

Additional Information on the DSH Reporting and Audit Requirements

Best Available Information/Cost Report Procedures

- 1. How can an independent auditor certify that DSH payments do not exceed the hospital-specific DSH limits if data used for calculating the limits is derived, at least in part, from as-filed Medicare cost reports?**

Certification means that the independent auditor engaged by the State follows the criteria of the Federal audit regulation and completes the verification, calculations and report under the professional rules and generally accepted standards of audit practice. This certification would include an assessment of the State's audit protocol to ensure that the Federal regulation is satisfied, an opinion for each verification detailed in the regulation, and a determination of whether or not the State made DSH payments that exceeded any hospital-specific DSH limit in the Medicaid State plan rate year under audit. The certification should also identify any data issues or other caveats that the auditor identified as impacting the results of the audit.

We expect that reports and audits will be based on the best available information. If audited Medicare cost reports are not available within the timeframe allowed for the reporting and audit submission, the DSH report and audit may need to be based on Medicare cost reports as filed. However, in the final rule, CMS modified the timeline for report and audit submission to allow States additional time for the inclusion of the most accurate and complete data possible. The required reports and audits may be submitted as late as the last day of the Federal fiscal year ending three years after the end of the Medicaid State plan rate year, with a special timing provision for the audits for 2005 and 2006, which will be due by December 31, 2009. Additionally, CMS has developed a General DSH Audit and Reporting Protocol that should assist States and auditors in utilizing information from each data source and developing methods to determine uncompensated costs of furnishing hospital services to the Medicaid and uninsured populations. The protocol is available on the CMS website at www.cms.hhs.gov/MedicaidGenInfo/Downloads/CMS2198FRptProtocol.pdf.

It should be noted that in light of States' concerns regarding budget cycles, planning complications, and the economic downturn, CMS has determined that it will apply a flexible enforcement strategy designed to ensure that States have sufficient time to properly implement the new requirements without undue hardship. Thus, CMS will not find a State to be out of compliance with the DSH reporting and auditing requirements for the initial (2005 and 2006) Medicaid State plan rate years until December 31, 2010. Pursuant to the provisions of the regulation, independent audits must begin with Medicaid State plan year 2005 and must be completed no later than September 30, 2009, for the State plan rate years 2005 and 2006. Audits and reports for State plan rate years 2005 and 2006 are due to CMS on or before December 31, 2009.

2. If as-filed Medicare cost reports are used to calculate hospital-specific DSH limits, do limits have to be adjusted to reflect the final settlement of the cost report or the outcome of cost report appeals?

We expect that reports and audits will be based on the best available information. If audited Medicare cost reports are not available, the DSH report and audit may need to be based on Medicare cost reports as filed. Most hospital cost reports are finalized within two years of the period being audited but there is always the possibility of post-audit adjustments. To the extent that such adjustments to cost reports affects Medicaid payments, States should notify CMS of the adjustments to the cost reports and any subsequent DSH audit report changes as well as make appropriate prior period adjustments through the MBES/CBES system. Additionally, we would anticipate the auditor's certification would identify any data issues or other caveats that the auditor has identified as impacting the results of the audit.

The statutory authority instructed States to report and audit specific payments and specific costs. Consistent with that provision, States must perform audits associated with defined periods of time and must identify the actual costs incurred and payments received during that defined time period. In order for the audits to properly measure these elements and in consideration of the many comments related to retroactivity and timing issues associated with gathering the data necessary to identify the costs and revenues, CMS has made several revisions to the final rule including identifying that: (i) the Medicaid State plan rate year 2005 is the first time period subject to the audit; and, (ii) the deadline on reporting the audit findings has been extended to at least three full years after the close of the Medicaid State plan rate year subject to audit.

The required reports and audits may be submitted as late as the last day of the Federal fiscal year ending three years after the end of the Medicaid State plan rate year, with a special timing provision for the audits for 2005 and 2006, which will be due by December 31, 2009. This three year period accommodates the one-year concern expressed in many comments regarding claims lags and is consistent with the varying cost report period and adjustments.

3. Data derived from multiple cost report years might have to be used in fulfilling audit and reporting requirements for a given State plan rate year. In order to complete reporting and auditing requirements relating to State plan rate years 2005 and 2006, for the 2005 and 2006 reports, would it be acceptable to obtain 2004 and 2007 costs from submitted or unreviewed cost reports?

In instances where the hospital financial and cost reporting periods differ from the Medicaid State plan rate year, States and auditors may need to evaluate multiple audited hospital financial reports and cost reports to fully cover the Medicaid State plan rate year under audit. Typically, at most, two financial and/or cost reports should provide the appropriate data. Please note that there are some circumstances where more than two cost reports are needed to cover a State plan year. Some occasions call for a hospital to file short-period cost reports within a normal 12-month cost reporting period. For example, if there is a change of ownership in the middle of a fiscal period, the hospital will have to file more than one cost report during its 12-month fiscal period. The data may need to be allocated based on the months covered by the financial or cost reporting

period that are included in the Medicaid State plan period under audit. CMS has developed a General DSH Audit and Reporting Protocol to assist States in using the information from each source identified above and developing the methods under which costs and revenues will be determined. The protocol is available on the CMS website at www.cms.hhs.gov/MedicaidGenInfo/Downloads/CMS2198FRptProtocol.pdf.

We expect that all reports and audits will be based on the best available information. If audited Medicare cost reports are not available, the DSH report and audit may need to be based on Medicare cost reports as filed. Moreover, in order to ensure a period for developing and refining audit practices, we are providing for a transition period through Medicaid State plan rate year 2010, before audit results will be given weight other than in making prospective estimates of hospital costs for the purposes of ongoing DSH payments.

