

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) Medical Assistance (MA) is required to annually submit a report to the Centers for Medicare and Medicaid Services (CMS) for the purpose of determining that PA MA payments funded through Medicaid comply with Section 1923 of the Social Security Act relating to Disproportionate Share Hospital (DSH) payment limits. 42 C.F.R. §447.299(c) requires that the report consist of twenty (20) 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 (DHS) has prepared, audited, and submitted DSH reports as required by CMS for State Plan Rate Years (SPRY) 2005 through 2015. These reports 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's 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 <https://www.medicaid.gov/medicaid/finance/dsh/index.html> under the *Annual DSH Reports* heading.

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 audit to exceed the hospital-specific uncompensated care cost limit. The hospital-specific uncompensated care cost limit is also referred to as a hospital's Upper Payment Limit (UPL).

3. What does federalizing mean?

Many PA MA payments are jointly funded by the federal and state governments through the Medicaid program. 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.

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

DHS periodically processes lump-sum MA DSH and supplemental payments during the fiscal year. General Assistance (GA) claims payments made directly by DHS or by MA Managed Care Organizations (MCOs)² are considered MA DSH payments.

Please reference the following information from CMS regarding FFP:
<https://www.medicaid.gov/medicaid/finance/>.

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 UPL on DSH payments. See 42 U.S.C. §1396r-4(g). A hospital's DSH payments may not exceed the hospital's costs incurred by furnishing services to Medicaid patients and uninsured patients during the year, less other Medicaid payments made to the hospital, and payments made by uninsured patients ("uncompensated care costs").³

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

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

Process 2: DHS 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 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 CMS no later than December 31 of the FFY ending three years from the Medicaid SPRY under audit.

5. Why is Pennsylvania preparing a report for a fiscal year from several years ago?

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

² State Plan Amendment (SPA) 4.19A pp. 25-26. Approved by CMS on October 12, 1995. Effective October 30, 1994.

³ 73 FR 77904 and 79 FR 71679-71694

6. Why is DHS asking for information specific to the charges and revenues 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 (OOS) Medicaid beneficiaries. See 42 C.F.R. §447.299(c). Following CMS protocol, DHS utilizes the Medicaid Management Information System (MMIS) as the source for PA MA Fee-For-Service (FFS) charges and payments. Since DHS' MMIS captures information related solely to PA MA beneficiaries, DHS is requesting hospitals provide information specific to OOS FFS and OOS MCO Medicaid and dual-eligible beneficiaries.

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

While lines 16 and 17 of the FY 2015-2016 MA-336 Cost Report, 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. Relatedly, charges and revenues associated with patients with insurance, but no coverage for the specific service received ("underinsured," see FAQ #9) are permitted, but may not have been reported on Schedule S-7.

8. 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 PA MA or local governmental programs are also considered uninsured. This includes self-pay and underinsured individuals as well as General Assistance (GA) recipients. For a detailed definition, please refer to CMS's Final Rule effective December 31, 2014 (79 FR 71679-71694).

9. What is "underinsured"?

CMS' Final Rule published December 3, 2014 (79 FR 71679-71694), provides a detailed definition of "underinsured" effective December 31, 2014. In general, if a patient does not have insurance coverage for the specific hospital service provided, 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.

10. What is General Assistance (GA)?

GA is a PA MA category of assistance for persons not eligible under a Medicaid category. For Medicaid DSH UPL calculation purposes, allowable costs associated with GA beneficiaries are considered uninsured costs. Rate 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 DHS

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 is available from DHS Bureau of Policy, Analysis and Planning at: <http://www.dhs.pa.gov/publications/medicaidstateplan/index.htm>

11. Why can't DHS 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 ("uninsured" and "underinsured"). "Charity care" is a term used by hospitals to describe an individual hospital's program of providing care for 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 regulation 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. Hospitals must also ensure no duplication of such charges in their accounting records.⁴

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

Hospitals should send an email clearly noting all the requested changes to RA-pwdshpymt@pa.gov, Subject: "[Hospital Name] FY 2015-2016 Cost Report Change Request". DHS will review the request and contact the hospital to discuss incorporating the request through the iPACRS system.

13. There is an error on my hospital's Medicare 2252-10 Cost Report. How can the error be corrected?

CMS manages the Medicare Cost Reporting process. Hospitals who discover errors on their Medicare Cost Reports should contact CMS to correct those errors.

