

# **Additional Information of the DSH Reporting and Audit Requirements – Part 2**

## **Independent Certified Audit Engagement Type**

### **1. What type of engagement are auditors required to utilize in conducting the annual DSH audit to ensure that the state and auditor meet all federal requirements?**

The final rule affords flexibility to states and auditors regarding the independent certified audit engagement type and does not specifying the type of audit engagement to be employed. To ensure that states and auditors meet all appropriate federal requirements, we are reiterating the 2008 final DSH rule requirements regarding the engagement type and providing clarifying guidance regarding how the audits must be conducted.

42 CFR 455.301 defines an independent certified audit as an audit that is conducted by an auditor that operates independently from the Medicaid agency or subject hospitals and is eligible to perform the DSH audit. Certification means that the independent auditor engaged by the state reviews 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 a review 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's specific DSH limit in the Medicaid SPRY under audit.

While Medicaid statute and federal regulations do not specify the type of engagement required for purposes of the independent certified DSH audit, regulations do require that the independent auditor review applicable federal audit requirements and complete the engagement under the professional rules and generally accepted standards of audit practice. To ensure that federal requirements are met:

- Each audit report must identify the scope and coverage of the audit.
- As part of the independent certified audit, auditors must review the data elements spreadsheet submitted by the state as part of the audit and conduct data testing for each element at 42 CFR 447.299 as part of certifying to the verifications at 42 CFR 455.301. Auditors are expected to test data on all hospitals or a valid sample.
- As part of the independent certified audit, auditors must conduct testing related to all verifications at 42 CFR 455.301.
- For audits in which auditors do not conduct onsite reviews of all hospitals in the state, the auditor must use a combination of onsite, detailed desk reviews, and desk

reviews determined under the professional rules and generally accepted standards of audit practice, such as using a risk assessment. For this process, the state must not participate in or influence which hospital reviews are onsite and which are desk reviews to avoid impairing auditor independence.

## **Audit Verifications**

- 2. Are states required to include in the annual DSH audit submission a state-specific definition of “inpatient hospital and outpatient hospital costs for furnishing inpatient hospital and outpatient hospital services to Medicaid eligible individuals and individuals with no source of third party coverage for the inpatient hospital and outpatient hospital services they received?”**

Yes, 42 CFR 455.304(d)(6) requires that states specify in their annual audit submission how they define “incurred inpatient hospital and outpatient hospital costs for furnishing inpatient hospital and outpatient hospital services to Medicaid eligible individuals and individuals with no source of third party coverage for the inpatient hospital and outpatient hospital services they received.” Additionally, states should ensure that this definition aligns with any definition of the hospital-specific DSH limit in their state plan.

## **Audit Reporting Requirements - Data Elements Report**

- 3. When are states required to begin reporting the three new data elements established by the final Medicaid DSH allotment reduction rule published on September 18, 2013?**

States should begin reporting the three new data elements for the first state plan rate year audits due to states following the effective date of the final rule. State plan rate year (SPRY) 2010 audits were due to states on September 30, 2013 and the rule establishing the three additional reporting requirements is effective on November 18, 2013. Therefore, states should include the new reporting elements with their DSH audit and report for SPRY 2011, which is due to states on September 30, 2014 and to CMS on December 31, 2014.

- 4. Are states required to complete each of the cells for every hospital on the Data Elements spreadsheet?**

Yes, states are required to complete each cell of the data element report that accompanies the DSH audit unless otherwise specified in regulation (e.g. – states are only required to report certain columns for out-of-state hospitals).

States must populate all payment, revenue, cost, and payment limit cells with a numeric value. The relevant cells are as follows:

42 CFR 447.299(c)(2, 6-17, 20)

If the state did not make a payment or if a hospital did not incur cost relating to these data elements, the state must enter a value of zero (0). Values of N/A, blank, or any other non-numeric values in these fields will be treated as missing data elements.

