

State of Georgia  
Disproportionate Share Hospital (DSH) Examination Survey Part I  
For State DSH Year 2019

N/A

N/A

**A. General Instructions and Identification of Cost Reports that Cover the DSH Year:**

1. Select the "Sec. A-C DSH Year Data" tab in Excel workbook. In row 1, select your facility from the drop-down menu provided (if not already populated). When your facility is selected, the following fields will be populated: in-state Medicaid provider number and Medicare provider number. Review information and indicate whether it is correct or incorrect. If incorrect, provide correct information.
  
2. Provide your cost reporting periods that are needed to completely cover the DSH year. If the end date for cost report period 1 is before the end date of the DSH year, report your next cost reporting period (cost report 2). If this cost report ends prior to the end of the DSH year, report your next cost reporting period (cost report 3). The cost reporting periods must cover the entire DSH year.

**NOTE: For the 2019 DSH Survey, if your hospital completed the DSH survey for 2018, the first cost report year should follow the last cost report year reported on the 2018 DSH survey. The last cost report year on the 2019 survey must end on or after the end of the 2019 DSH year. If your hospital did not complete the 2018 survey, your cost reports for 2019 must cover the entire 2019 DSH year.**

3. Supporting documentation for all data elements provided within the DSH survey must be maintained for a minimum of five years from the date of survey submission.

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**B. DSH OB Qualifying Information:**

1. Answer "B. DSH OB Qualifying Information" questions 1, 2 and 3 to determine if your hospital is eligible to receive DSH payments.

**C. Disclosure of Other Medicaid Payments Received:**

1. Medicaid and Medicaid Managed Care supplemental payments should include all non-claims payments for hospital services paid on the state fiscal year. This includes, but is not limited to) UPL payments, Medicaid GME payments, bonus payments, incentive payments, full Medicaid pricing (FMP) payments, etc. However, DSH payments should NOT be included.

**Certification:**

1. The hospital CEO or CFO must certify the accuracy of the survey responses. Provide hospital and outside preparer contacts who can respond to requests for additional information and answer questions related to the hospital's responses.

**N/A**

N/A N/A

**Please submit your completed survey Sections A through C and the certification electronically to Myers and Stauffer LC. Also include Sections D-L included in the separate DSH Survey Part II file.**

**General Instructions and Identification of Cost Reports that Cover the DSH Year:**

1. DSH Survey Sections A, B, and C are part of a separate Excel workbook titled DSH Survey Part I and should be submitted along with the completed DSH Survey Part II Excel workbook. DSH Survey sections A, B, and C contain DSH eligibility and certification questions.
2. Select the "Survey - Sec. D, E, F CR Data" tab in the Excel workbook. On Line 1, select your facility from the drop-down menu provided. When your facility is selected, the following Lines will be populated with your facility specific information: Line 2 - applicable cost report years, Line 4 - Hospital Name, Line 5 - in-state Medicaid provider number, Line 6 - Medicaid Subprovider Number 1 (Psychiatric or Rehab), Line 7 - Medicaid Provider Number 2 (Psychiatric or Rehab), and Line 8 - Medicare provider number. The provider must manually select the appropriate option from the drop down menu for Line 3 - Status of Cost Report Used for the Survey. Review the information and indicate whether it is correct or incorrect. If incorrect, provide correct information in the provided space and submit supporting documentation when you submit your survey.
3. You must complete a separate DSH Survey Part II Excel workbook for each cost report year needed to cover the State DSH year and not previously submitted for a DSH examination. To indicate the proper time period for the current survey select an "X" from the drop down menu on the appropriate box of Line 2 of the "Survey - Sec. D, E, F CR Data" tab in this Excel workbook. If two cost report years are selected at the same time the survey will generate an error message as only one cost report year may be selected per Excel workbook.

**NOTE: For the 2019 DSH Survey, if your hospital completed the DSH survey for 2018, the first cost report year should follow the last cost report year reported on the 2018 DSH survey. The last cost report year on the 2019 survey must end on or after the end of the 2019 DSH year. If your hospital did not complete the 2018 survey, you must report data for each cost report year that covers the 2019 DSH year.**

4. Supporting documentation for all data elements provided within the DSH survey must be maintained for a minimum of five years.

