Disproportionate Share Hospital Upper Payment Limits
Navigating through the course:

- Once the PowerPoint presentation is open, click on this icon located on bottom right of the PowerPoint to display your presentation in full-screen mode.

- Another way to show the presentation in full screen mode is by clicking on the Slide Show tab from the toolbar and select either ‘From Beginning’ or ‘From Current’ Slide buttons.

- Once your presentation is open in full screen mode, click on the arrow pointing to the right to advance to the next slide and arrow pointing to left to go back.

- To exit from full screen mode, click on the esc key on your keyboard.

- You can quickly navigate to any lesson in the course by clicking on the slide number from the Table of Contents (Slide 6).
This training has been designed for use by hospital finance and government reimbursement officers of private Pennsylvania hospitals, and is prepared by the Office of Medical Assistance Programs (OMAP) within the Department of Human Services (DHS).

Office of Medical Assistance Programs...

- Recognizes that the subject of DSH UPL can be confusing and wants to help hospitals to have a better understanding of it
- Wants hospital financial executives to be aware of certain changes to the DSH payment process
- Wants hospitals to understand the importance of properly reporting data used in the determination of DSH payments
Throughout this training module, we will refer to both Medicaid and Medical Assistance, but it is important for you to know that they are NOT synonymous.

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

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

- About Medicaid DSH UPL
- The importance of DSH UPL and how it can impact your hospital
- How DSH UPL is determined
- Why UPL is calculated twice for the same year
- DSH process timeline
- What important change went into effect recently
- What you can do to report your hospital’s data accurately
- Where to go to learn more
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Lesson 1:

DSH
What you will learn in lesson 1:

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

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

This training is ONLY on Medicaid DSH in Pennsylvania, and every reference we make to “DSH” means Medicaid DSH.
Medicaid was created in 1965 through Title XIX of the Social Security Act.

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

“...hospitals rendering high volumes of care to Medicaid recipients often lost money because of historically low Medicaid reimbursement rates.”

“Their also lost money because these hospitals are often the same facilities that provide high volumes of care to indigent patients, causing them to have high levels of uncompensated care.”

In 1981, Congress established the Medicaid DSH program.

The purpose of the Medicaid DSH program is to:

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

---

States have considerable freedom in designing their DSH program...

The level of DSH payments made to individual hospitals

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

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

1Hospitals must also meet the Federal Obstetrician requirement as described on slide 18.
Pennsylvania’s DSH Payments

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

- eligibility criteria
- separate funding
- payment distribution methodology

Each state’s DSH programs are funded by both state and federal funds in accordance with approved State Plan.
<table>
<thead>
<tr>
<th>DSH Payment Program Name</th>
<th>Description on Remittance Advice*</th>
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<tbody>
<tr>
<td><strong>1 Inpatient DSH</strong></td>
<td>INP DISPROPORTIONATE SHARE</td>
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<td><strong>2 Community Access Fund (CAF)</strong></td>
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<td><strong>7 Trauma DSH</strong></td>
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*A Remittance Advice (RA) is the explanation of payment(s) that OMAP provides to each hospital for each time it makes payment(s).
## DSH Payment Programs

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<td>8 Additional Class of DSH</td>
<td>DISPROPORTIONATE SHARE/ UNSPECIFIED</td>
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<td>9 Access to Care</td>
<td>DISPROPORTIONATE SHARE/ UNSPECIFIED</td>
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<td>10 OB/NICU</td>
<td>OB/NICU DISPROP SHARE PMTS</td>
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<td>11 Psychiatric Medical Education</td>
<td>PSYCH MED ED PAYMT</td>
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<td>12 Academic Medical Center</td>
<td>ACADEMIC MED. CTR. DSH PYMT</td>
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<td>13 General Assistance Claims</td>
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<tr>
<td>14 Enhanced Payments to Certain DSH Hospitals (beginning with FY13-14)</td>
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## DSH Payment Programs

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<td><strong>17</strong> Rural Academic Med. Ed. DSH</td>
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<td><strong>18</strong> Less Urban Academic Med. Ed. DSH</td>
<td>ACAD MED DSH, LESS URBAN</td>
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<td><strong>19</strong> Regional Academic Med. Ed.</td>
<td>REGIONAL ACAD. MED. ED.</td>
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Public notices of proposed and final DSH payments programs are published in the [Pennsylvania Bulletin](#).
What is NOT DSH?

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

- MA Stability
- MA Dependency
- MA Rehab Adjustment
- MCO Payments (Access Capitation Rate)
- Medical Education
- Outpatient “DSH”
- OP / ER
- Enhanced Payments to Certain DSH Hospitals (through FY12-13)
- Augmented Waiver
- MA Reliant

Despite the “DSH” in the name, Outpatient is not true DSH.
Eligible Hospitals

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

How does a hospital qualify for DSH?