⁴ 73 FR 77911

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

Many inpatient hospitals receive Medicaid DSH payments via several Pennsylvania MA DSH payment programs. Some individual payments are easily recognized as DSH payments, while others, particularly GA DSH, 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 2015-2016. DHS provides a record of these payments, including the date and amount disbursed, on Remittance Advice (RA) statements.

DSH Payment Program Name	DSH Payment Program RA Description	FY 2015-16
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
Hospital Enhanced DSH	HOS ENHANCED DSH	X
Small & Sole Community Hospital	SMALL/SOLE COMM HOSP DSH	X
Act 77 Tobacco DSH	TOBACCO UNCOMP CARE PYMT	X
	TOBACCO EXTRORDY PYMT	X
Trauma DSH	TRAUMA LEVEL I & II	X
	TRAUMA LEVEL III	X
Additional Class of DSH	CLEFT PALATE	X
	IMPOVERISHED AREA DSH	X
	UNDERSERVED AREA DSH	X
	DISPROPORTIONATE SHARE/UNSPECIFIED	X
	PHYSICIAN PRACTICE PLANS DSH	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
	RURAL ACAD MED ED DSH	X
	REGIONAL ACAD MED ED	X
	ACAD MED DSH, LESS URBAN	X
	INDEPENDENT AMC DSH	X
Enhanced ER Access	ENHANCED ER DSH	X
General Assistance Claims ⁵	Individual Claim Detail	X

⁵ 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.dhs.pa.gov/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://www.dhs.pa.gov/provider/promise/>).

Please reference

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

15. What information source(s) does DHS use for the DSH UPL calculation?

The DSH UPL calculation encompasses costs⁶ and revenues for Medicaid Title XIX patients. DHS utilizes a variety of sources to obtain data necessary to prepare the DSH report.

Title XIX FFS Charges and Revenues (including dual-eligibles)

DHS utilizes paid claim information from MMIS to identify Title XIX FFS charges and revenues.

Title XIX MCO Charges and Revenue (including dual-eligibles)

DHS utilizes the paid encounter information from MMIS to identify Title XIX managed care charges and revenue.

Uninsured Charges and Revenues

For Medicaid DSH UPL calculation purposes, individuals with no source of third party coverage for the hospital services they receive are considered uninsured.⁷ This includes self-pay and underinsured individuals as well as GA beneficiaries. DHS is able to identify a portion of uninsured charges and revenue from MMIS (related to GA), however, DHS cannot separately identify the self-pay and underinsured portions of uninsured charges and revenues as described in FAQ #7.

For DSH reporting purposes, costs relating to GA patients are considered uninsured costs. Rate payments made to the hospital on behalf of those GA patients are only used to offset those costs to the extent that DHS federalizes those payments. DHS utilizes paid claim and encounter information from MMIS to identify FFS and MCO GA charges and federalized revenues.

Cost-to-Charge Ratios (CCRs)

See FAQ #20.

Medicare Crosswalk

DHS will utilize the Medicare Crosswalk released with the FY 2015-2016 DSH Survey pricing and aggregating claims within twenty-two (22) cost centers. Both FFS claims data and MCO encounters will be processed through the crosswalk according to hospital-specific cost center CCRs.

⁶ Costs are estimated by applying a Cost-to-Charge Ratio (CCR) to charges. See FAQ #20 for more information related to CCRs.

⁷ 42 C.F.R. 447.299(c)

16. If DHS is utilizing paid claims data, how are OOS costs incorporated into the CMS DSH report?

DHS utilizes paid claims data from MMIS for both FFS and MCO delivery systems. The paid claims data does not include OOS charges or revenue. Hospitals must separately provide OOS FFS and OOS MCO inpatient and outpatient charges as recorded within the hospital's accounting records. Hospitals should submit this information to DHS as part of the survey response. Supporting documentation is not required at this time. Hospitals should retain supporting documentation for audit purposes.

17. How are the Statewide Quality Care Assessment (QCA) and Philadelphia Hospital Assessment (PHA) handled in the CMS DSH report?

DHS is requesting that hospitals indicate whether and how much assessment was paid, and how much assessment cost remains in both the Medicare Cost Report and the MA-336 after reclassification adjustments.

If a hospital did not report the assessment amount paid as a cost within its Medicare Cost Report, then the hospital should indicate in the survey how the assessment cost was treated in the hospital's accounting records. Supporting documentation is not required at this time. Hospitals should retain supporting documentation for audit purposes.

