

State of Indiana
Disproportionate Share Hospital (DSH) Eligibility Survey
For State DSH Years Ending 06/30/2010 and 06/30/2011

General Instructions

1. Select the "Survey" tab in the Excel workbook. Choose "Agree or Disagree" or "Yes or No", where applicable. Provide additional information, if needed.
2. The requested data should be provided for the same period as your facility's cost reporting period that ends in State Fiscal Year 2009 (July 1, 2008 - June 30, 2009.)
3. Supporting documentation for all data elements provided within the DSH survey must be maintained for a minimum of five years.

Identification of Cost Report Needed and General Information:

1. Answer questions 6, 7, and 8 to determine if your hospital is eligible to receive DSH payments.

Section A - Out-of-State Medicaid Provider Agreements (Numbers):

1. Provide the name and Medicaid provider number for any state (other than Indiana) where you had a current Medicaid provider agreement and received claims payments during the term of the DSH year. Per federal regulation, Medicaid DSH calculations must include both in-state Medicaid services as well as out-of-state Medicaid services.

Section B - Summary of Inpatient Days and Payments:

1. This section of the survey is used to collect information to calculate the Medicaid Inpatient Utilization Rate (MIUR) and Low Income Utilization Rate (LIUR). **Please note that the numerator of the Medicaid Inpatient Utilization Rate (Medicaid-eligible days) does not include days attributable to Medicaid patients between 21 and 65 years of age in Institutions for Mental Disease (IMDs).**
2. In Column one (Eligible Days), record your routine days of care provided to patients eligible for Medicaid. Days should be taken from the "Length of Stay" Column on the Medicaid Statistical Report (MSR). In Column two (Payments Received From Medicaid), record your inpatient and outpatient payments received from Medicaid. Payments received should represent those payments that were received for dates of service within the reporting period. In other words, data will match the service period represented by the Indiana MSR.
3. This section requires support for additional information submitted. The report should not include any Medicaid days already included in the MSR. Supporting information should include the patient name, Medicaid number, and dates of service. All support must be submitted electronically on CD, using the format in Exhibits A, B and C. Unsupported days and payments will not be used. Additional documentation to support a sample from this patient listing for Medicaid eligible services may be requested.

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4. Report in this section services provided to Medicaid-eligible patients. Include both Indiana and any other state's Medicaid patients, including routine, newborn, subprovider, and special units (ICU, CCU, etc.). Include days for inpatient services, even if reimbursed by Indiana Medicaid as an outpatient visit due to the stay being less than twenty-four (24) hours. These services should be identified on your patient listing as falling under the twenty-four (24) hour rule, or a separate listing of these services should be included as support.
5. Report services provided to patients eligible under the Healthy Indiana Plan (HIP) on lines 7 and 8.
6. **Do not** include services for patients in LTC (long-term care), SNF (skilled nursing facility), ICF/MR (intermediate care facility/mentally retarded), RTC (residential treatment care), Swing beds, or non-hospital service areas. Do not include HCl or indigent care days, as they are not considered Medicaid days. Do not include services attributable to Medicaid patients between the ages of 21 and 65 in Institutions for Mental Disease with 17 or more licensed beds. Do not include Title XXI CHIP.
7. Any out-of-state services reported must be supported by an electronic report using the format in Exhibit B. Verification of supporting documentation (such as paid claims summaries, EOBs, or RAs) may occur. Reports or supporting documentation from the State Agency (or their fiscal agent) is preferred.
8. Out-of-State data collected or summarized must be for the same cost reporting period as is being used for the cost report data and in-state payment information.

***In-State FFS Medicaid Primary:** Record your in-state Medicaid fee-for-services days and payments. The payments should reconcile to your "Total Paid Amount" from the Medicaid Statistical Report (MSR). Any Medicaid eligible services not included on the MSR should be reported on line 12.

***In-State Managed Care:** Same requirements as above. If your hospital does business with more than one in-state Medicaid managed care entity, your combined results should be reported (inpatient and outpatient). Any Medicaid eligible services not included on the MSR should be reported on line 12.

***In-State Cross-Over:** Same requirements as above. Each hospital must report its Medicaid cross-over claims summary data on the survey. Total cross-over days and Medicaid payments must be reported. Any Medicaid eligible services not included on the MSR should be reported on line 12.

