

CMS DSH Report and Audit Frequently Asked Questions

1. What is the CMS DSH Report?

In accordance with Federal regulation, 42 C.F.R. §447.299(c), Pennsylvania (PA) Medicaid is required to annually submit a report to the Centers for Medicare and Medicaid Services (CMS) for the purpose of determining PA Medicaid's compliance with Section 1923 of the Social Security Act (SSA) relating to disproportionate share hospital (DSH) limits. The regulation requires that the report consist of eighteen (18) specific data elements for each PA hospital that received a DSH payment. In addition, the report must undergo an audit as required by 42 C.F.R. Part 455 Subpart D.

2. Is submission of the CMS DSH Report a new requirement?

No. The PA Department of Human Services (Department) has prepared DSH reports as required by CMS for State Plan Rate Years (SPRY) 2005, 2006, 2007, 2008, 2009 and 2010. These reports were prepared, audited and submitted and are subject to the transition provisions of 42 C.F.R. §455.304(e); that is, findings for Medicaid SPRYs 2005 through 2010 are given weight only to the extent that they draw into question the reasonableness of State uncompensated care costs estimates used for calculations of prospective DSH payments for Medicaid SPRY 2011 and thereafter.

These DSH reports, along with the audit reports, can be accessed on CMS' website at <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Financing-and-Reimbursement/Medicaid-Disproportionate-Share-Hospital-DSH-Payments.html> within the *Annual DSH Reports* section.

Under 42 C.F.R. §455.304(a)(2), beginning with Medicaid SPRY 2011 (July 1, 2010 through June 30, 2011), Federal financial participation (FFP) is not available in expenditures for DSH payments that are found in the independent certified audit to exceed the hospital-specific eligible uncompensated care cost limit. The hospital-specific uncompensated care cost limit is also referred to as a hospital's Upper Payment Limit (UPL).

The report and audit for Medicaid SPRY 2011 were due to CMS by December 31, 2014. Likewise, future report and audit submissions are due to CMS no later than December 31 of the Federal fiscal year ending three years from the Medicaid SPRY year under audit.

3. What does federalizing mean?

The Medicaid program is jointly funded by the federal government and states. The federal government pays states for a specified percentage of program expenditures,

called the Federal Medical Assistance Percentage (FMAP).¹ States may claim federal funding in accordance with their CMS-approved State plan.

Many PA Medical Assistance (MA) payments consist of both State and Federal funding. Some payments are for specific billable services in the form of claim payments made directly by the Department or by Medicaid Managed Care organizations. In addition, lump-sum MA DSH and supplemental payments are processed by the Department periodically during the fiscal year.

Please reference the following information from CMS regarding FFP: <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Financing-and-Reimbursement/Financing-and-Reimbursement.html>.

4. What is DSH UPL / What is the difference between the prospective DSH UPL process and this CMS DSH Report?

DSH UPL is a federally imposed upper payment limit (UPL) on disproportionate share hospital (DSH) payments. See 42 U.S.C. §1396r-4(g). A hospital's DSH payments may not exceed the costs incurred by that hospital in furnishing services during the year to Medicaid patients and the uninsured, less other Medicaid payments made to the hospital, and payments made by uninsured patients ("uncompensated care costs").²

The Department reviews each hospital's DSH limit in two separate processes as described below.

Process 1: The Department annually prepares a prospective DSH UPL analysis for each hospital. This analysis utilizes historical utilization and financial data trended forward to estimate uncompensated care costs and related payments for the current fiscal year. This prospective UPL is utilized by the Department to limit DSH payments that may be in excess of hospital uncompensated care costs for the fiscal year. Since the prospective DSH UPL analysis is an estimate of uncompensated care costs and related payments, hospitals with DSH payments at risk of exceeding uncompensated care costs are notified and are provided an opportunity to submit additional information to better estimate uncompensated care costs and related payments for the fiscal year under review.