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

This training is focused on private hospitals.
Hospital Eligibility: The 2 OB Requirement

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

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

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

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

- Click to view the federal code ([Sec. 1923. [42 U.S.C. 1396r–4](d)](d) Requirements To Qualify as Disproportionate Share Hospital))
Pennsylvania statistics...

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

177 hospitals eligible for lump-sum DSH

31 hospitals not eligible for lump-sum DSH

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

Statistics are from FY13-14

Lump-sum DSH allocations totaled nearly $350 million (state and federal funds)
Lesson 1 review:

- DSH stands for Disproportionate Share Hospital
- A DSH Hospital is one which serves a disproportionate number of low-income patients
- States have some freedom in designing their DSH program
- There are 19 DSH payment types in PA, each with its own eligibility criteria and payment distribution methodology
- Some lump-sum hospital payments are “supplemental payments,” not DSH
- In FY13-14, 85% or 177 private inpatient hospitals qualified for lump-sum DSH in PA
Lesson 2: UPL and the Prospective DSH Analysis
What you will learn in lesson 2:

- About UPL
- About hospital-specific DSH UPL
- Impact to hospitals
- Federal regulations
- Data sources for DSH UPL analysis
- How DSH UPL is determined
- How DSH UPL is calculated
UPL stands for **Upper Payment Limit**

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

- This training is focused solely on the “hospital-specific DSH UPL”
The hospital-specific DSH UPL is also referred to as the “OBRA 1993 hospital-specific DSH limit,” for the Congressional Act from which it originated.

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

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

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

*FFP means “Federal Financial Participation” and refers to the portion of Medicaid funding that is provided by the federal government.
Other Federal Limits on Medicaid Spending

These limits are sometimes referred to as “UPL”.

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

**State-wide FFS Cap**
- Sometimes, “UPL” is used to refer to the federal cap on a state Medicaid program’s total FFS spending for a provider type (i.e. inpatient hospital, outpatient hospital, physicians)
- Typically, Federal Financial Participation (FFP) is authorized only on payments up to what Medicare would have paid facilities (in the aggregate) for the same services.
- A number of states have supplemental payment programs which they call “UPL payments” to increase provider reimbursement up to the UPL if there is room between current reimbursement levels and the applicable UPL.
- Pennsylvania has supplemental hospital payments, but they are not referred to as “UPL payments.”
In the early days of the DSH program, many states became adept at using it to leverage considerably more Federal dollars. Total DSH payments ballooned from $1.4 billion (1990) to $17.5 billion in just two years.¹

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

Prospective and Retrospective Analyses

Prospective

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

Retrospective

- After a given SFY is completed, and actual, experienced data for that year is gathered, each hospital’s DSH UPL is recalculated in a process known as the “retrospective DSH UPL analysis”
  - We will discuss the retrospective analysis, as well as the timeline for both analyses later in this training
Your DSH UPL determines whether or not the DSH payments for which you otherwise qualify will be paid to you or not.

It can mean millions of dollars to your hospital.

Hospitals play a role in determination of DSH UPL by providing accurate, timely data.

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

Basically...

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

Medicaid Shortfall

Uninsured Uncompensated Care

= Costs eligible for DSH reimbursement

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

Medicaid Shortfall

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

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

How is Medicaid Shortfall calculated?

Medicaid Costs - Medicaid Revenue (non-DSH) = Medicaid Shortfall
How is DSH UPL calculated?

Medicaid Shortfall

Medicaid Costs

- Medicaid charges are converted to costs using the cost-to-charge ratio (CCR) specific to the type of charge

- CCRs are calculated from data within a hospital’s Medicaid Cost Report (MA-336). *We will discuss CCRs more on the next slide.*

- Medicaid charges come from different sources depending on the specific type of charge

- Costs are estimated for each type of Medicaid charge. Then, they are added together

- For the prospective UPL, historical hospital costs are trended forward to the year of the DSH UPL calculation using market basket inflationary factors
**How is DSH UPL calculated?**

**Medicaid Shortfall**

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

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

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

- For more details, see Appendix II

The MA-336 hospital cost report includes information for MA which includes Title XIX and General Assistance (GA).
How is DSH UPL calculated?

Medicaid Shortfall

Medicaid Revenue

Here are the types of Medicaid revenue that are included:

- Medicaid Costs
- Medicaid Revenue (non-DSH)
- Medicaid Shortfall
- Medicaid FFS claims payments (IP&OP)
- Medicaid MCO Payments (IP&OP)
- Non-DSH supplemental hospital payments
- Out-of-state and other payer revenue* for Medicaid beneficiaries

*Claim and lump-sum
How is DSH UPL calculated?