**Exhibit A - Support of Uninsured I/P and O/P Hospital Services:**

1. See Exhibit A for an example format of the information that needs to be available to support the data reported in Section H of the survey related to uninsured services provided in each cost reporting year needed to completely cover the DSH year. This information must be maintained by the facility in accordance with the documentation retention requirements outlined in the general instructions section. Submit a separate Exhibit A for each cost reporting period included in the survey.
2. Complete Exhibit A based on your individual state Medicaid hospital reimbursement methodology (if your state reimburses based on discharge date then only include claims in Exhibit A that were discharged during the cost reporting period for which you are pulling the data).
3. Exhibit A population should include all uninsured patients whose dates of service (see above) fall within the cost report period.
4. The total inpatient and outpatient *hospital (excluding professional fees, and other non-hospital items)* charges from Exhibit A, column N should tie to Section H, line 128 of the DSH survey.

**Exhibit B - Support for Self-Pay I/P and O/P Hospital Payments Received:**

1. See Exhibit B for an example format of the information that needs to be available to support the data reported in Section E of the survey related to ALL patient payments received during each cost reporting year needed to completely cover the DSH year. This information must be maintained by the facility in accordance with the documentation retention requirements outlined in the general instructions section. Submit a separate Exhibit B for each cost reporting period included in the survey.

Note: Include Section 1011 payments received related to undocumented aliens if they are applied at a patient level.

2. Exhibit B population should include all payments received from patients during the cost report year regardless of dates of service and insurance status.
3. Only the payments received from uninsured patients should be included on Section H of the DSH survey, line 143. Payments from both the uninsured and insured patients should be reported on Section E of the DSH survey, lines 9 and 10, respectively. The total payments from Section H, line 143 should reconcile to Section E, line 9.

**Section D - General Cost Report Year Information**

1. For Lines 1 through 8 of Section D, please refer to the instructions listed above in the "General Information and Identification of Cost Reports that Cover the DSH Year" section.
2. For Lines 9 through 15, provide the name and Medicaid provider number for each state (other than your home state) where you had a current Medicaid provider agreement during the term of the DSH year. Per federal regulation, the DSH examination must review both in-state Medicaid services as well as out-of-state Medicaid services when determining the Medicaid shortfall or longfall.

**Section E - Disclosure of Medicaid / Uninsured Payments Received**

1. Please read "Note 1" located at the bottom of Section E before entering information for Lines 1 through 7. After reading through Note 1, please provide the applicable Section 1011 payment information as indicated.
2. Please read "Note 2" located at the bottom of Section E before entering information for Line 8. After reading through Note 2, please provide the total Out-of-State DSH payments as indicated.
3. Lines 9 and 10 should reconcile to the Exhibit B information provided by the facility.
4. Line 13 is a drop-down menu. Please answer 'Yes' or 'No' to the question.
5. Lines 14 and 15 should be completed if you answered 'Yes' to line 13. Please provide the amount of lump sum (non-claims-based) payments received from Medicaid Managed Care plans. Please also provide supporting documentation for the amounts reported in the form of cancelled checks, general ledger records, or some other financial records.

**Section F - MIUR / LIUR Qualifying Data from the Cost Report**

**Section F-1 Total Hospital Days Used in Medicaid Inpatient Utilization Ration (MIUR)**

1. Section F-1 is required to calculate the Medicaid Inpatient Utilization Rate (MIUR). The MIUR is a federal DSH eligibility criteria that must be met in order to receive DSH payments.

**Section F-2 Cash Subsidies for Patient Services Received from State or Local Governments and Charity Care Charges**

2. For Lines 2 through 6 report all state or local government cash subsidies received for patient care services. If the subsidies are directed specifically for inpatient or outpatient services, record the subsidies in the appropriate cell. If the subsidies do not specify inpatient or outpatient services, record the subsidies in the unspecified cell. If any subsidies are directed toward non-hospital services, record the subsidies in the non-hospital cell.
3. The unspecified subsidies will be allocated between inpatient and outpatient using your hospital volume statistics. State and local subsidies do not include regular Medicaid payments, supplemental (UPL) Medicaid payments or Medicaid/Medicare DSH payments. Subsidies are funds the hospital received from state or local government sources to assist hospitals to provide care to uninsured or underinsured patients.

