – Uninsured Days and Charges.
   - *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 transaction codes utilized to post payments during the cost reporting period and a description of which codes were included or excluded if applicable.

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DSH SURVEY PART I – DSH YEAR DATA

Submission Checklist (cont.)

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.

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DSH SURVEY PART I – DSH YEAR DATA

Submission Checklist (cont.)

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.

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DSH SURVEY PART I – DSH YEAR DATA

Submission Checklist (cont.)

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.

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DSH SURVEY PART I – DSH YEAR DATA

Submission Checklist (cont.)

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.

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DSH SURVEY PART I – DSH YEAR DATA

Submission Checklist (cont.)

15. (a). A detailed working trial balance used to prepare each cost report (including revenues).

15. (b). 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).

15. (c). Worksheet A Mapping, showing how WTB accounts map to worksheet A lines on the cost report.

16. Electronic copy of all cost reports used to prepare each DSH Survey Part II)

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DSH SURVEY PART I – DSH YEAR DATA

Submission Checklist (cont.)

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.

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

UPDATES

- Consolidated Appropriations Act (CAA) of 2021
  - Effective October 1, 2021
  - Allotment reductions delayed until SFY 2024-2027 ($8B reduction per year)
  - The CAA calls for the exclusion of dual eligible cost and payments from the uncompensated care cost calculation (UCC), unless the hospital qualifies for the 97th percentile SSI exception.
  - Hospital should continue to report all dual-eligible information as in previous years.
  - At this time, additional guidance is needed from CMS as to how the CAA should be applied.

Note: Due to CAA, hospitals should review query logic to ensure claims are reported in the proper payor buckets and primary/secondary payors are clearly and accurately labeled.

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UPDATES

- Provider Relief Funds
  - Under the CARES act enacted March 27, 2020, a portion of the provider relief funds were used to reimburse health care providers who provided COVID-19 treatment for uninsured individuals with a COVID-19 primary diagnosis on or after February 4, 2020.
  - Providers could request claims reimbursement and were generally reimbursed at Medicare rates.
  - Impact to DSH and UCC survey
    - Hospitals must include all claims-based provider relief fund payments for uninsured patients
    - Must include all payments applicable to their cost report period (accrual basis)
    - Included in Exhibit B

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

PRIOR YEAR DSH EXAMINATION (2018)

Significant Data Issues during 2018 Examination

- Incomplete DSH Survey Part I and Part II files.
- Charges, Days and/or payment amounts reported on DSH Survey Pt. II Sec. H did not tie to detail claims data submitted in Exhibits A, B, or C.
- No Uninsured payment data submitted (Exhibit B).
- No support or crosswalk did not accurately support the mapping of days and charges to cost centers in the DSH Survey Part II file, Section H & I.
- Provided templates (e.g., Exhibit A-C, crosswalk) not utilized for data submissions
  - Please do not use the old version of the Exhibit A-C templates.

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PRIOR YEAR DSH EXAMINATION (2018)

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.

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PRIOR YEAR DSH EXAMINATION (2018)

Common Issues Noted During Examination

- Charges and days reported on survey exceeded total charges and days reported on the cost report (by cost center).
- 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.

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PRIOR YEAR DSH EXAMINATION (2018)

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.
- Some hospitals did not include their charity care patients in the uninsured even though they had no third party coverage.
- 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.

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PRIOR YEAR DSH EXAMINATION (2018)

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.
- Exhibit B – Patient payments did not always include all patient payments – some hospitals incorrectly limited their data to uninsured patient payments.
- 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.

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PRIOR YEAR DSH EXAMINATION (2018)

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.
- Liability insurance claims were incorrectly included in uninsured even when the insurance (e.g., auto policy) made a payment on the claim.

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WEB PORTAL

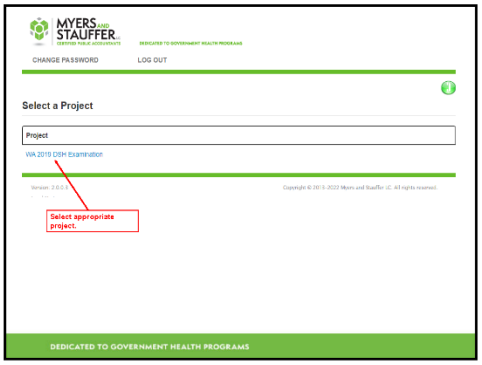
- First Time Log-In
  - Click Forgot Password
  - Enter the email address and click Send Forgot Password Email.
  - Expect an email with a link to set the password.
  - Log-in to the website using email address and new password.
  - Review and confirm providers visible on your account.