Process 2: The Department annually prepares a Medicaid DSH Report as required by Section 1923 of the Social Security Act (42 U.S.C. §1396r-4(j)). This report utilizes financial data pertinent to the year of the report and is based on actual, not estimated, uncompensated care charges (which are converted to costs) and related payments for the particular fiscal year. The prepared DSH report undergoes an independent audit prior to submission to CMS. The DSH report and audit for Medicaid SPRY 2011 were due to CMS by December 31, 2014. Likewise, future report and audit submissions are due to

¹ "Financing & Reimbursement | Medicaid.gov." *Financing & Reimbursement | Medicaid.gov*. N.p., n.d. Web. 06 Nov. 2014.

² 73 FR 77904 and 79 FR 71679-71694

CMS no later than December 31 of the Federal fiscal year ending three years from the Medicaid SPRY under audit.

5. Why is Pennsylvania preparing a report for a fiscal year from 3-4 years ago?

CMS regulations require that each report and accompanying audit be submitted to CMS no later than December 31 of the Federal fiscal year ending three years after the Medicaid SPRY under audit. See 42 C.F.R. §455.304(b).

6. Why is the Department asking for information specific to the charges and revenue for patients covered by other states' Medicaid programs?

The CMS regulations require the DSH Report to include costs incurred and revenue received by hospitals for out-of-state Medicaid beneficiaries. See 42 C.F.R. §447.299(c). The Department is able to capture such payments and estimate costs associated with the managed care delivery system by utilizing information reported on the Schedule S7 of the MA-336 Hospital Cost Report which includes both PA and out-of-state charges and revenue. The same is not true for fee-for-service inpatient and outpatient services. Following CMS protocol, the Department utilizes the Medicaid Management Information System (MMIS) as the source for PA Medicaid fee-for-service costs and payments. Since the Department's MMIS captures information related solely to PA beneficiaries, the Department is requesting hospitals provide information specific to out-of-state fee-for-service Medicaid beneficiaries.

7. Why is the Department asking for information specific to the underinsured population?

While lines 11 and 12 of FY 2012-2013 Schedule S-7, Part I relate to Self-Pay and Uninsured charges and revenues, the reported amounts may include elements of charity care that do not qualify for inclusion under CMS Guidelines, while charges and revenues related to the underinsured (those with insurance, but no coverage for the specific service received) are permitted, but may not have been reported on the S-7 schedule. While charges related to the General Assistance (GA) population are considered uninsured under CMS Guidelines, the Department is able to identify federalized GA revenue by utilizing the Department's federal reporting records in conjunction with MMIS data and is therefore not requesting information related to GA patients.

8. Isn't self-pay and uninsured information already available to the Department via the MA-336 Hospital Cost Report?

Yes. However, information related to self-pay, uninsured and General Assistance (GA) beneficiaries is not separately identifiable as self-pay or uninsured versus GA. Refer to FAQ #7.

The Department is able to determine the fee-for-service GA charges and revenue by utilizing the Department's claims processing records. However, in some cases GA

charges and/or revenue obtained from the claims processing system are more than the charges and/or revenue reported on lines 6 and 7 of the S7 Schedule. For this reason, the Department is providing each hospital with a copy of its MA-336 Hospital Cost Report Schedule S7 and is requesting each hospital provide the Department with the portion of charges and revenue specific to self-pay and uninsured reported on lines 6 and 7, exclusive of GA.

If you determine your MA-336 Hospital Cost Report contains an error, please see FAQ #13.

9. Who is considered uninsured?

For Medicaid DSH UPL calculation purposes, individuals with no source of third party coverage for the hospital services they receive are considered uninsured. Further, non-Medicaid patients covered by state or local governmental programs are also considered uninsured. This includes self-pay and underinsured individuals as well as GA recipients. For a detailed definition, please refer to CMS' Final Rule effective December 31, 2014, 79 FR 71679-71694.

10. What is underinsured?

CMS' Final Rule published December 3, 2014, 79 FR 71679-71694, provides a detailed explanation of underinsured effective December 31, 2014. In general, if a person does not have insurance coverage for the specific hospital 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.