States must also enter information for all the following qualifying criteria data elements:

42 CFR 447.299(c)(3-5)

States must enter numeric values for (c)(3) and (c)(4) unless federal requirements do not require the state to report either of these statistics. In such cases, the state should include “N/A” instead of a numeric value for this field. If a state uses an alternate broader DSH qualification methodology as authorized statute and implementing regulations, the state must enter the value of that statistic and specify the methodology used to determine that statistic, as required by 42 CFR 447.299(c)(5). If the state uses this field, the state must include a footnote on the data element spreadsheet specifying the methodology used to determine that statistic.

Any data element reports with missing information will be treated as incomplete. In accordance with 42 CFR 447.299(e), CMS will reduce state expenditures by the amount of FFP attributable to DSH payments made to hospitals with missing information until such time as the information is reported.

**5. How will CMS treat missing information from data elements after the transition period?**

Any data element reports with missing information will be treated as incomplete. In accordance with 42 CFR 447.299(e), CMS will reduce state expenditures by the amount of FFP attributable to DSH payments made to hospitals with missing information until such time as the information is reported.

**6. Are states required to identify Institutions for Mental Disease (IMDs) and out-of-state hospitals on the data elements report?**

Yes, 42 CFR 447.299(c)(1) requires that states identify IMDs and out-of-state hospitals on its data elements report. The separate identification of IMDs (including other mental health facilities as identified in section 1923(h) of the Social Security Act) is necessary to ensure the appropriateness of the DSH payments and compliance with the DSH payment limit for IMDs and other mental health facilities established at 1923(h) of the Social Security Act (Act). Separate identification of out-of-state hospitals is required to avoid duplicative audit work, to allow auditors and CMS to track hospitals that receive DSH payments from multiple states.

States must also include a note on the data elements report if they do make DSH payments to IMDs or if they do not make DSH payments to out-of-state hospitals.

## **Late Audits and Reports**

### **7. How will CMS treat incomplete audits and reports after the transition period?**

CMS treatment of late audits and reports will not change after the regulatory transition period. According to statute and implementing regulation, states' Medicaid DSH expenditures are conditioned upon timely receipt of the audit and report. Therefore, should a state not submit the DSH audit and report that comport with federal requirements by December 31st of each year, CMS will begin deferring FFP for all DSH expenditures claimed on the Quarterly Medicaid Statement of Expenditures for the Medicaid Assistance Program (Form CMS-64) for all subsequent quarters. Only after a state has submitted an acceptable audit and report will deferred claims for DSH payments be released.

## **Out-of-State Eligibles**

### **8. Are states required to include costs and revenues associated with out of-state Medicaid eligible individuals in the calculation of hospital-specific DSH limit?**

As stated in the preamble to the final rule (page 77946), states are required to include all eligible costs and revenues associated with out of state eligibles in the calculation of the hospital-specific DSH limit. Any Medicaid payments received by a hospital from any Medicaid agency (in-state or out-of-state) must be counted as revenue offsets against total incurred Medicaid costs. Any DSH payments received by a hospital from any Medicaid agency (in state or out of state) must be counted as an offset against uncompensated care for purposes of the DSH audit and ensuring that the hospital-specific DSH limit is not exceeded. States should modify audit protocols as necessary to provide guidance to hospitals regarding the inclusion of such costs. Additionally, states should develop and implement policies, procedures, and internal controls to ensure that hospitals include all out of state Medicaid eligible hospital days, charges and payments for reporting DSH costs.

## **Section 1011 Payments**

### **9. What will states be required to report related to Section 1011 payments now that many states have exhausted these funds?**

The regulation requires that states include section 1011 revenue received by hospitals when calculating hospital-specific DSH limits and when completing the DSH data elements report. CMS recognizes that many states have exhausted their available Section 1011 funds and are now in 'spent-down' status. The state should report "\$0" for each hospital that does not receive section 1011 payments. To the extent that hospitals still receive section 1011 payments, states must continue to report such payments on the data elements report.