***Healthy Indiana Plan (HIP):** Record your HIP days and payments on lines 7 and 8.

***Out-of-State FFS Medicaid Primary:** Record your out-of-state Medicaid fee-for-services days and payments on lines 13 and 14.

***Out-of-State Managed Care:** Same requirements as above. If your hospital does business with more than one out-of-state Medicaid managed care entity, your combined results should be reported (inpatient and outpatient). Report this information on lines 15 and 16.

***Out-of-State Cross-Over:** Same requirements as above. Each hospital must report its Medicaid cross-over claims summary data on the survey. Total cross-over days and Medicaid payments must be reported. Report this information on lines 17 and 18.

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Section C - Calculation of Net Hospital Revenue from Patient Services:

1. 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 Medicare audited cost report Worksheets G-2 and G-3 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 such an allocation is not reasonable, record a single amount for hospital services and a single amount for non-hospital services on Line 1. 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. Documentation supporting the allocation method must be maintained with the hospital's DSH records. Charges and contractual adjustments should agree to the filed cost report, or to the audited financial statements if different than the filed cost reports.

Section D - Cash Subsidies from State and Local Governments and Uninsured Charges:

1. 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 box. If the subsidies do not specify inpatient or outpatient services, record the subsidies in the unspecified column. Provide documentation to support cash subsidies.
2. 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.
3. 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.
4. A portion of the charges attributable to the uninsured are also used in the calculation of the low income utilization rate. Report total charity care charges in the second part of Section D, first column. This amount should tie to your hospital's financial statements. Your charity care charges will be allocated between inpatient and outpatient, since only inpatient charity care charges are used in the LIUR calculation. Information supporting your charity care charges must be maintained by the facility in accordance with the documentation retention requirements outlined in the general instructions section. Other uninsured inpatient charges not included in the charity care charges should be reported in the second column. Support for the other uninsured inpatient charges must be submitted electronically on CD with the eligibility survey. Include patient name, Social Security number and dates of service.

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Section E - Total Hospital Inpatient Days:

1. Total number of hospital's inpatient days as reported on your cost report. Include routine, newborn, subprovider, special wards, and out-of-state days. Do not include LTC (long-term care), SNF (skilled nursing facility), ICF/MR (intermediate care facility/mentally retarded), RTC (residential treatment care), Swing Beds, or non-hospital services.

If the facility netted any of the following days from total hospital inpatient days as reported on your cost report, list how many fall into each of the following categories:

- Self-insured days (These are days for which hospitals provide inpatient services to their employees in lieu of providing health insurance as an employee benefit.)
- "Leave of absence" days (These are typically days for which patients receiving psychiatric care leave for holidays or special occasions, and their room is held for them with the expectation that they will be returning.)
- Labor and delivery days that were billed on an inpatient claim (provide support for this calculation).

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.

Exhibit A - Support of In-State Medicaid-Eligible Not on MSR:

1. See Exhibit A for a sample format of the information that needs to be available to support the data reported in Section B of the survey related to services for In-State Medicaid-Eligible Not on MSR provided. This information must be maintained by the facility in accordance with the documentation retention requirements outlined in the general instructions section.
2. Complete Exhibit A based on Indiana Medicaid hospital reimbursement methodology (only include the claims that were discharged during the cost reporting period covered by the survey). State-Operated Facilities and long term acute care (LTAC) hospitals should include all Medicaid inpatient days during the cost reporting period.
3. Indicate if the patient is an infant. In cases where the infant's SSN is unavailable, provide the mother's SSN.

Exhibit B - Support of Out-Of-State Medicaid-Eligible

1. See Exhibit B for a sample format of the information that needs to be available to support the data reported in Section B of the survey related to services for Out-Of-State Medicaid-Eligible patients. This information must be maintained by the facility in accordance with the documentation retention requirements outlined in the general instructions section.

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Exhibit C - Support of Services to Members of the Healthy Indiana Plan (HIP)

1. See Exhibit C for a sample format of the information that needs to be available to support the data reported in Section B of the survey related to Healthy Indiana Plan (HIP) services provided. This information must be maintained by the facility in accordance with the documentation retention requirements outlined in the general instructions section.
2. Complete Exhibit C based on Indiana Medicaid hospital reimbursement methodology (only include the claims that were discharged during the cost reporting period covered by the survey). State-Operated Facilities and long term acute care (LTAC) hospitals should include all HIP inpatient days during the cost reporting period.