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

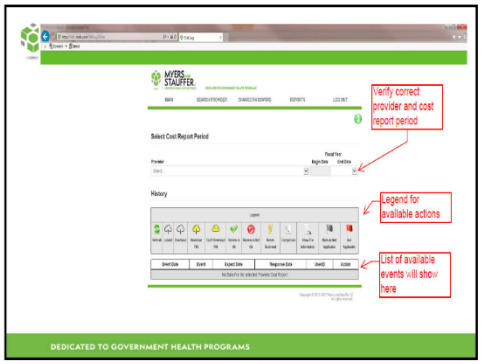
WEB PORTAL

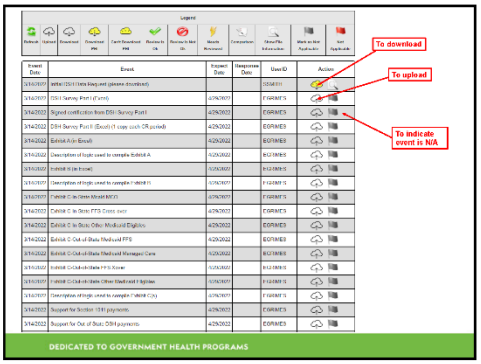
- Ability to upload DSH submission
  - MSLC will review
    - Accept or reject
    - Once document is approved provider is no longer able to upload to that event.
      - Will need to notify MSLC of need to revise as-filed documents.
- Ability to include notes up to 1,000 characters

DEDICATED TO GOVERNMENT HEALTH PROGRAMS



DEDICATED TO GOVERNMENT HEALTH PROGRAMS





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WEB PORTAL

Website: https://dsh.mslc.com

- Contact wadsh@mslc.com to request registration form or update contact information.
- Must provide valid IP address to be set up to send/receive data.
- Work From Home – Temporary public IP address

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

MYERS AND STAUFFER LC
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DEDICATED TO GOVERNMENT HEALTH PROGRAMS

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.

Questions concerning the Web Portal, DSH Surveys, and Exh. A-C can be directed to:
Aaron Marak: AMarak@mslc.com
Erik Grimes: EGrimes@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

FAQ

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

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

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

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17

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FAQ

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

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

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

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FAQ

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

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

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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 would not cover beneficiaries over 18.

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FAQ

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

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

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FAQ

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

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

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

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

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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).