Uninsured Uncompensated Care

This is the 2\textsuperscript{nd} component of the DSH UPL calculation.

Uninsured Uncompensated Care

Represents any individual with \textit{no source of third-party coverage} for the hospital services they receive

- Does \textit{not} include Medicaid patients

Who qualifies as “uninsured” as it relates to DSH UPL?

Self-pays  General Assistance (GA) patients  Underinsured

What exactly is “underinsured”?

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

\textsuperscript{1}CMS’ Final Rule effective December 31, 2014 (79 FR 71679-71694) provides a detailed definition of underinsured.
Although the cost of treating GA beneficiaries is considered uninsured and therefore is counted as an uninsured cost in the DSH UPL calculation, payments made by OMAP on behalf of GA beneficiaries are not counted here. We will discuss this in more detail later.
How is DSH UPL calculated?

4 Data Sources of the DSH UPL analysis

- **PROMISe**
  (Medicaid FFS charges and revenue; FFS GA charges; Other payer payments for GA beneficiaries)

- **OMAP MC Encounter Records**
  (MC charges for GA)

- **Hospital Financial Records**
  (Self-pay, uninsured and OOS charges and revenue)

- **Medicaid Hospital Cost Report**
  (CCRs; Medicaid MC charges and revenue; Other local/county program revenue and 1011 payments)

Uninsured charges and revenue are now being captured on the Medicaid hospital cost report as distinct elements beginning with the FY12-13 MA-336. OOS charges and revenue are targeted to be captured as distinct elements beginning with the FY14-15 MA-336.
How is DSH UPL calculated?

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

<table>
<thead>
<tr>
<th>RATE PAYMENTS</th>
<th>CHARGES</th>
<th>Conversion to Cost</th>
<th>COSTS</th>
<th>REVENUES</th>
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<td>Medicaid</td>
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<td>Patients with NSOTPC*</td>
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* NSOTPC = Patients with no source of third-party coverage. Includes self-pays and uninsured.
How is DSH UPL calculated?

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

The spreadsheet on the next slide adds these payments.

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

The DSH UPL analysis then considers the hospital’s DSH payments for the year to determine whether it will exceed its DSH Upper Payment Limit.
### How is DSH UPL calculated?

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<th>REVENUES</th>
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<td>Charges</td>
<td>By Cost-to-Charge Ratio (CCR)</td>
<td>Allowable Costs</td>
<td>Revenues</td>
<td>Costs eligible for DSH reimbursement</td>
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#### RATE PAYMENTS

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#### Patients with NSOTPC*

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#### LUMP-SUM PAYMENTS

- OOS supplemental payments
- Other non-state payments
- PA supplemental payments

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

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

*Excess or “remaining room”*

Includes GA DSH (federalized GA payments)
How is DSH UPL calculated?

Here is a simplified hypothetical example (in millions):

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<td>FFS &amp; MC</td>
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<tr>
<td>IP &amp; OP</td>
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<tr>
<td><strong>Patients with NSOTPC</strong>*</td>
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<tr>
<td>IP</td>
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<td>OP</td>
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</tr>
<tr>
<td><strong>Lump-Sum Payments</strong></td>
<td></td>
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</tr>
<tr>
<td>OOS supplemental payments</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other non-state payments</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PA supplemental payments</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Totals</strong></td>
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</tr>
<tr>
<td><strong>DSH Payments</strong></td>
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<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Remaining Room (Excess)</td>
<td></td>
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</tr>
</tbody>
</table>

This hospital is projected to be $1 million over its UPL if all DSH payments are made.
Lesson 2 review:

- UPL stands for Upper Payment Limit
- Federal law establishes an annual DSH allotment for each state that limits Federal Financial Participation (FFP) for total statewide DSH payments made to hospitals
- Your hospital-specific DSH UPL determines whether or not the DSH payments for which you otherwise qualify will be paid to you or not
- Hospital’s DSH UPL will change annually
- DSH UPL is calculated by adding the hospital’s Medicaid shortfall to its uncompensated costs for uninsured patients
- Medicaid revenue components in the calculation are FFS (claims) and MCO payments, and Non-DSH supplemental hospital payments
- There are 4 data sources for DSH UPL analysis: PROMISE, OMAP, MC encounter records, hospital financial records, and the Medicaid Cost Report
Lesson 3: Retrospective DSH Analysis
What you will learn in lesson 3:

- Why there is a retrospective analysis
- Who prepares the analysis
- When the analysis is done
- What the difference is between retrospective vs. prospective
States are required by Federal law to annually submit to CMS a report on Medicaid DSH payments. The report must identify each hospital that received a DSH payment, and provide any other information the Secretary needs to ensure the appropriateness of the payment amount.

