

State of Colorado
Department of Health Care Policy and Financing
Uniform Inpatient and Outpatient Medicaid and Uninsured Care Cost and Charge Report
Frequently Asked Questions – UPDATED April 2014

The Department of Health Care Policy and Financing (the Department) worked with Public Consulting Group (PCG) to create a Uniform Cost Report (UCR) template to streamline data reporting needs for Disproportionate Share Hospital (DSH) audits and the Hospital Provider Fee Survey. This document compiles frequently asked questions (FAQs) about the UCR template (as of April 2014).

The FAQ document is broken into sections:

- UCR Process Questions;
- UCR Data Questions;
- DSH Certifications and Statistics;
- Provider Fee Model Statistics; and
- Medicare Cost Report Questions.

UCR Process Questions:

1. Q: Is my hospital required to complete the UCR?

A: Yes. The Department requires the UCR for purposes of DSH and the Provider Fee, which involve federal funds. In order to keep the federal funds associated with these programs, hospitals must complete the UCR.

2. Q: Will the UCR replace another report?

A: Yes, it replaces the Hospital Provider Fee Model Survey. The Department continues to identify any other required hospital reports that can be replaced by the UCR. Such changes will take place in future reporting years.

3. Q: How long should it take me to complete the UCR?

A: The completion time for each hospital will depend on the hospital and the resources available.

4. Q: Is this a one-time request?

A: No. While this process is in its second year, the requirement will continue for the foreseeable future. Hospitals will need to complete the UCR on an annual basis, in the spring.

5. Q: Will previous year's data be locked? Can or should we make changes? Who should be notified if changes need to be made?

A: Yes, data previously reporting in the UCR system is locked and can no longer be edited. If any changes need to be made, you must notify and discuss with PCG or the Department. All UCR related questions should be directed to the following e-mail address: CO_UCR@pcgus.com.

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6. Q: Currently, Long Term Care, Rehabilitation, and Psychiatric hospitals are excluded from the Provider Fee Model. Will these hospital types need to complete the DSH reporting?

A: No, the Long Term Care, Rehabilitation, and Psychiatric hospital types will not need to complete the DSH reporting schedules. However, these hospital types will be given access to the UCR to respond to the Provider Fee Model Statistics questions.

7. Q: What type of data will my hospital need to report on the UCR?

A: Hospitals will need to report inpatient and outpatient hospital days, charges, and payments for different payer categories related to the Medicaid and uninsured population. The UCR will not collect data that is outside of the State definition of inpatient and outpatient hospital services. Data for Federally Qualified Health Centers (FQHCs), physician, pharmacy, and ambulance services are outside the State definition of inpatient and outpatient hospital services and will thus not be reported on the UCR.

8. Q: Will the UCR be auto-populated with previously reported data?

A: Yes, the document will be auto-populated to the greatest extent possible. The Department believes that such auto-population of data should keep the level of effort and time required for each hospital to complete the UCR to a minimum. Auto-populated data will include information from a hospital's Medicare CMS-2552 cost report form and also information from the Department's Medicaid Management Information System (MMIS), and the Colorado Financial Reporting System (COFRS).

Please note that the Department will auto-populate the data for Cost Report Year 2012 after hospitals have reported their data. This auto-population will take place in June 2014.

9. Q: How will the UCR data be auto-populated?

A: The UCR data will be auto-populated using two standard crosswalks. The first crosswalk maps Medicare cost report lines to Medicare cost centers. This crosswalk will be used to populate the UCR with necessary cost, charge, and day information from each hospital's Medicare CMS-2552 cost report. The UCR will also take into consideration any hospital-specific cost centers.

The second crosswalk will be used to crosswalk Medicaid claims data to Medicare cost centers using the revenue code on each claim line. The UCR will use a standard crosswalk issued by the Centers for Medicare and Medicaid Services (CMS). The Department acknowledges that hospitals may not adhere to the CMS standard crosswalk in their internal records. However, the Department believes that the standard crosswalk will allow most hospitals to demonstrate that they have met their DSH threshold. The Department may contact individual hospitals to discuss a hospital-specific crosswalk.