4. Can independent auditors utilize a risk-based approach to auditing hospitals or utilize some materiality guideline in developing different levels of data analysis for different hospitals? Additionally, does CMS expect that all hospitals are audited by the independent auditor annually?

The DSH audit and report is a necessary part of the administration of the Medicaid program. The purpose of the audit is to ensure that States make DSH payments under their Medicaid program that are in compliance with section 1923 of the Act. The audit does not encompass the review of the State's overall Medicaid program; it simply ensures that one portion of the program is conducted in line with Federal statutory limits. In addition, the DSH audit will rely on financial and cost report data provided by hospitals that are subject to generally accepted accounting principles as part of their primary reporting function.

There is no statutory authorization for an exception to audit and reporting requirements with respect to hospitals that receive DSH payments. The audit and reporting requirements under section 1923(j) of the Act apply to all States that make DSH payments, with respect to each hospital receiving a DSH payment. The statute further requires that CMS obtain information sufficient to verify that such payments are appropriate. Relying on a sample of cost reports and financial information will not ensure that each DSH payment is appropriate and does not exceed the hospital-specific DSH limit.

The data elements necessary for the State to complete the DSH audit and report should, in part, be information the State already gathers to administer the DSH program. The responsibility of the auditor is to measure DSH payments received by a hospital in a particular year against the eligible uncompensated care costs of that hospital in that same year as determined using the data provided in the cost, utilization and financial reporting documents described in the preamble to the final rule. Additionally, auditing a State's overall DSH payment methodology will not ensure that DSH payments to each hospital do not exceed the statutorily required hospital-specific DSH limit.

Finally, in order to certify to the verifications, the auditors should follow generally accepted auditing practices and requirements to assure a thorough and complete audit has been conducted. The auditor must develop sufficient confidence in the data to certify the results for

the State plan rate year subject to the audit. The final rule does not eliminate any flexibility that independent auditors might have in using accepted professional methodologies to conduct the audit and to certify to the verifications. However, the independent certified audits required to be submitted must be performed in compliance with section 1923(j) and implementing regulations as a condition for receiving Federal payments under section 1903(a)(1) and 1923 of the Act.

5. If DSH payments are based on hospital-specific DSH limits from prior year audits, recoupments and DSH payment redistribution might be necessary on an annual basis. How does CMS expect States to deal with this cost and with the potential hardship to the hospitals?

This regulation does not require States to implement retrospective DSH payment methodologies or otherwise change the basic approach to DSH payment used by the States. Nor does it require delay in making DSH payments consistent with the authority of the approved Medicaid State plan. CMS recognizes that States may need to estimate uncompensated care to determine DSH payments in an upcoming Medicaid State plan rate year, indeed, this is currently the way most States distribute DSH payments. The regulation is intended to ensure that those estimates do not exceed the actual hospital-specific limit in the year in which the payments are received.

States retain considerable flexibility in setting DSH State plan payment methodologies to the extent that such methodologies are consistent with 1923(c) and all other applicable statute and regulations. This regulation provided for time frames that should provide States with accurate information with which to determine prospective DSH payments and time to review and adjust rates once actual eligible uncompensated care amounts are determined. States will have to determine how to best ensure that prospective DSH methodologies do not result in payments that exceed hospital-specific DSH limits, either by revising those methodologies or by providing for reconciliation of prospective payments with those limits. Because FFP is only available for DSH payments that do not exceed the hospital-specific limit, some States may determine that a retrospective DSH payment methodology or a DSH reconciliation is a reasonable way to manage its DSH allotment.

CMS as always is available to offer technical assistance to States in developing such methodologies. Additionally, CMS included a transition period in the regulation to ensure that States may adjust prospective estimates to avoid any immediate adverse fiscal impact.

6. The final regulation requires a determination of whether or not the State made DSH payments that exceeded the hospital-specific DSH limit for any hospital in the Medicaid State plan rate year under audit. If the DSH audit identifies DSH payments made to a hospital in excess of the hospital-specific DSH limit, how should States treat such payments if the hospitals are no longer eligible for DSH, are bankrupt, or no longer exist?

As stated in the final rule, beginning in Medicaid State plan rate year 2011, to the extent that audit findings demonstrate that DSH payments made in that year exceed the documented hospital-specific cost limits, CMS will regard them as representing discovery of overpayments to

providers that, pursuant to 42 CFR Part 433, Subpart F, triggers the return of the Federal share to the Federal government (unless the DSH payments are redistributed by the State to other qualifying hospitals as an integral part of the audit process). This is not a “penalty” but instead reflects adjustment of an overpayment that was not consistent with Federal statutory limits. However, we note that, to the extent that States wish to redistribute any DSH payments that exceeded a particular hospital-specific limit, the Federally approved Medicaid State plan must reflect that payment policy and allow for individual payment adjustments based on the audit. Further, States need not refund the Federal share of overpayments made to providers who are determined to be bankrupt or out of business in accordance with 42 CFR 433.318.

7. To meet the reporting and auditing requirement, States must perform audits associated with defined periods of time and must identify the actual costs incurred and payments received during that defined time period. Can a State use adjudicated claims date, or must they change to admission or discharge date, which is reflected in the comment and response of the DSH final rule?

Section 1923(g) of the Social Security Act imposes a limit that is based in part on a year’s worth of services. The preamble language is merely illustrative of two approaches some States may already use to determine the volume of Medicaid services and payments to be included in the yearly limit and was not intend to be all inclusive. Adjudicated claims date would be another acceptable approach to determine the amount of services furnished during the year. However, the approach used must be consistent with the approved State plan language for the specified time period and should be clearly defined in the audit report.