Exhibit D - Names of Current Obstetricians on Staff

1. See Exhibit D for a sample format of the report for submitting the names of your hospital's current obstetricians.

Please submit your completed survey, along with your additional Medicaid data analyses (exhibits A, B, C and D) electronically to Myers and Stauffer LC. The data from Exhibits A, B, C and D may be submitted in Excel (.xls), Access (.mdb), Dbase or FoxPro (.dbf), or comma separated values (.csv). This information contains protected health information (PHI), and as such, should be sent on CD or DVD via U.S. mail, or via other carrier authorized to transfer PHI.

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DSH Survey Submission Checklist

- 1. Electronic copy of the Excel Survey
- 2. Electronic copy of Exhibit A - Support of In-State Medicaid-Eligible Not on MSR
 - Format can be Excel (xls), Access (mdb), Dbase (dbf), Comma Separated Values (CSV)
- 3. Electronic copy of Exhibit B - Support of Out-Of-State Medicaid-Eligible
 - Format can be Excel (xls), Access (mdb), Dbase (dbf), Comma Separated Values (CSV)
- 4. Electronic copy of Exhibit C - Summary of Services to Members of the Healthy Indiana Plan (HIP)
 - Format can be Excel (xls), Access (mdb), Dbase (dbf), Comma Separated Values (CSV)
- 5. Electronic copy of Exhibit D - Names of Current Obstetricians on Staff
 - Format can be Excel (xls), Access (mdb), Dbase (dbf), Comma Separated Values (CSV)
- 6. Documentation supporting out-of-state DSH payments received during all cost report periods covered by the survey
 - Examples may include remittances and detailed general ledgers

All electronic (CD or DVD) and paper documentation can be mailed (using certified or other traceable delivery) to:

Myers and Stauffer
ATTN: DSH Eligibility
9265 Counselors Row, Suite 200
Indianapolis, Indiana 46240-6419
Fax: (317) 571-8481
Phone: 1-800-877-6927

Please call Myers and Stauffer at 1-800-877-6927 if you have any questions on completing the DSH survey.

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Facility Name: 1-a

For State Fiscal years 2010 and 2011

Identification of Cost Report Needed:

	Cost Report Begin Date		Cost Report End Date
Cost Report Begin Date (The begin date must be on or before the DSH year begin date)	2-a	Cost Report End Date	2-b
Medicaid Claims Data Cut-Off Dates:	Inpatient FFS -	3-a	
	Inpatient MC -	4-a	
	Outpatient FFS -	5-a	
	Outpatient MC -	6-a	

General Information:

The following information is provided based on the information we received from the state. Please review this information for items 1 through 5 and select 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. Select Yes or No to questions 6 through 8.

	Data	If Disagree Proper Information
1. Hospital Name: (Hospital Name)	1-a	<div style="border: 1px solid black; height: 20px;"></div>
2. Medicaid Provider Number: (Medicaid Number)	9-a	<div style="border: 1px solid black; height: 20px;"></div>
Medicaid Subprovider Number 1 (Psychiatric or Rehab):	<div style="border: 1px solid black; height: 20px;"></div>	<div style="border: 1px solid black; height: 20px;"></div>
Medicaid Subprovider Number 2 (Psychiatric or Rehab):	<div style="border: 1px solid black; height: 20px;"></div>	<div style="border: 1px solid black; height: 20px;"></div>
3. Medicare Provider Number: (Medicare Number)	10-a	<div style="border: 1px solid black; height: 20px;"></div>
4. Type of Hospital: (Acute, LTC, Psych, Teaching, Children's, other)	11-a	<div style="border: 1px solid black; height: 20px;"></div>
5. Type of Ownership: (Private, State Govt, Non-State Govt, IHS/Tribal)	12-a	<div style="border: 1px solid black; height: 20px;"></div>
Obstetrician Requirement:		
6a. Did the hospital have at least two obstetricians who had staff privileges at the hospital and who agreed to provide obstetric services to Medicaid-eligible individuals through the cost reporting period listed at the top of this survey? (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 obstetric procedures.)	<div style="border: 1px solid black; height: 20px;"></div>	<div style="border: 1px solid black; height: 20px;"></div>
6b. Does the hospital currently have at least two obstetricians who have staff privileges at the hospital and who agree to provide obstetric services to Medicaid-eligible individuals? (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 obstetric procedures.) Provide names of hospital's current obstetricians in Exhibit D.	<div style="border: 1px solid black; height: 20px;"></div>	<div style="border: 1px solid black; height: 20px;"></div>
7. Was the hospital exempt from the requirement listed under #6 above because the hospital's inpatients are predominantly under 18 years of age?	<div style="border: 1px solid black; height: 20px;"></div>	<div style="border: 1px solid black; height: 20px;"></div>
8. Was the hospital exempt from the requirement listed under #6 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? (This exception does not apply to facilities that opened after 12/22/87.)	<div style="border: 1px solid black; height: 20px;"></div>	<div style="border: 1px solid black; height: 20px;"></div>