## **State-Only/Local Government-Only Indigent Care Programs**

### **10. Should states include costs and payments associated with individuals covered under a state-only or local government-only indigent care program when calculating the hospital-specific DSH limit?**

States should include costs associated with individuals covered under state-only or local government-only indigent care program to determine uninsured uncompensated care cost when calculating the hospital-specific DSH limit, unless the individuals has an additional source of third party coverage or health insurance.

Section 1923(g) of the Act specifies that any payment made by states or local units of government directly to DSH hospitals under such programs is not considered a source of third party payment. Therefore, such payments made by a state or unit of government directly to a DSH hospital should not be offset against the inpatient and outpatient hospital service costs for the individuals receiving services through these programs.

## **Managed Care/State-Only Indigent Care Programs**

### **11. Do costs and revenues associated with inpatient and outpatient hospitals services delivered through managed care organizations to Medicaid eligible individuals and uninsured individuals need to be included in the calculation of the hospital-specific DSH limit?**

Yes. Section 1923(g)(1)(a) of the Act and implementing regulations require that hospitals include costs associated with inpatient and outpatient hospital services provided to Medicaid managed care enrollees net of the inpatient and outpatient hospital payments made to the hospital from Medicaid MCOs when calculating the hospital-specific DSH limit.

### **12. How should states treat costs associated with individuals enrolled in a state-only/local government-only indigent care program under which services are delivered through a private managed care organization (MCO)?**

Unless the individual has an additional source of third party coverage, states should treat any individual enrolled in a state-only/local government-only indigent care program under services are delivered through a private managed care organization as uninsured for purposes of calculating the hospital-specific DSH limit. Accordingly, all inpatient hospital and outpatient hospital service costs associated with these individuals must be included in the calculation of the hospital-specific DSH limit.

When calculating the hospital-specific DSH limit, any revenues received by hospitals from the managed care organization for inpatient and outpatient services for individuals, whether enrolled in a state-only/local government-only indigent care program or not, must be offset against costs. The statutory exception applies only for payments received directly from a state or unit of government for a specific service. Managed care payments to DSH hospitals, including those relating to individuals enrolled in a state-only/local government-only indigent care program, must be offset against costs when calculating the DSH limit.

If the state carves out hospital services from the managed care contracts and the MCO has a separate contract to make payments as a fiscal agent for the state or local unit of government, CMS will consider the payments as being received directly from a state or local unit of government. The state is not required to offset such payments when calculating the hospital-specific DSH limit.

**13. If there are state-only indigent health programs that receive federal matching through a Medicaid section 1115 demonstration, should the payments received by the hospitals under those programs be offset?**

Yes, since those indigent programs are no longer funded only by state or local government money, the payments received by the hospitals under those programs no longer meet the exception under section 1923(g)(1)(A) of the Act and therefore are subject to offset against the costs of the uninsured services.

## **Physician Services**

**14. Can the state include physician service costs in calculating the hospital-specific DSH limit?**

No. For Medicaid eligible or uninsured individuals, only costs incurred in providing inpatient hospital and outpatient hospital services identified in section 1905 of the Act and covered under the approved Medicaid State plan as inpatient hospital or outpatient hospital services should be included when calculating the hospital-specific DSH limit. Any services that fall outside of either definition are not eligible for inclusion in the calculation of the hospital-specific limit.

Under the Medicaid statute, section 1905(a) of the Act identifies categories of medical items and services eligible for federal matching payment under the Medicaid program. Inpatient hospital services, outpatient hospital services, and physician services are listed as separate and distinct categories of Medical assistance. Inpatient hospital services are defined in section 1905(a)(1) and implementing regulations at 42 CFR 440.10, outpatient hospital services are defined at section 1905(a)(2)(A) and implementing regulations at 42 CFR 440.20(a), and physician services are defined at section 1905(a)(5)(A) and implementing regulation at 42 CFR 440.50(a). The DSH limit provided in section 1923(g) of the Act, refers only to hospital services and does not include physician services or any other Medicaid services listed in section 1905(a) of the Act.