8. What does the final rule mean by the term Medicaid State plan rate year?

In using the term State plan rate year, we recognize that while many States may set rates on a State fiscal year basis, some States set rates on a calendar or other annual basis and establish DSH limits accordingly. The State plan rate year is therefore the 12-month period defined by a State’s approved State plan in which the State estimates eligible uncompensated care costs and determines corresponding DSH payments as well as other Medicaid payment rates.

9. Some States utilize certified public expenditures (CPE) to finance the non-Federal share of DSH payments made up to hospital-specific DSH limits. Should States modify existing State plan provisions and/or special terms and conditions (STC) of section 1115 demonstrations in instances where the approved State plan and/or STCs methods for calculating costs for these CPE-funded payments differ from the method for calculating the hospital-specific limit required by the final regulation and associated DSH General Auditing and Reporting Protocol?

To ensure that claims for DSH expenditures do not exceed hospital-specific DSH limits, States should modify their methods for calculating CPE-funded DSH payments to the extent that the approved State plan and/or STCs methods vary from that required by the final DSH audit regulation and associated DSH General Auditing and Reporting Protocol. If this requires a

modification to the State plan or 1115 STCs, State should submit a State plan amendment or section 1115 demonstration amendment, respectively.

The final regulation does include a transition period to ensure that States may adjust uncompensated care estimates prospectively to avoid any immediate adverse fiscal impact and to assist States in ensuring that future DSH payments do not exceed the hospital-specific DSH limit. Additionally, to permit States an opportunity to develop and refine audit procedures, audit findings from Medicaid State plan rate year 2005-2010 will be limited to use for the purpose of estimating prospective hospital-specific uncompensated care cost limits in order to make actual DSH payments in the upcoming Medicaid State plan rate years. CMS is not requiring retroactive collection for Medicaid State plan rate years that have already passed. By using that time to improve State DSH payment methodologies, States may avoid circumstances in which DSH payments that exceed Federal statutory limits must be recouped from hospitals.

Audit Reports

10. Please provide clarification on the extent to which the State may rely upon hospitals to perform the DSH audit. Please clarify whether the State may rely upon hospitals' current or expanded financial audits for the certification of the hospital-specific DSH limits.

As stated in the final rule, the responsibility for certification of an independent audit rests with the State. States must engage an independent auditor to certify that the requirements of the Federal regulation are satisfied, to provide an opinion for each specified verification, and to make a determination as to whether any DSH payments exceeded any hospital's specific DSH limit. States would not meet the independent audit certification requirement by merely expanding audits of hospital financial statements to obtain audit certification from each hospital. However, States may utilize an independent auditor to independently analyze and certify information submitted by each hospital to the State.

Furthermore, the mere fact that a specific auditing entity completes a Medicaid financial audit for a hospital does not necessarily preclude the State from contracting with that auditing entity to complete the independent DSH audit. To the extent that the auditor attests in the DSH audit report that they meet the requirements for auditor independence described in Chapter 3 of the General Accounting Organizations General Audit Standards (GAGAS), an auditing entity of any hospital's financial audit may be eligible to complete the certified DSH audit for the State.

11. Please provide guidance on what auditing standards and procedures should be used in undertaking the DSH audit as well as what type of report auditors should issue.

The purpose of the DSH audit is to ensure that Medicaid DSH payments comply with Federal statutory limits. The DSH audit will necessarily rely upon financial and cost report data that are subject to generally accepted accounting principles, and accounting principles specific to hospital accounting under federal grant programs.

Audit procedures that are in accordance with applicable industry standards would meet the criteria established within the final rule if the auditors certify the audit in accordance with the definition of “independent certified audit” as defined at 455.301 of the final rule. We understand that the term “certification” may have specific meaning within the auditing profession. Our use of the term “certification” for purposes of DSH audits is limited to the actions set forth at 455.301. For this purpose, certification means that the auditor attests to qualifying as an independent auditor, has reviewed the criteria of the Federal audit regulation and has completed the verification, calculations, and report under professional rules and generally accepted standards of audit practice. To the extent that the auditor decides that specific methods (which may include requirements beyond the scope of those specifically outlined within the regulation and protocol) are necessary to certify to the audit in accordance with the certification criteria at 455.301 and 455.304, then the auditor should employ these methods. As noted in 455.301, the certification should identify any data issues or other caveats that the auditor identifies as impacting the results of the audit.

We look forward to working with States in refining the auditing process throughout the transition period. Once States and CMS gain greater experience with the auditing process, CMS will work further with States to highlight best practices and auditing methods.

12. The 2005 and 2006 DSH audit reports are to be completed by September 30, 2009, and must be submitted to CMS by December 31, 2009. Are States able to grant extensions to auditors to complete the audits subsequent to September 30, if the final report is still delivered to CMS by December 31, 2009?

CMS has determined that it will apply a flexible enforcement strategy designed to ensure that States have sufficient time to properly implement the new requirements without undue hardship. Thus, CMS will not find a State to be out of compliance with the DSH reporting and auditing requirements for the initial (2005 and 2006) Medicaid State plan rate years until December 31, 2010. We do not anticipate any further delay of compliance enforcement, or any delay of compliance enforcement for subsequent audit years.

Even though CMS will be delaying compliance enforcement, CMS expects that States will be making good faith efforts to comply with the new requirements. We asked each State to identify, and to provide in writing to its respective CMS Associate Regional Administrator, a contact individual by September 30, 2009 to brief CMS representatives on the State’s compliance status and progress. Based on those discussions, some States were/may be asked for detailed information about compliance efforts.