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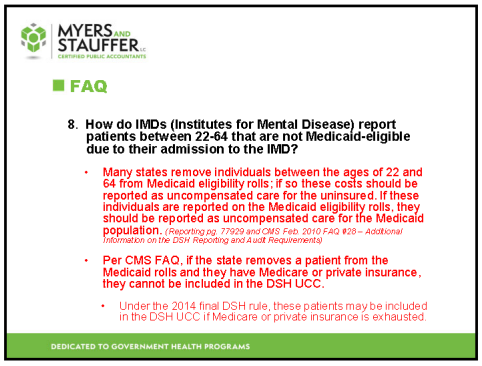
MYERS AND STAUFFER LC
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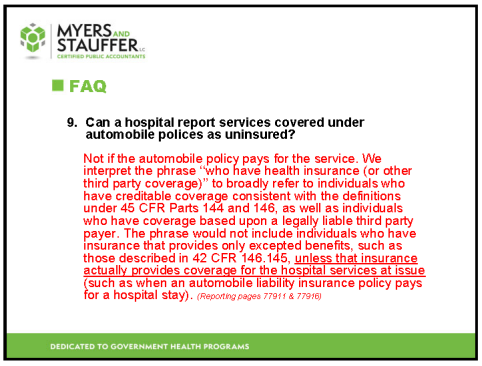
FAQ
8. How do IMDs (Institutes for Mental Disease) report patients between 22-64 that are not Medicaid-eligible due to their admission to the IMD?
• Many states remove individuals between the ages of 22 and 64 from Medicaid eligibility rolls; if so these costs should be reported as uncompensated care for the uninsured. If these individuals are reported on the Medicaid eligibility rolls, they should be reported as uncompensated care for the Medicaid population. (Reporting pg. 77929 and CMS Feb. 2010 FAQ #28 – Additional Information on the DSH Reporting and Audit Requirements)
• Per CMS FAQ, if the state removes a patient from the Medicaid rolls and they have Medicare or private insurance, 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 or private insurance is exhausted.
DEDICATED TO GOVERNMENT HEALTH PROGRAMS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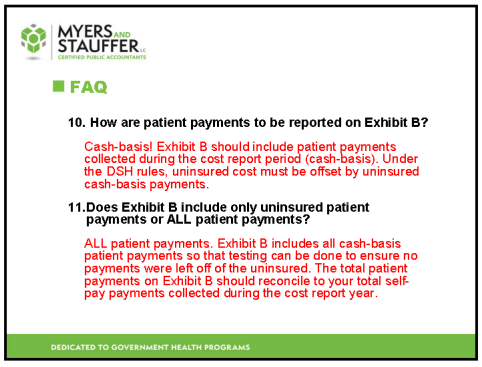
FAQ
9. Can a hospital report services covered under automobile polices as uninsured?
Not if the automobile policy pays for the service. We interpret the phrase "who have health insurance (or other third party coverage)" to broadly refer to individuals who have creditable coverage consistent with the definitions under 45 CFR Parts 144 and 146, as well as individuals who have coverage based upon a legally liable third party payer. The phrase would not include individuals who have insurance that provides only excepted benefits, such as those described in 42 CFR 146.145, unless that insurance actually provides coverage for the hospital services at issue (such as when an automobile liability insurance policy pays for a hospital stay). (Reporting pages 77911 & 77916)
DEDICATED TO GOVERNMENT HEALTH PROGRAMS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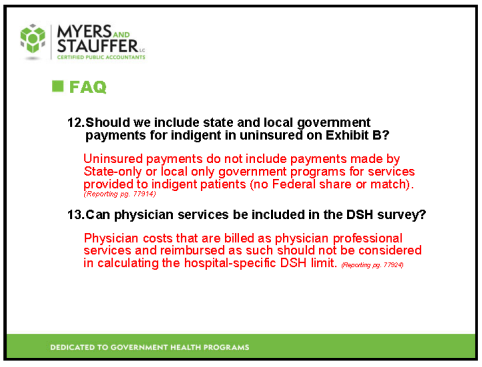
FAQ
10. How are patient payments to be reported on Exhibit B?
Cash-basis! Exhibit B should include patient payments collected during the cost report period (cash-basis). Under the DSH rules, uninsured cost must be offset by uninsured cash-basis payments.
11. Does Exhibit B include only uninsured patient payments or ALL patient payments?
ALL patient payments. Exhibit B includes all cash-basis patient payments so that testing can be done to ensure no payments were left off of the uninsured. The total patient payments on Exhibit B should reconcile to your total self-pay payments collected during the cost report year.
DEDICATED TO GOVERNMENT HEALTH PROGRAMS


MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS
FAQ
12. Should we include state and local government payments for indigent in uninsured on Exhibit B?
Uninsured payments do not include payments made by State-only or local only government programs for services provided to indigent patients (no Federal share or match). (Reporting pg. 77914)
13. Can physician services be included in the DSH survey?
Physician costs that are billed as physician professional services and reimbursed as such should not be considered in calculating the hospital-specific DSH limit. (Reporting pg. 77924)
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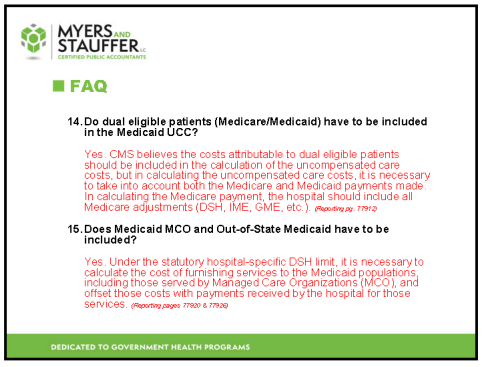
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FAQ
14. Do dual eligible patients (Medicare/Medicaid) have to be included in the Medicaid UCC?
Yes. CMS believes the costs attributable to dual eligible patients should be included in the calculation of the uncompensated care costs, but in calculating 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 77920 & 77929)
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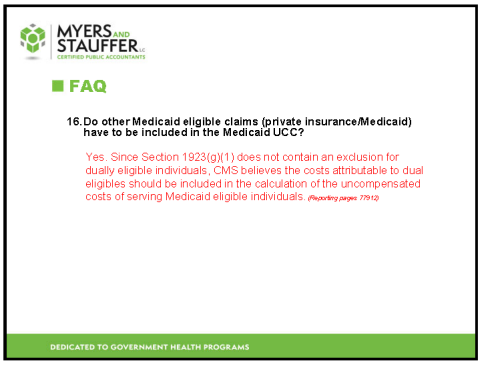
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FAQ
16. Do other Medicaid eligible claims (private insurance/Medicaid) have to be included in the Medicaid UCC?
Yes. Since Section 1923(g)(1) does not contain an exclusion for dually eligible individuals, CMS believes the costs attributable to dual eligibles should be included in the calculation of the uncompensated costs of serving Medicaid eligible individuals. (Reporting pages 77912)
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CERTIFIED PUBLIC ACCOUNTANTS