18. How will the Assessments' costs be treated and allocated to the Medicaid and uninsured patient costs?

DHS's treatment of QCA & PHA remains unchanged. DHS will treat the Medicaid and uninsured portion of the Assessments as a cost for purposes of the DSH UPL calculation.

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.”⁸

⁸ 73 FR 77909

20. What CCR is used to convert charges to cost?

For the SPRY 2016 Medicaid DSH UPL calculation, DHS will utilize the hospital’s Medicare Cost Report to derive cost-center-specific CCRs. These CCRs will be applied to charges to estimate costs for Medicaid DSH UPL calculation purposes.

21. Will the Medicare “Ratio of Cost-to-Charges” (RCCs) on Worksheet C of the Medicare Cost Report be the basis for the calculation, or will other Worksheets be used to calculate the CCRs?

DHS intends to use worksheets other than Worksheet C to determine CCRs. DHS is using the costs contained in the Medicare Cost Report to calculate a CCR for each of the twenty-two (22) cost centers DHS identified.

22. How did DHS determine the twenty-two Cost Centers?

The twenty-two cost center groupings are based on Medicare's approach for grouping the cost report cost centers together when using the cost report data to develop relative weights for the CMS Diagnosis-Related Group (DRG) system. CMS uses fewer than twenty-two groupings. DHS has expanded the cost centers to reflect Medicaid-specific costs (e.g. Nursery and Neonate ICU).

23. How will DHS treat costs not directly captured in the twenty-two Cost Centers?

DHS will utilize the Medicare Crosswalk to price claims and encounters. Hospitals will have an opportunity to provide additional information during the thirty-day preliminary review period. Ankura Consulting provided Cost Center and Revenue Code groupings (crosswalks). DHS will make these crosswalks available on the DHS website.

24. How will DHS calculate the “ungroupable” cost-to-charge ratio (i.e. the twenty-third RCC)

The calculation is as follows:

$$\frac{\text{Sum of costs in cost centers 1 through 22}}{\text{Sum of charges in cost centers 1 through 22}}$$

25. If DHS is using other Medicare Cost Report worksheets, which worksheets and how are they used?

For each Cost Center on Worksheet C Part I, costs from Column 5 are added together with Cost Center specific Medical Education costs from Worksheet B Part I, Column 21 (Intern & Resident Salary & Fringes) and Column 22 (Intern & Resident Program Costs) to determine total costs (including Medical Education). Charges by Cost Center are taken from Worksheet C Part I Column 8. The Cost Centers listed on Worksheet C Part I

are consolidated into twenty-two (22) Cost Center categories. Costs and charges in each consolidated Cost Center are subtotaled, then the CCRs for the twenty-two (22) consolidated Cost Centers are calculated by dividing total costs by total charges.

26. The Medicare Cost Report contains a Reasonable Compensation Equivalent (RCE) Disallowance adjustment on schedule A-8-2. This adjustment is not part of the MA-336. Will DHS remove the RCE Disallowance from the UPL calculation?

CMS requires DHS to use the Medicare Cost Report as the basis for the CMS DSH Report. While the RCE is an adjustment to costs applied by Medicare on the A-8-2, that adjustment is not included in the calculation of Medicare Cost Report RCC factors for the Worksheet C Schedules. Therefore, the DSH Limit calculations will not include any RCE limitations.

27. Does DHS utilize denied FFS claims and/or denied MCO Encounters when determining the UPL?

DHS utilizes only FFS paid claims and MCO paid encounters. Denied FFS claims and encounters submitted for MCO-denied claims are not utilized in the DSH UPL calculation.

28. How will DHS use \$0-paid claims in the cost calculation?

MMIS is the source for all claims and encounter data extraction. Providers are required to submit all claims to MMIS, including claims anticipated to pay \$0. DHS includes \$0-paid claims filed in MMIS in the cost calculation.

29. How does DHS plan to include charges for dual eligible recipients that were not billed to PROMISe as Medicare Part C and/or were paid more than Medicaid would have paid?

DHS has identified MMIS as the data source for claims and encounter data in submission to CMS. Therefore, hospitals must submit all claims to MMIS, even if they anticipate they will be \$0-paid. Any claims/encounters that are not present in MMIS will not be used in calculating the hospital specific upper payment limit.