The final rule included a transition period recognizing that auditing processes and techniques may need to be refined. This transition period lasts through Medicaid State plan rate year 2010, before audit results will be given weight other than in making prospective estimates of hospital costs for the purposes of ongoing DSH payments. In the transition, CMS will work with States that make a good faith effort to fulfill all of the DSH reporting and auditing requirements and that also submit a final report to CMS by the December 31 deadline. It should be noted that States will still be expected to make DSH payments that conform to the hospital-specific limits beginning in 2011.

13. The rule states that the 2005 and 2006 DSH audit reports are to be submitted to CMS by December 31, 2009. What method will CMS use to determine submission date?

CMS has determined that it will apply a flexible enforcement strategy designed to ensure that States have sufficient time to properly implement the new requirements without undue hardship. CMS will not find a State to be out of compliance with the DSH reporting and auditing requirements for the initial (2005 and 2006) Medicaid State plan rate years until December 31, 2010. We do not anticipate any further delay of compliance enforcement, or any delay of compliance enforcement for subsequent audit years. We asked each State to identify, and to provide in writing to its respective CMS Associate Regional Administrator, a contact individual by September 30, 2009 to brief CMS representatives on the State's compliance status and progress. Based on those discussions, some States were/may be asked for detailed information about compliance efforts.

When States have completed the DSH audits and reports, they should submit the required reports and audits electronically via email to the Associate Regional Administrator of their respective CMS Regional Office on or before the applicable deadline. States are encouraged to carbon copy their Regional Office National Institutional Reimbursement Team (NIRT) representative and CMS Regional Office State representative as well. The receipt date will be the email creation and submission date as indicated on the email.

Certified audits should be submitted in a PDF format using an Adobe Acrobat application and should contain a PDF file of the completed reporting element template. All audit files should be submitted in zip data compression formats to ensure ease of electronic delivery.

CMS is exploring the possibility of including the required reporting elements into the MBES process and will provide additional guidance in the near future. Absent the MBES reporting process, States should submit the report as an excel spreadsheet in addition to the PDF format included in the certified audit report.

14. Is CMS planning on setting a DSH payment threshold below which some or all of the reporting requirements will be waived?

There is no statutory authorization for an exception to audit and reporting requirements with respect to hospitals that receive DSH payments. The audit and reporting requirements under section 1923(j) of the Act apply to all States that make DSH payments, with respect to each hospital receiving a DSH payment. As we noted in the preamble to the final rule, the statute requires that each State report to CMS data, and submit a certified audit, that verifies that all hospitals receiving DSH payments under the Medicaid State plan actually qualify to receive such payments and that such payments do not exceed the hospital-specific DSH limit. Even if a State only makes DSH payments under its approved Medicaid State plan that relate to the uncompensated care of providing inpatient and outpatient hospital services to Medicaid individuals (that is, Medicaid shortfall), it would be possible for payments to a hospital to exceed

the hospital-specific limit if the hospital had a surplus in furnishing hospital services to the uninsured. While this may be an unlikely circumstance, we cannot at this time be certain that it never occurs. Therefore, in such a circumstance we will accept reporting limited to Medicaid uncompensated care only when the hospital provides a certification that it incurred additional uncompensated care costs serving uninsured individuals. When we review certified audit reports submitted by States, we will consider whether more flexibility would be warranted, and we may address the issue in future reporting instructions. However, prior to receiving the first set of annual State reports, CMS is not contemplating any changes to the reporting requirements.

Auditor Independence

15. What constitutes an independent auditor?

Medicaid regulations at 42 CFR 455.301 define a certified independent audit in part to mean an audit that is conducted by an auditor that operates independently from the Medicaid agency or subject hospital. The intent is for the auditor to be fully able to render objective and impartial judgment on all matters relating to a required DSH audit. Examples of potential conflicts for audit entities would be: calculating a State's DSH payments under the Medicaid State plan; developing State plan DSH payment methodologies for States; preparing uninsured/Medicaid source documents and/or originating data relating to the DSH program on behalf of subject hospitals and/or the State; serving as auditor to any subject hospital or the State agency; and possessing a direct or indirect financial interest in the State's DSH program. In this context, independence generally means that the audit organization and individual auditor is free of any impairment that may in fact or in appearance preclude an impartial opinion or reporting.

States are responsible for ensuring that no possible impairment exists between the auditing organization/auditors and the Medicaid agency and/or hospital. Within the auditing profession, standards have developed to help guide auditors and/or their clients with respect to independence and impairments that might potentially compromise it. The final rule provides that these principles are to be applied to Medicaid DSH audits. The General Accountability Office (GAO), in Chapter 3 of its most recent revision to Government Auditing Standard, identifies specific criteria for independence and outlines impairments to independence in government auditing practices (<http://www.gao.gov/govaud/govaudhtml/index.html>).

While we believe these generally accepted standards relating to independence in government auditing to be well understood by the auditing profession and would expect their correct application to the required audits, there are some situations that may warrant additional review. For instance, section 3.29 of the General Standards outlines non-audit services that impair auditor independence. The section states certain non-audit services directly support an entity's operations and impair an audit organization's ability to meet overarching audit principles (in this case we would consider the "entity" to be the Medicaid agency and/or hospital). Some examples of these types of services that may impair independence for purposes of conducting the DSH audit include:

- a.** maintaining or preparing the audited entity's basic accounting records or maintaining or taking responsibility for basic financial or other records that the audit organization will audit;
- b.** posting transactions (whether coded or not coded) to the entity's financial records or to other records that subsequently provide input to the entity's financial records;
- c.** determining account balances or determining capitalization criteria;
- d.** designing, developing, installing, or operating the entity's accounting system or other information systems that are material or significant to the subject matter of the audit;
- e.** providing payroll services that (1) are material to the subject matter of the audit or the audit objectives, and/or (2) involve making management decisions;
- f.** providing appraisal or valuation services that exceed the scope described in paragraph 3.28 c;
- g.** recommending a single individual for a specific position that is key to the entity or program under audit, otherwise ranking or influencing management's selection of the candidate, or conducting an executive search or a recruiting program for the audited entity;
- h.** developing an entity's performance measurement system when that system is material or significant to the subject matter of the audit;
- i.** developing an entity's policies, procedures, and internal controls;
- j.** performing management's assessment of internal controls when those controls are significant to the subject matter of the audit;
- k.** providing services that are intended to be used as management's primary basis for making decisions that are significant to the subject matter under audit;
- l.** carrying out internal audit functions, when performed by external auditors; and
- m.** serving as voting members of an entity's management committee or board of directors, making policy decisions that affect future direction and operation of an entity's programs, supervising entity employees, developing programmatic policy, authorizing an entity's transactions, or maintaining custody of an entity's assets.

Further examples of such potential conflicts for audit entities would be: providing audit services for the Medicaid program generally (not specifically related to DSH payments) such as auditing cost reports or determining Medicaid service rates; serving as auditor to any subject hospital or the State agency; and possessing a direct or indirect financial interest in the State's Medicaid program.

There are situations in which sufficient firewalls exist between such services that would serve to eliminate the potential conflict regarding auditor independence. In such cases, States must explain why such an audit firm meets the GAGAS independence standards despite the appearance that the auditing entity is not independent. The audit firm must also declare its independence in the audit and report submitted to CMS. States should look to the General Auditing Standards in their entirety to ensure that no possible impairments to independence exist.

For State plan rate year 2007 and thereafter, auditing organizations/auditors must submit a signed statement declaring independence of the respective Medicaid agency and hospitals. This statement should be included with the audit and report submitted to CMS on an annual basis.

16. Can States use provider-related donations, assessments, taxes on, or other similar funding arrangements with DSH hospitals to fund the required audits?

The DSH audit requirements and final rule do not supersede any Medicaid provisions relating to donations and taxes. As a practical matter, we do not see how a State could rely on “voluntary” donations to fund required Medicaid programs and expenses. As indicated in the preamble, section 1923(j) makes these DSH audit and reports a Medicaid program requirement and as such States are responsible for funding the costs to fulfill them just as they are any other Medicaid administrative costs. To the extent a State’s payment methodology for the audits and reports would be prohibited as an impermissible tax or donation, a State may not employ that methodology for purposes of funding the audits. States may not impose DSH fees or require financial participation in the funding of the audit as a condition for receiving DSH payments. Furthermore, to the extent that a provider-related donation presumed to be bona fide contains a hold harmless provision, it would not be considered a bona fide donation.

Revenue Recognition

17. How should States, hospitals, and auditors treat Medicaid payments received after the completion of the audit for a particular Medicaid State plan rate year?

In recognition of potential delays in obtaining needed information, we have extended the period for ongoing report and audit submission until the end of the Federal fiscal year that is at least three years after the close of the Medicaid State plan rate year. We believe that hospitals would have received most Medicaid, DSH payments, and other payments associated with that Medicaid State plan rate year.

Based on the modifications to the audit and reporting deadlines, the existing requirement at 42 CFR 447.45(d) for provider claims to be filed within a year from the date of service and promptly paid by the State, and the existing two-year timely claim filing requirement at 45 CFR 95.7, there should not be a significant adjustment to Medicaid payments that would warrant a corrected audit and report. To the extent that a significant adjustment to Medicaid payments occurs and States claim Federal matching dollars (or return Federal matching dollars) as a prior period adjustment, States should correct the audit and report by indicating post-audit adjustments to Medicaid and DSH payments (or uncompensated care costs if Medicaid payment adjustments affect the Medicaid shortfall). When post-audit retroactive adjustments to Medicaid payments are not significant, the payments should be measured during the audit of the Medicaid State plan rate year in which the revenues are received.

18. The final regulation and the preamble address which State plan rate year revenues apply to for purposes of calculating a hospital-specific DSH limits. It appears, however, that the preamble requires Medicaid payment offsets occurring after the completion of the DSH audit be applied duplicately in calculating hospital-specific DSH limits for two distinct State plan rate years. Can you confirm that these Medicaid revenues should be applied in calculating hospital-specific DSH limits for only one Medicaid State plan rate year?

Medicaid revenues identified in the post-audit period must only be applied against one State plan rate year for purposes of calculating hospital-specific DSH limits.

19. Against which Medicaid State plan rate year are revenues received by a hospital by or on behalf of either ‘self-pay’ or uninsured individuals during the Medicaid State plan rate year under audit offset?

The General DSH Audit and Reporting Protocol provides clarification regarding all payments received during cost reporting period(s) covering the Medicaid State plan rate year under audit by or on behalf of patients with no source of third party coverage. There will be no attempt to allocate payments received during the State plan rate year to services provided in prior periods. Since the goal of the audit is to determine uncompensated DSH costs in a given Medicaid State plan rate year, all payments received in the year will be counted as revenue to the hospital in that same year. It is understood that some costs incurred during the State Plan rate year under audit may be associated with future revenue streams (legal decisions, payment plans, and recoveries) but that the payments are not counted as revenue until actually received.