OTHER INFORMATION

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

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

Reach out to the Myers & Stauffer contact for your state for additional state specific information or with any questions or concerns.

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

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Appendix F: Certificates of Insurance

Client#: 52154 MYERSTA

ACORD™ **CERTIFICATE OF LIABILITY INSURANCE**

DATE (MM/DD/YYYY): 4/26/2022

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: Laura Weeks
CBIZ Insurance Services, Inc. 700 West 47th Street, Suite 1100 Kansas City, MO 64112 816 945-5500	PHONE (A/C, No, Ext): 816-945-5589 FAX (A/C, No): E-MAIL ADDRESS: lweeks@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 CLAIMS-MADE X OCCUR GEN'L AGGREGATE LIMIT APPLIES PER: X POLICY PRO-JECT LOC OTHER:			30SBAUH8895SA	05/01/2022	05/01/2023	EACH OCCURRENCE DAMAGE TO RENTED PREMISES (Ea occurrence) MED EXP (Any one person) PERSONAL & ADV INJURY GENERAL AGGREGATE PRODUCTS - COMP/OP AGG	$1,000,000 $300,000 $10,000 $1,000,000 $2,000,000 $2,000,000
A	AUTOMOBILE LIABILITY ANY AUTO OWNED AUTOS ONLY X HIRED AUTOS ONLY SCHEDULED AUTOS X NON-OWNED AUTOS ONLY			30SBAUH8895SA	05/01/2022	05/01/2023	COMBINED SINGLE LIMIT (Ea accident) BODILY INJURY (Per person) BODILY INJURY (Per accident) PROPERTY DAMAGE (Per accident)	$1,000,000
A	X UMBRELLA LIAB X OCCUR EXCESS LIAB CLAIMS-MADE DED X RETENTION $10,000			30SBAUH8895SA	05/01/2022	05/01/2023	EACH OCCURRENCE AGGREGATE	$5,000,000 $5,000,000
	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? Y / N (Mandatory in NH) If yes, describe under DESCRIPTION OF OPERATIONS below	N / A					PER STATUTE OTH-ER E.L. EACH ACCIDENT E.L. DISEASE - EA EMPLOYEE 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
For Informational Purposes Only	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 Mark A. Stolte

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#S3112884/M3096204 51LW

Client#: 2372 CBIZINC

ACORD™ CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY) 5/16/2022

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.

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PRODUCER	CONTACT NAME: Laura Weeks	
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: lweeks@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 :	
	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) If yes, describe under DESCRIPTION OF OPERATIONS below						E.L. DISEASE - EA EMPLOYEE	$
							E.L. DISEASE - POLICY LIMIT	$
A	Errors & Omission			42EPP30261107	06/01/2022	06/01/2023	$1,000,000 Per Occ/Agg	

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

CERTIFICATE HOLDER	CANCELLATION
For Informational Purposes Only	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.

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Client#: 2372 CBIZINC

ACORD™ CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY) 6/03/2022

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PRODUCER	CONTACT NAME: Laura Weeks	
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: lweeks@cbiz.com	
	INSURER(S) AFFORDING COVERAGE	NAIC #
	INSURER A : ACE American Insurance Company	22667
INSURED CBIZ, Inc. and Subsidiaries 6050 Oak Tree Blvd., South, Suite 500 Cleveland, OH 44131	INSURER B :	
	INSURER C :	
	INSURER D :	
	INSURER E :	
	INSURER F :	

COVERAGES CERTIFICATE NUMBER: REVISION NUMBER:

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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) If yes, describe under DESCRIPTION OF OPERATIONS below						E.L. DISEASE - EA EMPLOYEE	$
							E.L. DISEASE - POLICY LIMIT	$
A	Technology/Cyber			F14973205004	06/01/2022	06/01/2023	$1,000,000 Each Claim & Aggregate	

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

CERTIFICATE HOLDER	CANCELLATION
For Informational Purposes Only	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.

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