4. Cash subsidies are used to calculate Medicaid DSH eligibility under the federal low-income utilization rate formula. They are NOT used to reduce your net uninsured cost for DSH payment programs.
5. For Lines 7 through 10 report the applicable charity care charges. Charity care charges are used in the calculation of the low-income utilization rate. Report the hospital's inpatient and outpatient charity care charges for the applicable cost reporting period. Any charity care charges related to non-hospital services should be reported on the non-hospital charity care charges line. Total charity care charges must reconcile to the charity care charges reported in your financial statements and/or annual audit or they must be in compliance with the definition of charity per your state's DSH payment program.

**Section F-3 Calculation of Net Hospital Revenue from Patient Services (Used for LIUR)**

6. For purposes of the low-income utilization rate (LIUR) calculation, it is necessary to calculate net hospital revenue from patient services. This section of the survey requests a breakdown of charges reported on cost report Worksheet G-2 between hospital and non-hospital services. The form directs you to allocate your total contractual adjustments, as reported on cost report Worksheet G-3, Line 2, between hospital and non-hospital services. The form provides space for an allocation of contractual allowances among service types. If contractual adjustment amounts are not maintained by service type in your accounting system, a reasonable allocation method must be used. This will allow for the calculation of net "hospital" revenue. Total charges and contractual adjustments must agree to your cost report. Contractuals may have been spread on the survey using formulas but you can overwrite those amounts with actual contractuals if you have the data.
7. A separate Excel workbook must be used for each cost reporting period needed to completely cover the DSH year as indicated in the "General Information and Identification of Cost Reports that Cover the DSH Year" section of the instructions.

## **Section G - CR Data**

**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.**

1. The provider should enter all applicable Routine and Ancillary Cost Centers not currently provided in Section G. Once the Routine and Ancillary Cost Centers have been entered into Section G of the DSH survey, they will populate the Routine and Ancillary Cost Centers on DSH survey "Sec. H - In-State", "Sec. I - Out-of-State".
2. If your teaching hospital removed intern and resident costs in Column 25 of Worksheet B, Part I, you will need to enter those amounts in the column provided so the amounts can be added back to your total cost per diems and CCRs for Medicaid/Uninsured. If intern and resident cost was not removed in Column 25 of Worksheet B, Part I then no entry is needed. Teaching costs should be included in the final cost per diems and CCRs.
3. After the Routine and Ancillary Cost Centers have been identified, it will be necessary for the provider to fill in the remaining information required by Section G. The location of the specific cost report information required by Schedule G for both Routine and Ancillary Cost Centers is identified in each column heading. The provider will NOT need to enter data into the "Net Cost", or "Medicaid Per Diem/Cost-to-Charge Ratios" columns as these are calculated columns.
4. Once the "Medicaid Per Diem/Cost-to-Charge Ratios" column has been calculated, the values will also populate on DSH Survey "Sec. H - In-State", and "Sec. I - Out-of-State".

## **Section H - Calculation of In-State Medicaid and Uninsured I/P and O/P Costs:**

1. This section of the survey is used to collect information to calculate the hospital's Medicaid shortfall or longfall. By federal Medicaid DSH regulations, the shortfall/longfall must be calculated using Medicare cost report costing methodologies.
2. The routine per diem cost per day for each hospital routine cost center present on the Medicaid cost report will automatically populate in Section H after DSH Survey "Sec. G - CR Data" has been completed. These amounts are calculated on Worksheet D-1 of the cost report. The ancillary cost-to-charge ratio for each ancillary cost center on your cost report will also automatically be populated in Section H after DSH Survey "Sec. G - CR Data" has been completed.
3. Record your routine days of care, routine charges and I/P and O/P ancillary charges in the next several columns. This information, when combined with cost information from the cost report, will calculate the total cost of hospital services provided to Medicaid and uninsured individuals.