Allowable Costs/Medical Necessity

20. Will CMS be issuing guidance on what constitutes medically necessary services?

CMS does not intend to issue guidance on what constitutes medically necessary services. CMS will continue to allow States flexibility in determining medical necessity under their individual Medicaid programs within the guidelines of the Social Security Act provided at 1902(a)(30) and 1902(a)(19), and the implementing regulations at 42 CFR 440.230(d), which state "The [Medicaid] agency may place appropriate limits on a service based on such criteria as medical necessity or on utilization control procedures." Generally, services that are considered reimbursable under the Medicaid State plan would also be considered as necessary services when calculating a hospital's eligible uncompensated care cost.

21. Are States required to follow only Medicare reasonable cost principles, or will they be allowed to establish allowable cost rules that may differ from Medicare?

As noted in the preamble to the final rule, section 1923(g)(1) of the Act provides for a Federal limitation based on costs that must be calculated in accordance with Federal accounting standards. The same methods used in preparing the Medicare 2552-96 cost report should be applied in determining costs to be used in calculating the hospital-specific DSH limits.

Hospitals' Medicare cost reports, audited financial statements, and accounting records should contain the information necessary for reporting and auditing responsibilities, in combination with information provided by the States' Medicaid Management Information Systems (MMIS) and the

approved Medicaid State plan governing the Medicaid payments made during the audit period. The CMS developed General DSH Audit and Reporting Protocol will assist States and auditors in using information from each of these sources to determine allowable uncompensated care costs consistent with the statutory requirements. The protocol is available on the CMS Web site at: www.cms.hhs.gov/MedicaidGenInfo/Downloads/CMS2198FRptProtocol.pdf.

22. If a State allows for graduate medical education as an allowable component of cost and is included in the Medicaid State Plan, should the State require the filing of Medicaid cost reports that incorporate the graduation medical education in the determination of program cost?

All costs that are associated with services that are defined and reimbursed under the approved Medicaid State plan as inpatient hospital services and outpatient hospital services to Medicaid eligible individuals and to individuals with no source of third party coverage may be included in calculating the hospital-specific DSH limit. To properly capture these costs in the hospital-specific DSH limit, State's should include these costs as part of the Medicare 2552-96 cost report step-down process and utilize the General DSH Audit and Reporting Protocol.

To the extent that a State allows graduate medical education (GME) as a component of cost and it is reimbursed under the Medicaid State plan, the State can include these costs in determining hospital-specific DSH limits. Please be reminded that the State still must use the cost reporting and apportionment process as prescribed by the Medicare 2552-96 identified in the General DSH Audit and Reporting Protocol.

23. "How should States treat unpaid Medicaid days or charges for purposes of calculating hospital-specific DSH limits?" What if the unpaid days are a result of untimely filing or a hospitals failure to seek prior authorization?

The hospital-specific DSH limit includes the costs incurred during the year of furnishing hospital services to Medicaid beneficiaries and the uninsured, net of Medicaid payments and payments made by or on behalf of the uninsured. To be included as Medicaid cost in the limit, a hospital service must be included in a State's definition of an inpatient hospital service or outpatient hospital service under the approved State plan and furnished to Medicaid eligible individuals.

Individuals with Medicaid or other third party coverage are not considered as uninsured under 1923(g)(1). Improper billing by a provider does not change the status of an individual as insured or otherwise covered. In no instance should costs associated with claims denied by a health insurance carrier for such a reason be included in the calculation of hospital-specific uncompensated care costs.

24. A Medicaid program in a State covers speech therapy services for beneficiaries under 18 years of age. A hospital in that State provided speech therapy to a Medicaid enrollee who was over 18 and claimed the services as uninsured care. Are

the costs incurred by the hospital in providing the speech therapy service allowed to be included in the calculation of hospital-specific DSH limits?

In this example the costs associated with speech therapy services can be included in the calculation of hospital-specific DSH limits to the extent that such services are treated as “hospital services” under the State plan because the patient is eligible for Medicaid. **The hospital-specific limit is based on the costs incurred for furnishing “hospital services” and does not include costs incurred for services that are outside either the State or Federal definition of inpatient or outpatient hospital services. While States have some flexibility to define the scope of “hospital services,” States must use consistent definitions of “hospital services.” Hospitals may engage in any number of activities, or may furnish practitioner or other services to patients, that are not within the scope of “hospital services,” including speech therapy. A State cannot include in calculating the hospital-specific DSH limit cost of services that are not defined under its Medicaid State plan as a Medicaid inpatient or outpatient hospital service.**

Determination of Uninsured Status

25. CMS seems to contradict itself in replying to the question of including patients who lack coverage for the service provided but not necessarily any coverage at all. CMS states that they have never read the statute to be service-specific and believe that such an interpretation would be inconsistent with the broad statutory references to insurance or other coverage. Furthermore, CMS replies that such a reading would result in cost shifting from private sector coverage to the Medicaid program. However, in a January 10, 1995 letter to Donna Checkett, Chair of the State Medicaid Director’s Association, CMS clarified that: “it would be permissible for States to include in their determination of uninsured patients those individuals who do not possess health insurance which would apply to the service which the individual sought”. Is it CMS’s position now that it depends on whether the individual has creditable coverage consistent with 45 CFR 144 and 146 and not whether the specific service is covered?

Section 1923(g)(1) of the Act refers to the costs of hospital services furnished by the hospital to individuals who have no health insurance (or other source of third party coverage). This language is not service-specific and any interpretation to the contrary would be inconsistent with the broad statutory references to insurance or other coverage. In an effort to adhere to a more accurate representation of the broad statutory references to insurance or other coverage; and to delineate more definitively the meaning of the term uninsured, CMS clarified the populations for which hospitals may calculate uncompensated care costs. We interpret the phrase “who have health insurance (or other third party coverage)” to broadly refer to individuals who have creditable coverage consistent with the definitions under 45 CFR Parts 144 and 146, as well as individuals who have coverage based upon a legally liable third party payer. Creditable coverage would include coverage of an individual under a group health plan, Medicare, Medicaid, a medical care program of the IHS or tribal organization, and other examples as outlined in the rules relating to creditable coverage at 45 CFR 146.113.