11. What is General Assistance (GA)?

GA is a State category of assistance for persons not eligible under a Federal (Medicaid) category. For Medicaid DSH UPL calculation purposes, allowable costs incurred by hospitals associated with GA beneficiaries are considered uninsured costs. Payments made to the hospital on behalf of those GA beneficiaries are not used to offset those costs to determine the UPL per CMS regulations (42 C.F.R. §447.299(c)(12)), except to the extent that the Department federalizes those payments. Federalized payments received by hospitals associated with GA beneficiaries are considered DSH payments.

Pages 25 and 26 within Attachment 4.19A of Pennsylvania's Medicaid State Plan authorizes federal DSH funding for the GA program. Pennsylvania's Medicaid State Plan can be requested from the Department's Bureau of Policy, Analysis and Planning at: <http://www.dhs.pa.gov/publications/medicaidstateplan/index.htm>

12. Why can't the Department use Charity Care charges from the MA-336 Hospital Cost Report as uninsured charges?

Costs that can be included in determining the hospital specific UPL set forth at Section 1923(g) of the Social Security Act (Act) are hospital costs associated with uncompensated Medicaid costs and uncompensated costs of hospital services provided to individuals without health insurance (for example, the uninsured). Charity care is a term used by hospitals to describe an individual hospital's program of providing care free or at reduced charges to those that qualify for the particular hospital's charity care program.

Depending on the definition used, hospital costs associated with the uninsured may be a subset of a hospital's charity care or may entirely encompass a 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 UPL. 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 exist in their accounting records.³

13. There is an error on my hospital's MA-336 Hospital Cost Report. How can the error be corrected?

If the error pertains to ten (10) or fewer pages, please email the affected page(s) clearly noting the requested changes to RA-pwdshpymt@pa.gov, **Subject: "[Hospital Name] FY 2012-2013 Cost Report Change Request"**.

If the changes are extensive, pertaining to more than ten (10) pages, please send an email to RA-pwdshpymt@pa.gov, **Subject: "[Hospital Name] FY 2012-2013 Cost Report Change Request"** to indicate a forthcoming change request and mail the revised cost report express delivery to the following address.

Federal Express:

Department of Human Services
Office of Medical Assistance Programs
Bureau of Fee-for-Service Programs
Division of Rate Setting
Commonwealth Tower – 6th Floor
PO Box 2675
Harrisburg, PA 17101

14. How do hospitals know the amount of DSH payments they received for a given fiscal year?

³ 73 FR 77911

Many inpatient hospitals receive Medicaid DSH payments via several Pennsylvania Medical Assistance (MA) DSH payment programs. Some individual payments are easily recognized as DSH payments, while others, particularly GA DSH which is processed at a claim level, may be more difficult to recognize as a DSH payment.

The table below lists all of the lump-sum DSH payment programs (paid either quarterly or annually) applicable to FY 2012-2013. A record of these payments, including the date and amount disbursed, is provided to hospitals by the Department via Remittance Advice (RA) statement.

Please reference

http://www.dpw.state.pa.us/cs/groups/webcontent/documents/communication/s_002926.pdf, for an explanation about the information provided within an RA statement. To request a duplicate RA or access your RA online, please follow the instructions provided at <http://www.dhs.pa.gov/dhsassets/duplicateraform/index.htm>.