Why is there a retrospective analysis?

1. States are required by Federal law to annually submit to CMS a report on Medicaid DSH payments.
2. States must also submit an independent certified audit to verify that DSH payments comply with specified DSH program requirements.
3. If a state fails to do so, CMS can discontinue Federal Financial Participation.
4. The report must identify each hospital that received a DSH payment, and provide any other information the Secretary needs to ensure the appropriateness of the payment amount.

The annual certified independent audit includes specific verifications to make sure all DSH payments are appropriate.
The retrospective calculation of DSH UPL is based on actual experience during the payment year (July-June). Those results are independently audited.

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

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

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

Prospective is an estimated calculation of the DSH UPL using historical claims projected to the effective DSH UPL payment year

Retrospective uses actual experience data (claims, payments, etc.) from the payment year (rather than using prior year data and adjustments)

Your retrospective UPL will likely be different from your prospective UPL

In the past, some hospitals were found to have received payments in excess of the retrospective UPL. CMS required audited retrospective reports, but did not require the excess payments to be returned

That has changed -- which leads us to our next topic….
Lesson 3 review:

- Retrospective DSH analysis is required by Federal law

- OMAP does a retrospective calculation of DSH UPL based on actual experience during the payment year and there is also an independent audit assessment of the results

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

- The retrospective analysis uses experienced data from the payment year instead of projecting historical data as the prospective analysis does
Lesson 4: The Payment Process and a Few Important Changes
What you will learn in lesson 4:

- About the OMAP process for determining and making payments
- About a federally-required change that could affect your hospital
- About recoupments
- About OMAP changes that could also affect your hospital
The OMAP process for DSH payments (as well as the non-DSH supplemental payments) works like this:

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

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

Eligibility Hospital Specific Payments
The process continues...

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

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

**Payments transmitted**
- All DSH and supplemental payments are transmitted electronically (EFT) or by check
  - If your hospital still receives payment by check, click here for information regarding how to switch to EFT
  - You receive a Remittance Advice (RA) prior to each payment’s transaction. The RA describes what kind of payment is being made and can be used to reconcile hospital records
  - There is a limit to the number of characters in the description on the RA, so some payment names are abbreviated. Please refer to the lists of DSH and supplemental payments included earlier in this training module to see the abbreviated names and associated payment programs
The CMS 2008 DSH Final Rule requires that, beginning with State Plan Rate Year 2011 (FY10-11 in PA), federal funds used in the overpayments be recouped (taken back) from the hospitals that received them, and be returned to CMS unless the state’s Medicaid State Plan prescribes a method for redistributing the funds.
Recoupments

Is my hospital over its limit?

OMAP will notify each hospital found to exceed its retrospective DSH UPL.

When will I be contacted and when will the recoupment take place?

OMAP is in the process of developing a procedure to implement this requirement. The dates are not set. OMAP will provide advanced notice prior to any recoupment.

What if my hospital was withheld payments based on the prospective UPL, but the retrospective UPL is higher? Will we be paid the difference?

These are questions that OMAP is considering as it develops its policy regarding recoupment.
Beginning with the FY14-15 prospective DSH UPL analysis, OMAP has changed the primary **data source** and **source year** for the projection.

Formerly.....

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

Beginning with FY 2014-2015...

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

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

Formerly…..

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

Beginning with the FY14-15 results …

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

If your hospital is identified to exceed its DSH UPL, OMAP will automatically send your prospective hospital-specific DSH analysis (as before)
Lesson 4 review:

- For each type of payment, eligibility and payment amounts are determined.
- Hospital payments are made quarterly or annually, depending on the program.
- Remittance Advice (RA) lists all FFS payments, both patient accounting (claims) and lump-sum DSH and supplemental payments.
- The CMS 2008 DSH Final Rule requires that, beginning with SFY10-11, federal funds that were used in the overpayments be recouped from the hospitals that received them and be returned to CMS unless the state’s Medicaid State Plan prescribes a method for redistributing the funds.
- OMAP is making two changes:
  - OMAP will prepare the prospective DSH UPL analysis using the most recently available DSH report and audit submitted to CMS as the basis.
  - OMAP will prepare and share the prospective results with any DSH hospital that requests them.
Lesson 5: Data Issues
The calculation for each hospital’s DSH UPL requires specific data elements.

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

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

- [ ] Yes, include it
- [ ] No, do not include it
Data Issues – What about bad debt?

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

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

“States and hospitals cannot substitute ... bad debt data as a proxy for uninsured cost as defined in federal regulations. The definitions of charity care and bad debt may vary significantly from the federal definition of uninsured costs.” – CMS¹

¹From point #16 in the CMS guidance entitled “Additional Information of the DSH Reporting and Audit Requirements – Part 2”
Based on what you know so far, do you think your hospital’s physicians’ services should be included as part of the costs for the DSH UPL calculation?