26. Does an advance beneficiary notice for a medically necessary procedure satisfy the requirement that "[c]laims denied by a health insurance carrier, including a Medicaid contracted managed care organization, for any reason other than the inpatient/outpatient service or services provided were not covered services within the individuals health benefit package are furnished to individuals who have health insurance coverage"?

The quoted sentence is taken out of context and does not reflect a "requirement." The underlying requirement is that, to be included in the calculation of the hospital-specific limit, the services at issue must be furnished to an individual who does not have "health insurance (or other source of third party coverage)." As indicated in the sentence prior to the quoted sentence, "[t]he costs of services for individuals who have health insurance are not included in calculating the hospital-specific limit, even if insurance claims for that particular service are denied for any reason." And the following sentence states that services are considered to have been provided for an individual with health insurance or third party coverage even though a claim has been "denied due to improper billing, lack of preauthorization, lack of medical necessity, or non-coverage under the third party insurance package." While the quoted sentence may have been inartfully drafted, the overall meaning is clear. The quoted sentence does not indicate that costs related to denials for non-coverage automatically qualify for inclusion in the hospital-specific limit; it simply indicates that certain denied claims cannot be included in the cost limit. When a claim is denied as non-covered, the hospital may then wish to verify that the individual was actually insured, and that the insurance was creditable coverage. Both the statute and the rule clearly indicate that costs of services for individuals who have health insurance (or other source of third party coverage) are not included in calculating the hospital-specific limit, even if insurance claims for that particular service are denied for any reason.

27. The preamble states, "To the extent the Medicaid payment does not fully cover the cost of the inpatient or outpatient hospital services provided, the unreimbursed costs of those services would be counted in calculating that limit." Some hospitals have interpreted this language to mean that any services provided to Medicaid beneficiaries but not reimbursed by Medicaid should be treated as uninsured. Is this interpretation correct?

The interpretation referenced in the question does not accurately reflect the provisions at section 1923(g)(1) of the statute which expressly refers to uncompensated costs of furnishing hospital services to individuals eligible for Medicaid or individuals who have no health insurance or other third party coverage. If an individual is Medicaid eligible on the day they received medically necessary inpatient or outpatient hospital services, then those services (to the extent that they are allowable under the State's plan) would be included in calculating the Medicaid portion of the hospital-specific limit.

28. How should States count costs not otherwise covered for individuals in an IMD (as Medicaid shortfall, uncompensated care costs, or not included) for those individuals

with Medicaid ages 22-64 while in an IMD if the individual is also a dual eligible (Medicare)?

For the costs of services provided to those patients between the ages of 22 and 64 who are otherwise eligible for Medicaid, the treatment of the service costs in the hospital-specific limit may vary based on State practice. Many States remove these individuals from eligibility rolls for administrative convenience (and must reinstate them if they are discharged from the IMD); if so, the costs should be reported as uncompensated care for the uninsured. States that do not remove the individuals from the Medicaid eligibility rolls should report the costs as uncompensated care for the Medicaid population. Therefore, the costs of services provided in an IMD to an individual who is 22-64 and who is otherwise Medicaid eligible, can be included either as uninsured uncompensated or Medicaid uncompensated in the UCC, depending on the eligibility status (as determined by the state) of the individual while in the IMD.

For dual eligible patients ages 22-64 old in an IMD, the treatment of costs would be determined by the State Medicaid eligibility policies. In States that do not remove the individual from Medicaid eligibility, these dual eligibles are Medicaid eligible and their uncompensated costs should be included as Medicaid uncompensated costs. In States that remove such individuals from Medicaid eligibility rolls while in an IMD, these individuals would be Medicare only during the IMD stay and therefore considered to have third party coverage (Medicare).

Uncompensated care costs would therefore not be allowed in the uninsured uncompensated cost portion.

Hospital Data

29. Because hospitals may not have detailed cost center-specific charge information for uninsured and Medicaid MCO patients for prior years, would it be acceptable to allocate total uninsured or Medicaid MCO charges to specific ancillary cost centers based on the percent to total of Medicaid charges, or, should uninsured or Medicaid MCO costs be disallowed entirely for these hospitals?

We expect that State reports and audits will be based on the best available information in conjunction with guidance from their independent auditors. If audited Medicare cost reports are not available for each hospital, the DSH report and audit may need to be based on Medicare cost reports as filed. We note that hospitals must follow the cost reporting and apportionment process as prescribed by the Medicare 2552-96 cost report process. To the extent that these cost reports do not contain the precise information needed for the DSH calculation, it may be necessary for hospitals to modify their accounting techniques. In those circumstances, for the initial audits, it will be necessary to use other source materials such as audited hospital financial records and other records, and to develop methodologies to determine the necessary information from such records. We expect States, independent auditors and hospitals to work cooperatively to develop such methodologies.

CMS has developed a General DSH Audit and Reporting Protocol which will be available on the CMS Web site that should assist States and auditors in utilizing information from each source

identified above and developing methods to determine uncompensated costs of furnishing hospital services to the Medicaid and uninsured populations. The protocol is available on the CMS Web site at: www.cms.hhs.gov/MedicaidGenInfo/Downloads/CMS2198FRptProtocol.pdf.

30. The regulation requires use of a Medicare hospital cost report to provide data to States and CMS. Some children's hospitals do not care for a large number of Medicare patients and may not file Medicare cost reports or may provide low utilization reports. Is there an alternative reporting tool that children's hospitals could use and still be in compliance with the regulation provisions?