**In-State Medicaid FFS Primary**

*Traditional Medicaid Primary (should exclude non-Title 19 programs such as CHIP/SCHIP)*

In these two columns, record your in-state Medicaid fee-for-services days and charges. The days and charges should reconcile to your Medicaid provider statistics and reimbursement (PS&R) report, or your state version generated from the MMIS. Record in the box labeled "Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)," the total (gross) payments, prior to reductions for third party liability (TPL), your hospital received for these services. Reconcile your responses on the survey with the PS&R total at the bottom of each column. Provide an explanation for any unreconciled amounts.

**In-State Medicaid Managed Care Primary**

*Managed Care Medicaid Primary (should exclude non-Title 19 programs such as CHIP/SCHIP)*

Same requirements as above, except payments received from the Medicaid Managed Care entity should be reported on the line titled "Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down)". If your hospital does business with more than one in-state Medicaid managed care entity, your combined results should be reported in these two columns (inpatient and outpatient). NOTE: 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.

**In-State Medicare FFS Cross-Overs (with Medicaid Secondary)**

*Traditional Medicare Primary with Traditional Medicaid or Managed Care Medicaid Secondary*

Each hospital must report its Medicare/Medicaid cross-over claims summary data on the survey. Total cross-over days and routine and ancillary charges must be reported and grouped in the same cost centers as reported on the hospital's cost report. Report payments as instructed on each line. In total, payments must include all amounts collected from the Medicare program, patient co-pays and deductible payments, Medicare bad debt payments, and any Medicaid payments and other third party payments.

**N/A**

*Traditional Medicare Primary with Traditional Medicaid or Managed Care Medicaid Secondary*

Each hospital must report its Medicare/Medicaid cross-over claims summary data on the survey. Total cross-over days and routine and ancillary charges must be reported and grouped in the same cost centers as reported on the hospital's cost report. Report payments as instructed on each line. In total, payments must include all amounts collected from the Medicare program, patient co-pays and deductible payments, Medicare bad debt payments, and any Medicaid payments and other third party payments.

**N/A**



**In-State Other Medicaid Eligibles (Not Included Elsewhere)**

*In-State Other Medicaid Eligibles (Not Included Elsewhere) (should exclude non-Title 19 programs such as CHIP/SCHIP)*

Enter claim charges, days, and payments for any other Medicaid-Eligible patients that have not been reported anywhere else in the survey. The patients must be Medicaid-eligible for the dates of service and they must be supported by Exhibit C and include the patient's Medicaid ID number. This would include Medicare Part C cross-overs not reported elsewhere on the survey.

**N/A**

N/A

**N/A**

N/A

**N/A**

N/A

**N/A**

N/A

### **Uninsured**

Federal requirements mandate the uninsured services must be costed using Medicare cost reporting methodologies. As such, a hospital will need to report the uninsured days of care they provided each cost reporting period, by routine cost center, as well as inpatient and outpatient ancillary service revenue by cost report cost center. Exhibit A has been prepared to assist hospitals in developing the data needed to support responses on the survey. This data must be maintained in a reviewable format. It must also only include charges for inpatient and outpatient hospital services, excluding physician charges and other non-hospital charges. Per federal guidelines uninsured patients are individuals with no source of third party healthcare coverage (insurance) or third party liability for the specific service provided. See "Uninsured Definitions" tab for additional details.

4. Federal requirements mandate the hospital cost of providing services to the uninsured during the DSH year must be reduced by uninsured self-pay payments received during the DSH year. Exhibit B will assist hospitals in developing the data necessary to support uninsured payments received during each cost reporting period. The data must be maintained in a reviewable format and made available upon request.

### **Section I - Calculation of Out-of-State Medicaid Costs:**

1. This schedule is formatted similar to Schedule H. It should be prepared to capture all out-of-state Medicaid FFS, managed care, FFS cross-over and managed care cross-over services the hospital provided during the cost reporting year. Like Schedule H, a separate schedule is required for each cost reporting period needed to completely cover the DSH year. Amounts reported on this schedule should reconcile to the out-of-state PS&R (or equivalent schedule) produced by the Medicaid program or managed care entity.