DSH Payment Program Name	DSH Payment Program RA Description	FY 2012-13
Inpatient DSH	INP DISPROPORTIONATE SHARE	X
Community Access Fund (CAF)	COMMUNITY ACCESS PMTS	X
Burn DSH	BURN CENTER DSH	X
Critical Access Hospital (CAH)	CRITICAL ACCESS DSH	X
Small/Sole Community Hospital	SMALL/SOLE COMM. HOSP DSH	X
Tobacco DSH	TOBACCO UNCOMP CARE PYMT TOBACCO EXTRORDY PYMT	X
Trauma DSH	TRAUMA LEVEL I & II TRAUMA LEVEL III	X
Additional Class of DSH	DISPROPORTIONATE SHARE/UNSPECIFIED	X
Access To Care	DISPROPORTIONATE SHARE/UNSPECIFIED	X
OB/NICU	OB/NICU DISPROP SHARE PMTS	X
Psychiatric Medical Education	PSYCH MED ED PAYMT	X
Academic Medical Center	ACADEMIC MED. CTR. DSH PYMT	X
General Assistance Claims ⁴	Individual Claim Detail	X

⁴ 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>).

15. What is the Department using as the source of the information for the DSH UPL calculation?

The DSH UPL calculation encompasses both Medicaid Title XIX and uninsured costs⁵ and revenues. The Department utilizes a variety of sources to obtain data necessary to prepare the DSH report.

Title XIX Fee-for-Service Charges and Revenue

The Department utilizes paid claim information from its claims processing records to identify Title XIX Fee-for-Service charges and revenue.

Title XIX Managed Care Charges and Revenue

The Department utilizes the MA 336 hospital cost report records to identify Title XIX managed care charges and revenue.

Uninsured Charges and Revenue

For Medicaid DSH UPL calculation purposes, individuals with no source of third party coverage for the hospital services they receive are considered uninsured.⁶ This includes self-pay and underinsured individuals as well as GA beneficiaries. As described below, the Department is able to identify a portion of uninsured charges and revenue from its claim processing records (related to GA); however, the Department cannot separately identify the self-pay and underinsured portions of uninsured charges and revenue as described in FAQ #8.

For DSH reporting purposes, costs relating to GA patients are considered uninsured costs. Payments made to the hospital on behalf of those GA patients are not used to offset those costs to determine the DSH limit, except to the extent that the Department federalizes those payments since these federalized payments are considered DSH payments. The Department utilizes paid claim information from its claims processing records to identify Fee-for-Service GA charges and federalized revenue. The Department utilizes encounter information from its claims processing records to identify managed care GA charges and federalized revenue.

The Department is providing each hospital with a copy of its MA-336 Hospital Cost Report Schedule S7 and is requesting each hospital provide the Department with the portion of charges and revenue specific to self-pay and uninsured reported on lines 6 and 7 (exclusive of GA). The Department is requesting hospitals to provide/confirm the payment amounts received from self-pay and other uninsured (non-GA) sources.

⁵ Costs are estimated by applying a cost-to-charge ratio (CCR) to charges. See FAQ #20 for more information related to CCRs.

⁶ 42 C.F.R. 447.299(c)

Cost-to-Charge Ratios

See FAQ #20.

16. If the Department is utilizing paid claims data, how are out-of-state costs incorporated into the DSH UPL report?

The Department utilizes MA-336 Hospital Cost Report data from the Schedule S7 as the source for managed care inpatient and outpatient charges and revenue; therefore, out-of-state charges are included in the DSH Report for the managed care delivery system.

Since the Department utilizes paid claims data for fee-for-service (FFS) delivery system, which does not include out-of-state charges or revenue, the hospital needs to provide FFS inpatient and outpatient charges (separately) as recorded within the hospital's accounting records. Hospitals should submit this information to the Department as part of the survey response. Submission of supporting documentation is not required at this time; however, please retain supporting documentation for audit purposes.

17. How is Statewide Quality Care Assessment handled in calculation?

Beginning with FY 2012-2013 Cost Reports, hospitals were instructed to include the cost of hospital assessments on Schedule A-1, but also offset that cost by related revenues received on Schedule A-3. While offsetting revenues are separately reported on lines 22 and 23 of Schedule A-3, the cost report does not provide the Department with the necessary level of detail to identify how much, if any, assessment cost is reported on Schedule A-1. The Department is requesting that hospitals indicate whether and how much assessment was paid, whether the assessment cost was included in the cost report, and whether and how much offsetting revenue was reported.