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However, such a discussion will take place on a hospital by hospital basis and will be initiated by the Department.

10. Q: What if my hospital’s crosswalk differs from the standard crosswalk?

A: The Department acknowledges that hospitals may not adhere to the CMS standard crosswalk in their internal records. However, the Department believes that the standard crosswalk will allow most hospitals to demonstrate that they have met their DSH threshold. If the Department finds that there is an issue with a hospital specific DSH limit, then the Department will explore the use of a hospital-specific, non-standard crosswalk with that hospital on a hospital by hospital basis and will be initiated by the Department.

11. Q: What if my hospital’s records have different data than what is auto-populated?

A: The DSH Final Rule states that when the State has the most central and current information through its MMIS data, that data should be utilized. The Department realizes that this may limit a hospital’s ability to reconcile some data elements in the UCR. Hospitals can contact the Department to discuss significant discrepancies.

12. Q: Why is it necessary to report “service utilization days” or “ancillary and routine service cost center” information?

A: This information is necessary because CMS uses it to determine cost center specific routine per diems and ancillary ratios of cost to charges following the Medicare cost allocation process. The data is used to determine a hospital’s costs for providing services to Medicaid eligible and uninsured individuals.

13. Q: My hospital does not currently maintain the detailed level of information required by this UCR.

A: The Department recognizes that hospitals may need to change their reporting and tracking processes in order to report this information. It will be important for hospitals to know that this is not a one-time request only. The UCR will be completed annually by hospitals.

14. Q: Will the UCR be completed using audited Medicare CMS-2552 cost reports?

A: CMS prefers that hospitals use audited Medicare cost reports when reporting information for DSH purposes. If an audited Medicare cost report is not available, CMS expects hospitals and the state to rely on the best available information. An example of best available information is an as filed Medicare cost report.

If a hospital cost report is revised, please contact PCG using the following email address:
CO_UCR@pcgus.com.

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15. Q: For what time period should hospitals report information?

A: Hospitals should report information based on their cost report year. The Department understands that your hospital cost report year may not align with your hospital fiscal year.

16. Q: If my hospital's fiscal year does not correspond to the State Fiscal Year (7/1-6/30), how do I report the correct data to the Department?

A: Hospitals should report information based on their cost report year.

17. Q: If my hospital changed ownership and/or modified its cost reporting period, how should I report the correct data to the Department the UCR?

A: If your hospital's cost report year is less than twelve months, please contact PCG (CO_UCR@pcgus.com).

18. Q: What should I do if information that I reported in my hospital's UCR changes?

A: Please contact PCG (CO_UCR@pcgus.com) if any changes need to be made to information previously submitted.

As a reminder, hospitals will be expected to keep copies of any information that supports the data reported in their UCR for six (6) years.

UCR Data Questions:

19. Q: What if my hospital has more than one Medicare provider number?

A: Hospitals should use their hospital Medicare number (that is used to file the CMS-2552 cost report), not any other number for a distinctly licensed unit.

20. Q: Should Days by Payer be reported using a census or a discharge basis?

A: Days by Payer will be reported on the UCR on a discharge basis. The Department understands that the total days for a hospital are reported on the Medicare CMS-2552 cost report on a census basis and, therefore, the days reported by payer and the total days from the cost report will not reconcile; there will be no reconciliation between the two data sources. The total days from the Medicare CMS-2552 cost report will be used to calculate a per diem cost that will then be multiplied by the different days by payer to calculate an inpatient routine cost for the payer.

The Department reminds all hospitals that they must maintain the backup documentation used to populate the UCR report.

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21. Q: Where do swing beds get reported?

A: Hospitals should not include any data related to swing beds on the UCR. For the purposes of the DSH audit, swing beds are not considered an allowable hospital service that can be included in the calculation of hospital cost.