We recognize that some states include certain service activities associated with physicians in their definition of inpatient hospital or outpatient hospital services. To the extent that such service activities are within the federal definition and approved state plan definition of inpatient hospital or outpatient hospital services and are billed and paid as inpatient hospital or outpatient hospitals services, states should include such incurred costs and associated revenues in calculating the hospital-specific DSH limit. Services that are billed and paid as professional services, even if they are processed by or through a hospital's billing department, cannot be included in the calculation of the hospital-specific DSH limit.

State must use consistent definitions of inpatient and outpatient hospital services for purposes of Medicaid coverage, Medicaid reimbursement, the Medicaid DSH program, and health care-related taxes.

## **Data Sources**

### **15. Is it permissible for a state to rely on a hospital's own data instead of MMIS data for determining paid Medicaid days and charges?**

No. The General DSH Audit and Reporting Protocol indicates that it is the DSH hospital's responsibility to utilize MMIS data obtained from the state for Medicaid FFS IP/OP hospital ancillary charges and Medicaid FFS IP hospital routine days.

### **16. Are there ways for states to determine uninsured costs without relying on audited hospital records to obtain uninsured hospital charges, such as using charity care or bad debt to estimate uninsured cost?**

No, states must follow the regulatory requirements and the General DSH Reporting and Auditing Protocol by utilizing the Medicare 2552 cost report and audited hospital financial statements (and other auditable hospital accounting records) to determine uninsured cost. States and hospitals cannot substitute charity care and/or bad debt data as a proxy for

uninsured cost as defined in federal regulations. The definitions of charity care and bad debt may vary significantly from the federal definition of uninsured costs.

## **Calculation of Uncompensated Care Cost**

### **17. Are states required to use the Medicare 2552 cost report as the basis for calculating hospital-specific DSH limits or can the state rely on state-only hospital cost reports?**

42 CFR 455.304(c)(3) and CMS policy guidance requires that states use the Medicare 2552, in conjunction with audited hospital financial statements and accounting records, 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 to the hospital-specific DSH limit.

States cannot substitute an alternate cost report for the Medicare 2552 when calculating uncompensated care costs unless a hospital (e.g. a children's hospital) does not file or files only a partial Medicare 2552 cost report. In such circumstances, 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. To fulfill the federal DSH audit and reporting requirements, states may require such hospitals to provide the same data to the State as if they were filing the Medicare 2552. State audit and reports that impermissibly rely on alternate cost reports will be determined incomplete.

### **18. Where can states, hospitals, and auditors find information regarding the requirements for using Medicare cost report data for calculating allowable hospital costs?**

States, hospitals, and auditors should rely on the federal regulations at 42 CFR 447.299, the DSH audit and reporting final rule published on December 13, 2008, the General DSH Audit and Reporting Protocol, the Additional Information on DSH Reporting and Auditing, and this document. CMS is available to provide technical assistance regarding the requirements upon request.

### **19. What is the proper way to treat observation bed days in the calculation of uncompensated care costs?**

States and hospitals must include observation bed days when computing total bed days. If these days are omitted, total days used to calculate routine cost center per diems would be understated. This would result in routine cost center per diems being overstated and, in turn, cause an overstated hospital-specific DSH limit. States should p correct instructions/references



to hospitals to obtain and report accurate routine total day counts, including observation bed days, for purposes of calculating the hospital-specific DSH limit.

**20. Should “allowed days” or “billed days” be used when calculating hospital Medicaid routine costs?**

Item #23 of the Additional Information on the DSH Reporting and Audit Requirements clarified how unpaid Medicaid days and charges should be treated. Specifically, the guidance stated that the cost of furnishing services to any individual who is eligible for Medicaid is included in a hospital's uncompensated care cost, as long as the services are inpatient and outpatient hospital services under the approved Medicaid state plan.

States should ensure that the determination of a hospital's uncompensated care cost properly includes Medicaid days and charges related to state plan inpatient and outpatient hospital services furnished to Medicaid-eligible individuals, regardless of whether or not those days and charges are actually paid by the State. Some states have limits on the number of days reimbursed annually for hospital services. Only including the reimbursed days (allowed days), understates Medicaid costs reported for the hospital, potentially understating the hospital-specific DSH limit. States and hospitals must use covered days for purposes of calculating the hospital-specific DSH limit.