If a hospital did not report the assessment amount paid as a cost within the hospital's MA-336 Hospital Cost Report, then the hospital can/should provide complete the survey sent by the Department to show how the assessment cost was treated in the hospital's accounting records and on the MA-336 Hospital Cost Report. Submission of supporting documentation is not required at this time; however, please retain supporting documentation for audit purposes.

18. How are charges and revenue relating to the adultBasic program handled in the CMS DSH Report?

AdultBasic payments are used as a proxy for costs for treating adultBasic individuals. AdultBasic payments are not included as revenue since adultBasic was a state-only funded program for uninsured individuals per CMS regulations (42 C.F.R. §447.299(c)(12)). Hospitals that wish to provide documentation in support of a different cost associated with the adultBasic program may submit this information to the Department as part of the survey response.

19. How is bad debt handled in the CMS DSH Report?

Bad debt is not included in the DSH UPL calculation.

According to CMS,

Bad debt arises when there is non-payment on behalf of an individual who has third party coverage. Section 1923(g)(1) is clear that the hospital-specific uncompensated care limit is calculated based only on costs arising from individuals who are Medicaid eligible or uninsured, not costs arising from individuals who have third party coverage. Thus, while the Medicaid statute does not specifically exclude bad debt from the definition of uncompensated care costs, there is nothing in the statute that would suggest that any costs related to services provided to individuals with third party coverage, including bad debt, are within that definition.⁷

20. What cost-to-charge ratio is used to convert charges to cost?

For Medicaid DSH UPL calculation purposes, the Department calculates separate cost-to-charge ratios (CCRs) based on the type of service and specialty utilizing data from the MA-336 Hospital Cost Report. These CCRs are applied to charges as reported on the hospital cost report and paid claims data to estimate costs for Medicaid DSH UPL calculation purposes.

Title XIX Fee-for-Service (FFS) Inpatient

PA MA FFS inpatient charges from the Department's claims processing records are converted to estimated costs using the ratio of the inpatient costs from Schedule S1 to the inpatient charges from Schedule S3 by provider specialty (acute care, psychiatric, medical rehabilitation, drug and alcohol rehabilitation). In cases where the CCR calculation results in zero or cannot be calculated, the total hospital inpatient CCR for the appropriate service type is utilized.

Title XIX FFS Outpatient⁸

PA MA FFS outpatient charges from the Department's claims processing records are converted to estimated costs using the ratio of MA FFS outpatient costs to MA FFS outpatient charges from Schedule S3⁹.

Title XIX Managed Care (MC)

PA MA MC charges from Schedule S7 are converted to estimated costs using the ratio of MA MC costs to MA MC charges from Schedule S3 Part Ia by service type (inpatient and outpatient).

⁷ 73 FR 77909

⁸ Including dental claims, if applicable

Uninsured – General Assistance (GA)

PA MA FFS GA charges from the Department's claims processing records are converted to estimated costs using the CCRs calculated for the Title XIX FFS inpatient (by provider specialty) and outpatient.

PA MA Managed Care GA charges from the Department's encounter records are converted to estimated costs using the CCRs calculated for the Title XIX managed care by service type (inpatient and outpatient).

Uninsured – non-GA

Once provided by the hospital, uninsured charges are converted to estimated costs using the ratio of the total costs for the service type (inpatient or outpatient) from the Schedule S3 to total charges for that service type from the Schedule S3.

FFS Out-of-State

Once provided by the hospital, FFS out-of-state charges are converted to estimated costs using the total hospital CCR. The total hospital CCR is the ratio of total hospital IP costs plus total hospital OP costs to total hospital IP charges plus total hospital OP charges, the source of which is Schedule S3⁹ of the MA-336 Hospital Cost Report for the audit period.