A. Out-of-State Medicaid Provider Number. List all states with which your hospital had a Medicaid provider agreement during the DSH year if related data for that state is also included:

		Provider No.
1. State Name & Number	<div style="border: 1px solid black; height: 20px;"></div>	<div style="border: 1px solid black; height: 20px;"></div>
2. State Name & Number	<div style="border: 1px solid black; height: 20px;"></div>	<div style="border: 1px solid black; height: 20px;"></div>
3. State Name & Number	<div style="border: 1px solid black; height: 20px;"></div>	<div style="border: 1px solid black; height: 20px;"></div>
4. State Name & Number	<div style="border: 1px solid black; height: 20px;"></div>	<div style="border: 1px solid black; height: 20px;"></div>
5. State Name & Number	<div style="border: 1px solid black; height: 20px;"></div>	<div style="border: 1px solid black; height: 20px;"></div>
6. State Name & Number	<div style="border: 1px solid black; height: 20px;"></div>	<div style="border: 1px solid black; height: 20px;"></div>
7. State Name & Number	<div style="border: 1px solid black; height: 20px;"></div>	<div style="border: 1px solid black; height: 20px;"></div>
8. State Name & Number	<div style="border: 1px solid black; height: 20px;"></div>	<div style="border: 1px solid black; height: 20px;"></div>
9. State Name & Number	<div style="border: 1px solid black; height: 20px;"></div>	<div style="border: 1px solid black; height: 20px;"></div>
10. State Name & Number	<div style="border: 1px solid black; height: 20px;"></div>	<div style="border: 1px solid black; height: 20px;"></div>

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Facility Name: 1-a

For State Fiscal years 2010 and 2011

B. Summary of Inpatient Days and Payments, Attributable to Patients Eligible for Medical Assistance

Patient Type	Eligible Days	Payments Received From Medicaid
1. Medicaid Indiana FFS - Inpatient Claims	21-a	21-b
2. Medicaid Indiana FFS - Outpatient Claims		22-b
3. Medicaid Indiana MCO - Inpatient Claims	23-a	23-b
4. Medicaid Indiana MCO - Outpatient Claims		24-b
5. Medicaid Indiana Cross-Overs - Inpatient Claims	25-a	25-b
6. Medicaid Indiana Cross-Overs - Outpatient Claims		26-b
7. Healthy Indiana Plan (HIP) - Inpatient [Exhibit C needed]		
8. Healthy Indiana Plan (HIP) - Outpatient [Exhibit C needed]		
9. SFY2009 Supplemental Payment to Privately Owned Hospitals		29-b
10. SFY2009 Indiana Medicaid Municipal Hospital Payment		30-b
11. SFY2009 Safety Net Payment		31-b
12. Medicaid - Indiana - eligible not included in Claims Reports [Exhibit A needed]		
13. Medicaid Out-of-State FFS - Inpatient [Exhibit B needed]		
14. Medicaid Out-of-State FFS - Outpatient [Exhibit B needed]		
15. Medicaid Out-of-State MCO - Inpatient [Exhibit B needed]		
16. Medicaid Out-of-State MCO - Outpatient [Exhibit B needed]		
17. Medicaid Out-of State Cross-Overs - Inpatient [Exhibit B needed]		
18. Medicaid Out-of State Cross-Overs - Outpatient [Exhibit B needed]		
Total	-	-