22. Q: What is “Medicaid Fee for Service (FFS) not billed to Medicaid”?

A: This category is used for Medicaid eligible individuals that were not billed to Colorado Medicaid. These claims could be for Medicaid out of state clients that were not billed to an out of state Medicaid agency or Medicaid eligible patients with a third-party insurer. When reporting “Medicaid FFS payments not billed to Medicaid” a provider should include any third-party payments, deductibles paid by the patient, and/or coinsurance payments for Medicaid eligible individuals. This category excludes individuals who were billed to Medicaid and denied. This may not apply to every hospital.

23. Q: How should I report Medicaid pending patients?

A: For DSH purposes, Medicaid pending patients cannot be reported on the UCR or in the calculation of the hospital specific DSH limit. Hospitals will need to complete their UCR with the best available data at the time of submission.

Please contact PCG (CO_UCR@pcgus.com) if any changes need to be made to information previously submitted.

24. Q: What if my hospital cannot distinguish between out-of-state Medicaid FFS and out-of-state Medicaid Managed Care?

A: If your hospital is not able to separate out-of-state Medicaid FFS and out-of-state Medicaid Managed Care, you may report all out-of-state Medicaid activity under one category, out-of-state Medicaid FFS, for DSH purposes. There is a distinction made on the provider fee between managed care and non-managed care days. There is a discounted fee for managed care days. Therefore, to the extent possible, it is in a hospital’s interest to separately report Medicaid FFS and Medicaid managed care days.

25. Q: Should payments be reported based on date of service or date of payment?

A: Payments are to be reported based on date of service, so as to line up with the days and charges, which are also reported based on date of service.

26. Q: How should a hospital report payments if a portion of the payments it receives are for professional fees (hospital based physician fees)?

A: In Colorado, the Medicaid State Plan does not currently include physician services as a hospital service cost. The DSH limit is determined by computing a hospital’s “cost of

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providing hospital services” to Medicaid eligible and uninsured individuals. Hospital services are those service approved by the Medicaid State Plan as inpatient and outpatient services. In Colorado, physician services are not considered to be “hospital service costs” since these costs are usually identified as professional costs. These costs are removed from a hospital’s inpatient and outpatient hospital costs through the costs step-down process used in the Medicare cost report.

However, in cases where the state consistently includes physician services as an integral part of outpatient hospital services and does not make a separate payment for physician services, then the state can use the same methodology for calculating the hospital’s DSH limit. Medicaid outpatient costs for hospital-based physicians are only to be used in cases when the state bundles outpatient payments with the physician rate for outpatient services and the hospital is unable to separate out the physician-related component of the outpatient payment.

If a hospital cannot reasonably identify separate payments for outpatient hospital services and physician services billed together, the hospital may need to allocate the payments based on the ratio of charges for hospital services to total charges, or another reasonable allocation method.

27. Q: What are “Section 1011” payments?

A: Section 1011 payments are made to hospitals for when they provide specific services to undocumented residents that would not otherwise be reimbursed through insurance or another method. If a hospital receives Section 1011 payments, then it must obtain and report this information using its audited financial statements or accounting records. A portion of Section 1011 payments are recognized as an amount paid on the behalf of the uninsured and this amount is used to offset a hospital’s uncompensated care costs.

Please note that this category may not apply to your hospital.

28. Q: Does the Medicaid Managed Care payer category include patients with Colorado Behavioral Health Organization (BHO) coverage?

A: Yes.