21. Who performs the audit of the CMS DSH Report for Pennsylvania?

Audits for SPRY 2005 through SPRY 2011 DSH Reports were performed by the Commonwealth of Pennsylvania, Office of the Budget, Office of Comptroller Operations, Bureau of Audits. The Bureau of Audits operates independently from the Department and subject hospitals and is eligible to perform the DSH audit.

The independent auditor selected for the SPRY 2012 DSH report Maher Dussel.

The independent auditor for the SPRY 2013 DSH report has not been selected at this time.

22. How will I know whether my hospital will be audited?

Historically, hospitals selected for audit have been notified by United States Postal Service (USPS) letter by the Department on behalf of the auditor.

The audit notification process for the SPRY 2012 has not yet been determined.

⁹ If not available on Schedule S3, costs were obtained from Schedule C2, charges were obtained from Schedule C1

23. Can I request that my hospital be audited?

Yes. Please contact the Department via email, RA-pwdshpymt@pa.gov Subject: “[Hospital Name] FY 2012-2013 Audit Request”. The Department will forward your request to the audit firm, but cannot guarantee an audit will occur.

24. Will the Department be providing hospitals with supporting data and calculations used to prepare the CMS DSH Report?

The Department is in the process of determining next steps/timelines, etc. and will communicate this information when it is available.

25. Will hospitals be able to review the supporting data and calculations used to prepare the CMS DSH Report prior to submission to the auditors or CMS?

The Department is in the process of determining next steps/timelines, etc. and will communicate this information when it is available.

26. When will hospitals be notified of a final determination or outcome?

The Department is in the process of determining next steps/timelines, etc. and will communicate this information when it is available.

27. What avenue does the hospital have to dispute the amount once determined?

The Department is in the process of determining next steps/timelines, etc. and will communicate this information when it is available.

28. When will hospitals be required to pay back DSH payments made in excess of the DSH UPL?

The Department is in the process of determining next steps/timelines, etc. and will communicate this information when it is available.

29. Who can I contact with additional questions?

Please email additional questions to RA-pwdshpymt@pa.gov Subject: “[Hospital Name] FY 2012-2013 Survey Response Additional Question(s)”.

30. What resources are available related to the CMS DSH audit and reporting requirements for states, hospitals, and auditors?

Following is a list of web links to Federal Medicaid DSH audit and reporting requirements:

Section 1923 of the Social Security Act

http://www.ssa.gov/OP_Home/ssact/title19/1923.htm

December 19, 2008 DSH Audit and Reporting Final Rule

<http://www.gpo.gov/fdsys/pkg/FR-2008-12-19/pdf/E8-30000.pdf>

April 24, 2009 DSH Audit and Reporting Rule Correcting Amendment

<http://www.gpo.gov/fdsys/pkg/FR-2009-04-24/pdf/E9-9232.pdf>

July 17, 2009 DSH Audit and Reporting Compliance Enforcement Delay Letter

<http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Financing-and-Reimbursement/Downloads/DSH-Guidance71709.pdf>

September 18, 2013 Additional DSH Reporting Requirements Rule

<http://www.gpo.gov/fdsys/pkg/FR-2013-09-18/pdf/2013-22686.pdf>

December 3, 2014 Medicaid Program; Disproportionate Share Hospital Payments—
Uninsured Definition Final Rule

<http://www.gpo.gov/fdsys/pkg/FR-2014-12-03/pdf/2014-28424.pdf>

General DSH Audit and Reporting Protocol

http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Financing-and-Reimbursement/Downloads/General_DSH_Audit_Reporting_Protocol.pdf

Additional Information on the DSH Reporting and Audit Requirements

<http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Financing-and-Reimbursement/Downloads/AdditionalInformationontheDSHReporting.pdf>

Additional Information on the DSH Reporting and Audit Requirements - Part 2

<http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Financing-and-Reimbursement/Downloads/Additional-Information-on-the-DSH-Reporting-and-Auditing-Req.pdf>

Medicaid.gov DSH Page

<http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Financing-and-Reimbursement/Medicaid-Disproportionate-Share-Hospital-DSH-Payments.html>