- Yes, include it
- No, do not include it
Data Issues – What about physicians’ services?

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

- [ ] Yes, include it
- [x] No, do not include it

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

¹See point #14 in the CMS guidance entitled “Additional Information of the DSH Reporting and Audit Requirements – Part 2”
Based on what you know so far, do you think your hospital’s statewide hospital assessment should be included as part of the costs for the DSH UPL calculation?

- [ ] Yes, all of it is included
- [ ] No, none of it is included
- [ ] A portion of it may qualify to be included
Based on what you know so far, do you think your hospital’s statewide hospital assessment should be included as part of the costs for the DSH UPL calculation?

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

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

- Yes
- No
Data Issues – What about charity care?

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

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

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

¹73 FR 77910
Data Issues – What about OOS Medicaid patients?

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

- Yes, include them
- No, do not include them
Do you think that your hospital costs and payments related to treating out-of-state (OOS) Medicaid patients should be included as part of the costs and revenues for the DSH UPL calculation?

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

- However, the PROMISe system does not capture OOS FFS claims, and the MA-336 captures only a part of the needed data
- Your managed care charges and revenue for these patients are captured on the MA-336 S7, as part of your total MC Medicaid data; therefore, OOS charges and revenue are included in the DSH Report for the managed care delivery system
- OMAP needs you to supply OOS FFS IP and OP charges and revenue from your hospital’s accounting records.
  - Retain supporting documentation for audit purposes
Do you think that your hospital costs and payments related to treating General Assistance (GA) patients are included as part of the costs and revenues for the DSH UPL calculation?

- Yes, they are included
- No, they are not included
- It depends
Data Issues – What about GA patients?

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

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

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

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

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

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

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

\(^1\)This applies to any state-only or local government-only payment toward hospital services for those with no source of 3rd party coverage. Payments from other payers for GA beneficiaries are counted as revenue from or on behalf of uninsured.
Data Issues – What about adultBasic?

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

- Yes, they are included
- No, they are not included
- Costs are included, but revenues are not
Data Issues – What about adultBasic?

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

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

- adultBasic was a state-only program, so the costs are included, but the revenues are not. The adultBasic program ended February 28, 2011, but its costs are figured into the FY 10-11 retrospective DSH report and the FY 14-15 prospective DSH analysis (which is based on the FY 10-11 retrospective DSH report and audit).
Do you think that your hospital costs and payments related to treating **Healthy PA patients** are included as part of the costs and revenues for the DSH UPL calculation?

- Yes, they are included
- No, they are not included
- Costs are included, but revenues are not
Data Issues – What about Healthy PA?

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

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

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

\(^1\)The GA program will continue for eligible legal aliens.
Finally, here are some less-common payment types:

- **Section 1011 Payments**
  - These are for “Emergency Health Services Furnished to Undocumented Aliens”
  - These ARE included in the DSH UPL calculation

- **Grants for Medicaid or uninsured hospital care**
  - These ARE included in the DSH UPL calculation

- **State-only or local government-only indigent programs** (other than GA, which we have covered)
  - The costs ARE included, but the revenue is NOT

- **CHIP (Children’s Health Insurance Program)**
  - CHIP costs and revenue, which are not Title XIX or uncompensated care, are not included in DSH UPL calculation

- **Prisoner Revenue**
  - Revenue, as well as costs and charges for the treatment of prisoners, is not included in the DSH UPL calculation

---

1See point #41 in the CMS guidance entitled “Additional Information of the DSH Reporting and Audit Requirements – Part 2”
## DSH UPL Analysis: Summary of Costs & Payments

<table>
<thead>
<tr>
<th>Patient Services</th>
<th>COSTS</th>
<th>PAYMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>PA Medicaid (Title XIX)</td>
<td>Include</td>
<td>Include</td>
</tr>
<tr>
<td>OOS Medicaid</td>
<td>Include</td>
<td>Include</td>
</tr>
<tr>
<td>Self-Pays</td>
<td>Include</td>
<td>Include</td>
</tr>
<tr>
<td>Uninsured</td>
<td>Include</td>
<td>Include</td>
</tr>
<tr>
<td>Underinsured (see slide 34)</td>
<td>Include</td>
<td>Include</td>
</tr>
<tr>
<td>Healthy PA (program to end in 2015)</td>
<td>Include</td>
<td>Include</td>
</tr>
<tr>
<td>FEDERALIZED GA</td>
<td>Include</td>
<td>Include</td>
</tr>
<tr>
<td>State-Only GA</td>
<td>Include</td>
<td>EXCLUDE</td>
</tr>
<tr>
<td>Indigents covered by a state-only or local govt.-only indigent program</td>
<td>Include</td>
<td>EXCLUDE</td>
</tr>
<tr>
<td>adultBasic (program ended Feb. 2011)</td>
<td>Include</td>
<td>EXCLUDE</td>
</tr>
</tbody>
</table>