29. Q: How is “managed care” defined?

A: Consumers with managed care are generally restricted to a specified or preferred network of providers. Examples of Managed Care plans include: AETNA (Aetna Quality POS, Aetna HMO, Aetna Managed Choice POS, Aetna Open Choice PPO), Anthem Wellpoint (Premier PPO, Lumenos HSA Plus, SmartSense Plus, CoreShare Plus, Clear Protection, Tonik, HMO Colorado) Blue Cross/Blue Shield (include plans that restrict clients to a preferred network of providers, and Blue Cross/Blue Shield has a contractual arrangement with the provider), Cigna/Great West (Cigna HMO, Cigna PPO, Cigna POS,

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Cigna OAP, Cigna Consumer Advantage, Great West Life PPO, Great West Life POS), Rocky Mountain Health Plan (SOLO Outlook PPO), Kaiser Permanente (Kaiser Traditional HMO, Kaiser Deductible/Coinsurance HMO, Kaiser HMO Plus, Kaiser Deductible/Coinsurance HMO Plus, Kaiser PPO, Kaiser Added Choice POS, Kaiser MultiChoice POS), PacifiCare (PacifiCare Signature Value HMO, PacifiCare Signature POS, PacifiCare SignatureElite PPO), United Healthcare (United Choice Plus, United Options PPO, United Choice, United HMO, United Healthcare Core, United Healthcare Catalyst, United Healthcare EDGE, United Healthcare Tiered Benefits), Humana (Copay Plans, 100% After Deductible Plans), Other HMO (not listed elsewhere), Other PPO (not listed elsewhere), Other POS (not listed elsewhere), Other EPO (not listed elsewhere), Other Managed Care (not listed elsewhere). This category may also include TriCare and other government managed care plans.

30. Q: How is “uninsured” defined?

A: An uninsured person is defined as any individual determined to have no source of third-party insurance. Individuals with a policy that provides excepted benefits are included in this category unless their insurance pays for the coverage of a hospital stay.

Colorado Indigent Care Program (CICP) clients without third-party insurance would be included in the uninsured category. Do not include CICP clients who have third-party insurance.

Do not include unpaid patient coinsurance and deductibles in this category.

31. Q: What are “cash subsidies from state and local governments”?

A: These are cash payments from state and local governments given to a hospital for services provided to non-Medicaid eligible individuals during the hospital’s fiscal year. Providers should obtain and report this information using audited financial statements and accounting records. This information is used to calculate a hospital’s Low-Income-Utilization-Rate (LIUR), which is used to qualify a hospital as Medicaid DSH eligible.

This category does not include any payments from the Department (State Medicaid agency). Any payments from the Department will be auto-populated into each hospital’s UCR.

Please note that this category may not apply to your hospital.

32. Q: If we bill Medicaid for a client but Medicaid does not pay, does it show up in the report?

A: Claims submitted to Medicaid that are determined to be allowable claims that would receive Medicaid reimbursement but for which no actual payment is made by Medicaid (because another third party is the primary payer and Medicaid has no further liability) would be included in the MMIS data and included in the DSH cost calculation. Claims

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submitted to Medicaid that are denied are not Medicaid allowable and are also not allowable for purposes of the DSH cost calculation.

33. Q: Where do Medicaid pending cases show up in the data? These cases could have a large impact on a hospital's DSH limit.

A: Pending cases will not be in the MMIS until they are resolved. Please contact PCG (CO_UCR@pcgus.com) if any changes need to be made to information previously submitted.

34. Q: How will providers identify the CICIP money received just for the uninsured?

A: Providers do not need to report any CICIP payments on the UCR. The Department has the CICIP payments on file and will populate that information into the UCR.

35. Q: Are distinct hospital units that have separate provider numbers (skilled nursing facility, long term care, etc.) included in the DSH calculations?

A: While these units cannot be included in the final DSH calculations, the UCR has been designed to ask for information related to these types of units/Medicare cost centers. This provides the Department with assurances that hospitals are reporting appropriately, that is, not including data for these units on the same row as their hospital units. For the DSH cost calculations, the Department will include only those hospital units/cost centers that are allowable for DSH purposes in the calculation.

36. Q: How will the certification process work? Who can certify the report? Will an electronic sign-off on the report be acceptable?

A: An electronic signature certifying the DSH template data will be acceptable. The Department asks hospitals to use the Medicare requirements for certification of the cost report as the level within the organization that is required to certify the report. In other words, whoever signs off on the Medicare Cost report is fine for the UCR, also.