C. Calculation of Net Hospital Revenue from Patient Services

	Total Patient Revenues			Contractual Adjustments			Net Hospital Revenue (G=A+B-D-E)
	Inpatient Hospital (A)	Outpatient Hospital (B)	Non-Hospital (C)	Inpatient Hospital (D)	Outpatient Hospital (E)	Non-Hospital (F)	
1. Hospital							-
2. Psych Subprovider							-
3. Rehab. Subprovider							-
4. Swing Bed - SNF							-
5. Swing Bed - NF							-
6. Skilled Nursing Facility							-
7. Nursing Facility							-
8. Other Long-Term Care							-
9. Intensive Care Unit							-
10. Coronary Care Unit							-
11. Burn Intensive Care Unit							-
12. Surgical Intensive Care Unit							-
13. Other Special Care							-
14. Ancillary Services							-
15. Outpatient Services							-
16. Home Health Agency							-
17. Ambulance							-
18. Outpatient Rehab Providers							-
19. ASC							-
20. Hospice							-
21. Other							-
Total	-	-	-	-	-	-	-
Total Hospital and Non Hospital		Total from Above			Total from Above		
		Total Patient Revenues (G-3 Line 1)	41-a		Total Contractual Adj. (G-3 Line 2)	41-b	
		Unreconciled Difference (Should be \$0)	#VALUE!		Unreconciled Difference (Should be \$0)	#VALUE!	
				Total Net Patient Revenue		-	
				Total Net Patient Revenue per Audited Financial Statement			
					Difference		-

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Facility Name: 1-a

For State Fiscal years 2010 and 2011

D. Cash Subsidies for Patient Services Received from State or Local Governments and Charity Care and Additional Uninsured Charges:

	Inpatient Hospital Cash Subsidies	Outpatient Hospital Cash Subsidies	Unspecified I/P and O/P Hospital Cash Subsidies	Total Hospital Cash Subsidies
Cost Report Year	<input type="text"/>	<input type="text"/>	<input type="text"/>	\$ -
	(Supporting documents required for cash subsidies)			

	Charity Care Charges Reported on Financial Statements	Additional Uninsured Inpatient Charges Not Included in Charity Care
Cost Report Year	<input type="text"/>	<input type="text"/>
	(Supporting documents must be provided)	

E. Total Hospital Inpatient Days

1. Total number of hospital's inpatient days as reported on the cost report	<input type="text"/>
2. Hospital inpatient days deducted from total for cost reporting purposes (See Instructions)	<input type="text"/>
Total	<input type="text"/>

Certification:

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

Hospital CEO or CFO

Date

Title

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

Hospital Contact:

Name

Title

Telephone Number

E-Mail Address

Outside Preparer:

Name

Title

Firm Name

Telephone Number

E-Mail Address

EXHIBIT A

Summary of In-State Medicaid-Eligible Not on MSR

Patient Identifier			Date(s) of Service		Inpatient XIX-Eligible Days	Medicaid Payments
Indiana Medicaid Recipient Number	Social Security Number (XXX-XX-XXXX)	Name	From	To		

Please submit the above data in an electronic file included with this survey document. The electronic file can be in several formats including Excel (.xls), Access (.mdb), Dbase (.dbf), and Comma Separated Values (CSV).

Exhibit B

Summary of Out-Of-State Medicaid-Eligible

Patient Identifier			Date(s) of Service		Inpatient XIX-Eligible Days	Medicaid Payments
Medicaid Recipient Number	Social Security Number (XXX-XX-XXXX)	Name	From	To		

Please submit the above data in an electronic file included with this survey document. The electronic file can be in several formats including Excel (.xls), Access (.mdb), Dbase (.dbf), and Comma Separated Values (CSV).

EXHIBIT C

Summary of Services to Members of the Healthy Indiana Plan (HIP)

Patient Identifier			Date(s) of Service		Inpatient HIP-Eligible Days	HIP Payments
Recipient Number	Social Security Number (XXX-XX-XXXX)	Name	From	To		

Please submit the above data in an electronic file included with this survey document. The electronic file can be in several formats including Excel (.xls), Access (.mdb), Dbase (.dbf), and Comma Separated Values (CSV).

EXHIBIT D

Names of Current Obstetricians on Staff

Last name	First Name

Please submit the above data in an electronic file included with this survey document. The electronic file can be in several formats including Excel (.xls), Access (.mdb), Dbase (.dbf), and Comma Separated Values (CSV).