We anticipate that States and auditors will use the best available and most accurate data. The DSH reports and audit will rely on existing financial and cost reporting tools including the Medicare 2552-96 cost report as well as audited hospital financial statements and accounting records in combination with information provided by the States' Medicaid Management Information Systems (MMIS) and the approved Medicaid State plan governing the Medicaid payments made during the audit period. If a hospital (e.g. a children's hospital) does not file or files only a partial Medicare 2552-96 cost report, the State remains responsible for reporting the information which would have otherwise been available on the Medicare 2552-96 from each hospital for Medicaid and uninsured purposes. In order to fulfill the requirements of this section, States may require such hospitals to provide the same data to the State as if they were filing the Medicare 2552-96.

31. When you say "costs of services" or "costs for dual eligibles" do you mean that this term is interchangeable with charges or do you mean just costs?

A. In the regulation, the term "costs" is not interchangeable with the term "charges."

32. As part of the reporting requirements, is the State required to submit a LIUR calculation for every hospital that received a DSH payment or only for the hospitals which are deemed eligible for disproportionate share based on their LIUR?

Under section 1923(b), hospitals may be deemed as disproportionate share hospitals based on either their MIUR or LIUR. We recognize that some hospitals may be so deemed based on both their MIUR and their LIUR. In order to fulfill the requirements of the final rule, States should submit the appropriate calculation for both the LIUR and the MIUR for these hospitals. We believe this is beneficial to both the State and to hospitals. The report must show that each hospital receiving DSH payments meets applicable DSH eligibility requirements. Should a hospital thought to be qualified under the LIUR but is later found not to be, a determination can readily be made about its potential DSH eligibility under the other formula.

Dual Eligibility

33. Would days, costs, and revenues associated with patients that have both Medicaid and private insurance coverage (such as Blue Cross) also be included in the calculation of the MIUR percentage and the DSH limit in the same way States include days, costs and revenues associated with individuals dually eligible for Medicaid and Medicare?

Days, cost, and revenues associated with patients that are dually eligible for Medicaid and private insurance should be included in the calculation of the Medicaid inpatient utilization rate (MIUR) for the purposes of determining a hospital eligible to receive DSH payments. Section 1923(g)(1) does not contain an exclusion for individuals eligible for Medicaid and also enrolled in private health insurance. Therefore, days, costs, and revenues associated with patients that are eligible for Medicaid and also have private insurance should be included in the calculation of the hospital-specific DSH limit. As Medicaid should be the payer of last resort, hospitals should also offset both Medicaid and third-party revenue associated with the Medicaid eligible day against the costs for that day to determine any uncompensated amount.

34. The regulation states that costs for dual eligibles should be included in uncompensated care costs. Could you please explain further? Under what circumstances should we include Medicare payments?

Section 1923(g) of the Act defines hospital-specific limits on FFP for Medicaid DSH payments. Under the hospital-specific limits, a hospital's DSH payment must not exceed the costs incurred by that hospital in furnishing services during the year to Medicaid and uninsured patients less payments received for those patients. There is no exclusion in section 1923(g)(1) for costs for, and payment made, on behalf of individuals dually eligible for Medicare and Medicaid. Hospitals that include dually-eligible days to determine DSH qualification must also include the costs attributable to dual eligibles when calculating the uncompensated costs of serving Medicaid eligible individuals. Hospitals must also take into account payment made on behalf of the individual, including all Medicare and Medicaid payments made on behalf of dual eligibles. In calculating the Medicare payment for service, the hospital would have to include the Medicare DSH adjustment and any other Medicare payments (including, but not limited to Medicare IME and GME) with respect to that service. This would include payments for Medicare allowable bad debt attributable to dual eligibles.

35. Is it CMS' intention that dual eligibles would include individuals with Medicare for whom Medicaid pays only Medicare deductibles, coinsurance, or Medicare Part A or B premiums?

For the purposes of the DSH audits and reporting requirements, dual eligibles include all individuals with Medicare who also are eligible for some form of Medicaid benefit. This includes those individuals for whom Medicaid pays only Medicare deductibles, coinsurance, or Medicare Part A or B premiums.

36. Medicare DSH allows hospitals to claim additional Medicaid days beyond the paid days for patients with commercial insurance through their employer and Medicaid. Would these patients be included in Medicaid DSH since they are Medicaid eligible?

The Medicare DSH program and the Medicaid DSH program are separate programs authorized by different sections of the statute and with different purposes and goals. If the patients are Medicaid eligible, then costs and revenues associated with inpatient and/or outpatient services furnished to them must be included in the hospital-specific limit calculation. Revenues required to be offset against a hospital's DSH limit would include any amounts received by the hospital by or on behalf of the Medicaid eligible individuals (for any days those individuals remain Medicaid eligible) during the Medicaid State plan rate year under audit (except payments from State or local programs based on indigency).

ARRA

37. How is the DSH audit and reporting rule affected by section 5002 of the American Recovery and Reinvestment Act of 2009 (ARRA)?

DSH payment adjustments made using the ARRA increased state allotments are subject to DSH audit and reporting requirements. ARRA provided additional potential fiscal relief to States by increasing most States' Federal fiscal year (FFY) 2009 and 2010 Medicaid DSH allotments by 2.5 percent. Specifically, section 5002 of ARRA amended section 1923(f)(3) of the Act to provide a temporary increase in state DSH allotments for these fiscal years. Section 5002 of ARRA did not otherwise modify DSH requirements. States are required to follow the same requirements for payment adjustments made under the increased allotment as they would for any other DSH payment adjustments, including DSH reporting and auditing requirements.