#### **Out-of-State Medicaid FFS Primary**

*Traditional Medicaid Primary (should exclude non-Title 19 programs such as CHIP/SCHIP)*

#### **Out-of-State Medicaid Managed Care Primary**

*Managed Care Medicaid Primary (should exclude non-Title 19 programs such as CHIP/SCHIP)*

#### **Out-of-State Medicare FFS Cross-Overs (with Medicaid Secondary)**

*Traditional Medicare Primary with Traditional Medicaid or Managed Care Medicaid Secondary*

#### **Out-of-State Other Medicaid Eligibles (Not Included Elsewhere)**

*Out-of-State Other Medicaid Eligibles (Not Included Elsewhere) (should exclude non-Title 19 programs such as CHIP/SCHIP)*

### **Section J - Calculation of In-State Medicaid and Uninsured Organ Acquisition Costs:**

1. **This section is to be completed by hospitals that have incurred in-state Medicaid or uninsured organ acquisition costs only. Information is collected in a format similar to Section H.**
2. Total Medicaid and uninsured organ acquisition cost is calculated based on the ratio of Medicaid and uninsured useable organs to total organs.

**Section K - Calculation of Out-of-State Medicaid Organ Acquisition Costs:**

1. **This section is to be completed by hospitals that have incurred out-of-state Medicaid organ acquisition costs only. Information is collected in a format similar to Section I.**
2. Total Medicaid and uninsured organ acquisition cost is calculated based on the ratio of Medicaid and uninsured useable organs to total organs.
3. The following columns will **NOT** need to be entered by the provider as they will automatically populate after Section J has been completed: "Total Organ Acquisition Cost", "Revenue for Medicaid/Uninsured Organs Sold", and "Total Useable Organs (Count)".

**Section L. Provider Tax Assessment Reconciliation / Adjustment:**

1. **This section is to be completed by all hospitals in states that assess a provider tax on hospitals. Complete all lines as instructed below.**

**The objective of this form is to determine the state-assessed total hospital provider tax not included in your cost-to-charge ratios and per diem cost on the cost report.**

2. Line 1 should be the total hospital Provider Tax Assessment from the general ledger, whether it is included as an expense, a revenue offset, etc..

It should exclude non-hospital assessments such as a nursing facility tax unless an adjustment is made on W/S A-8 to remove the non-hospital expense.

3. Line 2 should be the total amount of the Provider Tax Assessment from line 1 that is included in Expense on Worksheet A, Column 2 of the cost report. Please report the cost report line number in which the expense is included in the box provided.
4. If there is a difference in the values you are reporting in lines 1 and 2, please explain that difference in the box provided (or attach separate explanation if it won't fit).
5. Lines 4-7 should identify any amount of the Provider Tax expense that was reclassified on Worksheet A-6 of the cost report. Please report the reasons for the reclassifications and the cost report line numbers affected in the boxes provided.
6. Lines 8-11 should identify any amount of the hospital allowable Provider Tax expense (assessed by the state) that was adjusted on Worksheet A-8 of the cost report.  
Please report the reasons for the adjustments and the affected cost report line numbers in the boxes provided.
7. Lines 12-15 should identify Provider Tax expense adjustments on Worksheet A-8 of the cost report that are not related to the actual tax assessed by the state (e.g., association fees, other funding arrangements outside of the state's assessed tax).

Please report the reasons for the adjustments and the affected cost report line numbers in the boxes provided.

8. Line 16 calculates the net Provider tax expense included in the cost report after all reclassifications and adjustments.
9. Line 17 calculates the total Provider Tax expense that has been excluded from the cost report - this amount is used to determine the amount that will be added back to your hospital's DSH UCC.
10. The amount on Line 25 may NOT be the final amount added into your DSH UCC. The examination will review the various adjustments and reconciliations and make a final determination.

**Please submit your completed cost report year surveys (Part II), along with your Part I DSH Year Survey, and uninsured data analyses (exhibits A and B) electronically to Myers and Stauffer LC. This information contains protected health information (PHI), and as such, should be uploaded to the secure web portal at <https://dsh.mslc.com> or sent on CD or DVD via U.S. mail, or via other carrier authorized to transfer PHI.**

**Submit To:**

**Myers and Stauffer LC  
Attention: DSH Examinations  
700 W. 47th Street, Suite 1100  
Kansas City, MO 64112  
Web Portal: <https://dsh.mslc.com>  
Phone: (800) 374-6858  
e-mail: [GADSH@mslc.com](mailto:GADSH@mslc.com)**