## Special Payments

<table>
<thead>
<tr>
<th>Special Payments</th>
<th>COSTS</th>
<th>PAYMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>DSH Payments</td>
<td></td>
<td>Include</td>
</tr>
<tr>
<td>Non-DSH supplemental payments</td>
<td></td>
<td>Include</td>
</tr>
<tr>
<td>Section 1011 payments</td>
<td></td>
<td>Include</td>
</tr>
<tr>
<td>Grants for Medicaid or uninsured hospital care</td>
<td></td>
<td>Include</td>
</tr>
</tbody>
</table>

## Other Considerations

<table>
<thead>
<tr>
<th>Other Considerations</th>
<th>COSTS</th>
<th>PAYMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bad Debt</td>
<td></td>
<td>Not Applicable</td>
</tr>
<tr>
<td>&quot;Charity Care&quot; costs as defined by hospital</td>
<td></td>
<td>Use Federal standards instead</td>
</tr>
<tr>
<td>Statewide Hospital Assessment</td>
<td></td>
<td>Correct portion is already accounted for in the CCR¹</td>
</tr>
<tr>
<td>Physicians' Services</td>
<td></td>
<td>EXCLUDE</td>
</tr>
</tbody>
</table>

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

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

• Your hospital’s fiscal year may be different from the State’s fiscal year

• The data you enter into your Medicaid Cost Report must match the State fiscal year (July 1 – June 30)

• For example, if your hospital uses the calendar year as its FY, to complete the FY14-15 MA-336, you will need to use 50% of your costs and charges from your 2014 financial reports, and 50% from your 2015 financial reports

• For more details, see CMS-2198-F (“General DSH Audit and Reporting Protocol”)

• For more details, see CMS-2198-F (“General DSH Audit and Reporting Protocol”)
Data Issues – Medicaid Cost Report

Change to the S7 Schedule

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

GA Eligibility – How to Tell

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

Reporting the Correct Days

• **Observation Days**
  - Include observation bed days in the calculation of uncompensated care costs

• **“Allowed”/ “Billed” / “Covered” Days**
  - Which type should be used when calculating hospital Medicaid routine costs?
    - “States and hospitals must use covered days for purposes of calculating the hospital-specific DSH limit.” [regardless of whether they were billed or paid] – CMS¹

¹See point #20 in the CMS guidance entitled “Additional Information of the DSH Reporting and Audit Requirements – Part 2”
Lesson 6: The Timeline
What you will learn in lesson 6:

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

**Prospective UPL Calculation**

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

### Prospective UPL Calculation timeline (Using FY15-16 as an example):

<table>
<thead>
<tr>
<th>Year 1</th>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>FY15-16 (Payment Year)</td>
<td>FY16-17</td>
<td>FY17-18</td>
<td>FY18-19</td>
<td>FY19-20</td>
</tr>
<tr>
<td><strong>Prospective UPL Calculation</strong></td>
<td><strong>Payments Made</strong></td>
<td><strong>Hospital Financial Records</strong></td>
<td><strong>Medicaid Cost Report</strong></td>
<td><strong>OMAP Data-Gathering &amp; Checking</strong></td>
</tr>
<tr>
<td><strong>Retrospect. DSH Analysis</strong></td>
<td><strong>DSH UPL Audit</strong></td>
<td><strong>Report to CMS</strong></td>
<td><strong>Notice and Recoup-ment</strong></td>
<td></td>
</tr>
</tbody>
</table>

---

**Notice and Recoup-ment**
What is the DSH UPL timeline?

Using FY15-16 as an example:

<table>
<thead>
<tr>
<th>Year 1</th>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>FY15-16 (Payment Year)</td>
<td>FY16-17</td>
<td>FY17-18</td>
<td>FY18-19</td>
<td>FY19-20</td>
</tr>
</tbody>
</table>

**OMAP Makes Hospital Payments**
- OMAP distributes DSH and supplemental hospital payments, but is required to withhold any DSH payments that are expected to exceed a hospital’s prospective UPL

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

**Using FY15-16 as an example:**

<table>
<thead>
<tr>
<th>Year 1</th>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>FY15-16 (Payment Year)</td>
<td>FY16-17</td>
<td>FY17-18</td>
<td>FY18-19</td>
<td>FY19-20</td>
</tr>
<tr>
<td>Prospective UPL Calculation</td>
<td>Payments Made</td>
<td>Hospital Financial Records</td>
<td>Medicaid Cost Report</td>
<td>OMAP Data-Gathering &amp; Checking</td>
</tr>
<tr>
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</tbody>
</table>