Please note that the Department's DSH Auditor, Myers and Stauffer, may send a separate request for data to hospitals as part of their audit work.

37. Q: What data is being certified?

A: Hospitals are certifying the data supplied by them and attest that they will maintain the documentation for at least 7 years. The federal DSH rules also require that hospitals certify that they received DSH money. We are asking hospitals to certify those items, not the cost calculations.

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DSH Certifications and Statistics

38. Q: What if my facility does not have 2 Obstetricians with staff privileges at the hospital who agree to provide nonemergency obstetric services to Medicaid clients?

A: A facility will not qualify to receive DSH payments if it does not have 2 Obstetricians with staff privileges at the hospital who agree to provide nonemergency obstetric services to Medicaid clients unless it meets one of the following exceptions:

- (1) In the case of a hospital located in a rural area outside a Metropolitan Statistical Area (MSA) or Core-Based Statistical Area (CBSA) (as defined for purposes of Section 1886), the term “obstetrician” includes any physician with staff privileges at the hospital to perform nonemergency obstetric procedures. In this instance, providers must still report the names, and NPIs or UPINs of the physicians that satisfy the requirement under this exception.
- (2) If your facility is a pediatric hospital that predominantly provides services to individuals under 18 years of age, the OB requirement does not apply. Facilities that fall under this exception are not required to report physicians for survey question 21. (In Colorado, this only applies to the Children’s Hospital Colorado.)
- (3) If your facility does not offer non-emergency obstetric services as of December 21, 1987, the OB requirement does not apply. Facilities that fall under this exception are not required to report physicians for survey question 21. (In Colorado, this only applies to National Jewish Health and Family Health West.)

39. Q: If a hospital meets the requirements for the MIUR, are they required to input the information for the LIUR?

A: Yes, the Department requires that hospitals provide all information that may be used for DSH audit purposes on the UCR. However, as a reminder to hospitals, if a hospital meets the requirements of the MIUR, then the LIUR results will not be used to establish eligibility for DSH.

Provider Fee Model Statistics

40. Q: Should Days by Payer be reported using a census or a discharge basis?

A: Days by Payer will be reported on a discharge basis.

41. Q: Are the days reported only for hospital days?

A: Yes. For the purposes of the Provider Fee Model, do not report days related to swing-beds, long term care, nursing facility, home health, or residential treatment centers. Inpatient days for rehabilitation and psychiatric care should be reported. This may include distinct part unit rehabilitation or psychiatric care, or sub-acute rehabilitation and psychiatric care.

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42. Q: For the Provider Fee Model, there is a specific question related to a distinct part psychiatric unit. Does this unit need to be active during a particular time period? For example, at my hospital, we had an operational distinct part psychiatric unit during the time period of the data being requested, but the unit is now closed.

A: In this case, **currently** is define as the time that the UCR is being certified. Therefore, answer “yes” if your facility has an active psychiatric unit at the time you certify the UCR.

A pediatric specialty hospital may still qualify for the Acute Care Psychiatric supplemental payment if it has the characteristics required to qualify as a distinct part unit. These qualifying characteristics are:

- Meet state licensing requirements;
- Have a separate admissions and discharge records from the hospital in which it is located;
- Have a ward that is physically separate from the rest of the hospital (beds are not comingled);
- Report costs for the unit as a separate cost center, and maintain adequate statistical data to support the cost allocation of costs; and
- Have the appropriate staff and equipment to provide inpatient psychiatric care.

Medicare Cost Report Questions

43. Q: The electronic cost reports are to be submitted with the Provider Fee amounts removed but do those amounts flow back through the UCR?

A: Yes, the Department will add the Medicaid portion of the Provider Fee in as a separate allowable cost using an allocation of inpatient days or outpatient charges.

44. Q: Will the Department request a copy of my hospital Medicare cost report with the Provider Fee expense removed every year?

A: Yes. Hospitals can plan to submit a copy of the Medicare cost report with the Provider Fee expense removed on an annual basis, at the time that the hospital files its Medicare report.