30. How will DHS account for Provider-Based Physician Adjustments to revenue?

DHS will not apply a broad-based adjustment for provider based physician revenue. If a hospital believes that a provider based physician adjustment is reasonable, the hospital should submit the following to DHS for consideration and review:

- The calculated amount of the requested adjustment to MA revenues;
- Supporting documentation which includes:
 - a written explanation of the methodology used to compute the proposed adjustment; and

- the instances when bundled payments for physician and hospital services are paid by the MCO to the hospital.
- The hospital must provide source documentation related to this adjustment upon request by DHS or the independent auditor.

If a hospital believes this adjustment is reasonable, it should present the adjustment to DHS as part of the thirty-day preliminary review period. Hospitals should prepare this adjustment and supporting documentation sufficiently in advance of deadlines for DHS review.

31. How will DHS determine uninsured costs using the information provided on the FY 2015-2016 DSH Survey?

DHS will apply a blended CCR to the hospital's reported total uninsured/self-pay costs listed on the FY 2015-2016 DSH Survey.

32. How will DHS determine UPLs for hospital that are not required to file Medicare Cost Reports?

DHS will utilize data from the Medicaid Cost Report (MA-336) for hospitals that are not required to file Medicare Cost Reports.

33. 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 DHS and subject hospitals and is eligible to perform the DSH audit.

Maher Duessel was chosen as the independent auditor for the SPRYs 2012, 2013, 2014, 2015, and 2016 DSH Reports.

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

Historically, hospitals selected for audit have been notified by email directly from the auditor. In the event that email communication proves unsuccessful, the auditor will follow up with phone calls and/or United State Postal Service (USPS) letters.

35. Can I request that my hospital be audited?

Yes. Please contact DHS via email, RA-pwdshpymt@pa.gov Subject: "[Hospital Name] FY 2015-2016 Audit Request". DHS will forward your request to the audit firm, but cannot guarantee an audit will occur.

36. Will DHS provide hospitals with supporting data and calculations used to prepare the CMS DSH Report?

As the CMS DSH Report determines if hospital DSH Payments were made in excess of the UPL, DHS will provide hospitals determined to have received excess DSH payments a limited time to review their hospital-specific analysis and submit additional information for the fiscal year period under review. In order to assist hospitals in analyzing the reports, DHS will provide claims data utilized in the report with the analysis via email. Once the limited review window has closed, DHS will incorporate acceptable changes and submit the report for audit.

NOTE: as was the case with SPRY 2014 and 2015, DHS will group SPRY 2016 hospital charges by cost center, FFS separate from MCO, IP separate from OP, dual eligible separate from non-dual eligible, and GA separate from non-GA. Consistent with past practice, DHS will continue to provide Patient ID numbers to facilitate hospitals with cross-referencing the claims data.

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

DHS will notify hospitals determined to have received excess DSH payments in writing and via email, after submitting the DSH Report to CMS. The notice will request return of overpaid funds within thirty (30) days of issuance. In addition to the original limited hospital review window, hospitals determined to have received excess DSH payments on the final DSH report will have an opportunity to appeal the final determination. Specific appeal rights and procedures are detailed in the notification sent to hospitals.

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

Irrespective of whether hospitals appeal the final determination, repayment of the excess DSH funds is required within thirty (30) calendar days of DHS' written request. Failure to remit payment within the stated period will result in credit gross adjustments in the amount of the excess DSH funds.

39. Who can I contact with additional questions?

Please email additional questions to RA-pwdshpymt@pa.gov Subject: “[Hospital Name] FY 2015-2016 Survey Response Additional Question(s)”.

40. 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
<https://www.medicaid.gov/medicaid/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
https://www.medicaid.gov/medicaid/financing-and-reimbursement/downloads/general_dsh_audit_reporting_protocol.pdf

Additional Information on the DSH Reporting and Audit Requirements
<https://www.medicaid.gov/medicaid/financing-and-reimbursement/downloads/part-1-additional-info-on-dsh-reporting-and-auditing.pdf>

Additional Information on the DSH Reporting and Audit Requirements - Part 2
<https://www.medicaid.gov/medicaid/financing-and-reimbursement/downloads/part-2-additional-info-on-dsh-reporting-and-auditing.pdf>

Medicaid.gov DSH Page
<https://www.medicaid.gov/medicaid/finance/dsh/index.html>