**Hospital Financial Records for the Payment Year**

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

Using FY15-16 as an example:

<table>
<thead>
<tr>
<th>Year 1</th>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>FY15-16 (Payment Year)</td>
<td>FY16-17</td>
<td>FY17-18</td>
<td>FY18-19</td>
<td>FY19-20</td>
</tr>
<tr>
<td>Prospective UPL Calculation</td>
<td>Payments Made</td>
<td>Hospital Financial Records</td>
<td>Medicaid Cost Report</td>
<td>OMAP Data-Gathering &amp; Checking</td>
</tr>
<tr>
<td></td>
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<td></td>
<td>Retrospect. DSH Analysis</td>
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<td></td>
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<td></td>
<td>DSH UPL Audit</td>
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<td>Report to CMS</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Notice and Recoup-ment</td>
</tr>
</tbody>
</table>

**Medicaid Cost Report for the Payment Year**
- The hospital Medicaid cost report in Pennsylvania is also known as the “MA-336”

- About five months after the payment year ends, you receive your new PA Medicaid Cost Report Software (PACRS, which is pronounced like “pacers”) and instructions from OMAP

- Your completed report is due several months later, after your Medicare cost report is due
What is the DSH UPL timeline?

Using FY15-16 as an example:

<table>
<thead>
<tr>
<th>Year 1</th>
<th>Year 2</th>
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<td></td>
<td>Payments Made</td>
<td>Hospital Financial</td>
<td>OMAP Data-Gathering &amp;</td>
<td>Report to CMS</td>
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<td>Records</td>
<td>Checking</td>
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<td>Retrospect. DSH</td>
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<td>Analysis</td>
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<td>DSH UPL Audit</td>
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<td></td>
</tr>
</tbody>
</table>

**OMAP Gathers and Checks Data**

- Conducts desk reviews of the MA-336 data submitted, and accepts corrections from hospitals for a time

- Extracts and compiles FFS MA and GA claims data from the PROMISe system and Managed Care data from its MC encounter database

- Gathers the required DSH UPL data elements and supplies them to a vendor to perform the retrospective analysis
What is the DSH UPL timeline?

Using FY15-16 as an example:

<table>
<thead>
<tr>
<th>Year 1</th>
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<td></td>
<td>Notice and Recoupment</td>
</tr>
</tbody>
</table>

**Retrospective DSH Analysis**

- The calculation is usually performed during the final half of the third SFY following the payment year
**What is the DSH UPL timeline?**

**Using FY15-16 as an example:**

<table>
<thead>
<tr>
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</table>

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

Using FY15-16 as an example:

<table>
<thead>
<tr>
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<tr>
<td>Submission of the Audited Report to CMS</td>
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<td>Report to CMS</td>
</tr>
</tbody>
</table>

**Submission of the Audited Report to CMS**

- Must be submitted within 90 days of the completion of the audit. (At the latest, this is Dec. 31, three and a half years following the close of the payment year)

- This report is officially known as the “CMS DSH UPL Report”
What is the DSH UPL timeline?

Using FY15-16 as an example:

<table>
<thead>
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Notice and recoupment of overpayments
- OMAP will notify each hospital found to exceed its retrospective DSH UPL and will indicate the timing and procedure for any recoupment of overpayment.
What is the DSH UPL timeline?

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

The following slide illustrates the overlap...
What is the DSH UPL timeline?

**DSH Timeline by State Fiscal Year (SFY)**

| DSH Year | 1/10 | 7/10 | 1/11 | 7/11 | 1/12 | 7/12 | 1/13 | 7/13 | 1/14 | 7/14 | 1/15 | 7/15 | 1/16 | 7/16 | 1/17 | 7/17 | 1/18 | 7/18 | 1/19 | 7/19 | 1/20 | 7/20 |
|----------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|
| 10/11    |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |
| 11/12    |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |
| 12/13    |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |
| 13/14    |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |
| 14/15    |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |
| 15/16    |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |

- **Prospective Source Data**
- **Prospective Data Gathering**
- **Prospective Calculation**
- **DSH Payment Year**
- **Cost Report Prep and Release**

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

**Current Quarter**

**FY14-15 prospective DSH analysis has been delayed to incorporate audited FY10-11 DSH UPL report as basis (to satisfy CMS request.)**
Lesson 6 review:

- DSH UPL is a 5-year process

- Using FY15–16 as an example...
  
  - Year 1 – FY15–16
    - OMAP gathers historical data needed for the DSH UPL prospective calculation
  
  - Year 2 – FY 16–17
    - Hospitals complete cost reports
  
  - Year 3 – FY 17–18
    - OMAP conducts desk reviews of the MA-336 data submitted
  
  - Year 4 – FY 18–19
    - OMAP gathers required DSH UPL data elements and supplies them to a vendor to perform the retrospective analysis
  
  - Year 5 – FY 19–20
    - Audit commences; OMAP submits report and audit to CMS; OMAP contacts affected hospitals
Lesson 7: Closing
What you will learn in lesson 7:

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

After lesson 7, you will find Appendix I, II and III which are the Glossary, CCR, and Contact Information
Each hospital has a hospital-specific UPL that is essentially equal to the sum of its Medicaid shortfall and its uninsured uncompensated care.

Payments to a hospital from or on behalf of Medicaid or uninsured patients may not exceed its UPL.

The prospective DSH analysis creates an estimated UPL for the current payment year by utilizing cost data from a previous year and projecting it forward.

The retrospective DSH analysis calculates a hospital’s UPL by using cost and payment data for the payment year itself.

The retrospective DSH analysis is audited and submitted to CMS.

The audited DSH report triggers recoupment of payments found to be in excess of a hospital’s UPL.
OMAP is planning to send you these DSH-related communications in the next six months of 2015:

- **May**: Your hospital’s FY14-15 prospective DSH analysis results
  - Normally, you would receive the prospective DSH analysis results much earlier in the state fiscal year (SFY)
  - This year, preparation was delayed because OMAP needed to gather additional data from hospitals and because it has changed the primary source data to the audited results from the FY10-11 report

- **July**: Your hospital’s FY10-11 retrospective DSH analysis results
  - The FY10-11 retrospective DSH analysis results will include information on the recoupment process

- **September**: Your hospital’s FY15-16 prospective DSH analysis results

- **November**: Your hospital’s FY14-15 Medicaid Cost Report to complete
What details will I receive regarding my FY14-15 prospective analysis?

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

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

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

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

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

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

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

**Report corrections to submitted MA-336**
- Report corrections to your submitted MA-336

**Check your prospective UPL analysis**
- Respond by the indicated deadline

**Understand the DSH process**
- Understand the DSH process so that withheld payments or recoupments do not come as a surprise
On December 19, 2008, a final rule was published by CMS in the Federal Register to implement the reporting and audit requirements within section 1923 of the Act, specifying the elements for the required report and the verifications required for the audit. There is a correcting amendment here.

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

2008 DSH Final Rule

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

Additional information from CMS:
- Part 1
- Part 2

Medicaid DSH Page
Federal Medicaid DSH website

DSH UPL FAQs
Posted on the DHS website
Appendix I

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

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

**RA**
Remittance Advice, statement available to hospitals on a weekly basis. Refer to the Department’s website for more information or click the links provided below:

- View the Provider Quick Tip: “Are You Puzzled By Your Remittance Advice Statement?”
- View “Checks, Payments and Remittance Advice Frequently Asked Questions”
- View “How to Save a Remittance Advice to your Computer”

**SFY**
State Fiscal Year. The fiscal year for the Commonwealth of Pennsylvania runs from July 1 through June 30. The fiscal year that begins on July 1, 2015 is called FY 2015-2016, or FY15-16. References to PA’s SFY in this training are simply abbreviated as “FY”

**SPRY**
State Plan Rate Year. Each state can set its own Medicaid year. Pennsylvania uses its fiscal year as its SPRY, so this training will treat them as synonymous

**Title XIX**
(pronounced Title 19) Social Security Act Section XIX created the Medicaid program and includes Medicaid federal regulations
Appendix II

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

<table>
<thead>
<tr>
<th>INPATIENT</th>
<th>OUTPATIENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Source for charges to be converted by the CCR</td>
<td>Source for charges to be converted by the CCR</td>
</tr>
<tr>
<td>CCR source -- Costs</td>
<td>CCR source -- Charges</td>
</tr>
<tr>
<td>Medicaid FFS*</td>
<td>Claims</td>
</tr>
<tr>
<td>Medicaid Managed Care</td>
<td>MA-336: S7</td>
</tr>
<tr>
<td>Uninsured – GA FFS</td>
<td>Claims</td>
</tr>
<tr>
<td>Uninsured – GA MC</td>
<td>Encounter Records</td>
</tr>
<tr>
<td>FFS Out-of-State Medicaid</td>
<td>Hospital records</td>
</tr>
</tbody>
</table>

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

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

PA does not collect claims for OOS Medicaid patients
Appendix III
Contact Information
Have questions?

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

RA-pwdshpymt@pa.gov

Subject: “[Hospital Name] DSH UPL Training Additional Question(s)”
You have completed this course

You should now be able to:

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