## **Cost Report Proration**

**21. When instances arise in which the hospital fiscal year end (and related Medicare 2552 cost report) do not coincide with the Medicaid state plan rate year, and the hospitals need to develop per diem rates and cost-to-charge ratios for state year that use two cost report periods, can such per diem rates and cost-to-charge ratios be averaged from the applicable cost reports? For example, if the hospital year end is June 30, 2011 and the state reporting period is September 30, 2011, can the hospitals use an average per diem rate and cost-to-charge ratio that is based on a calculation that involves 9/12ths of the rates and ratios for the period ended June 30, 2011 and 3/12ths of the rates and ratios for the period ended June 30, 2012? Or, are the hospitals required to generate more precise measurements of the per diem rates and cost-to-charge ratios for the state’s reporting period ended September 30, 2011?**

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 may file more than one cost report during its 12-month fiscal period.) The data will 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](http://www.cms.hhs.gov/MedicaidGenInfo/Downloads/CMS2198FRptProtocol.pdf).

The protocol requires that hospitals proportionately allocate all costs and revenues in each financial and cost reporting period to determine costs and revenues associated with the Medicaid state plan rate year. The hospitals should utilize one of the following methods of allocating data from multiple cost reports in order to calculate costs and revenues associated with the Medicaid State plan rate year:

#### Method 1

**A.** Cost Report #1 - Hospitals should calculate DSH eligible hospital cost and revenues for the time period relating to the portion of the cost report applicable to the State plan rate year under audit. Cost center specific routine per diems and ancillary ratios of costs to charges (RCC) from the cost report should be used. The per diems and cost-to-charge ratios will be applied to days and charges from MMIS or other sources for services specific to the portion of the cost reporting period that coincides with the state plan rate year. The established revenue identification process described in the General DSH Audit and Reporting Protocol should be used for the partial period.

**B.** Cost Report #2 - Hospitals should calculate DSH eligible hospital cost and revenues for the time period relating to the portion of the cost report applicable to the State plan rate year under audit. Cost center specific routine per diems and ancillary ratios of costs to charges (RCC) from the cost report should be used. The per diems and cost-to-charge ratios will be applied to days and charges from MMIS or other sources for services specific to the portion of the cost reporting period that coincides with the state plan year. The established revenue identification process described in the General DSH Audit and Reporting Protocol should be used for the partial period.

**C.** The sum of A and B should represent DSH eligible hospital costs and revenues for the State plan rate year under audit.

#### Example Calculation

Cost Report #1 (January 1, 2010 – December 31, 2010)

Cost Report #2 (January 1, 2011 – December 31, 2011)

State Plan Rate Year (July 1, 2010 – June 30, 2011)

**A.** Total DSH Eligible Hospital State Plan Rate Year Costs for July 1, 2010 through December 31, 2010 = Costs Report #1 DSH Eligible Hospital Costs for the Period July 1, 2010 – December 31, 2010, computed using routine per diems and ancillary cost-to-charge ratios from the cost report for the period of January 1, 2010-December 31, 2010, applied to Medicaid and uninsured days and charges for the period of July 1, 2010-December 31, 2010, offset by applicable revenues for the period of July 1, 2010-December 31, 2010.

**B.** Total DSH Eligible Hospital State Plan Rate Year Costs for January 1, 2011 through June 30, 2011 = Costs Report #1 DSH Eligible Hospital Costs for the Period January 1, 2011 through June 30, 2011, computed using routine per diems and ancillary cost-to-charge ratios from the cost report for the period of January 1, 2011-December 31, 2011, applied to Medicaid and uninsured days and charges for the period of January 1, 2011-June 30, 2011, offset by applicable revenues for the period of January 1, 2011-June 30, 2011.

**C.** The sum of A and B should represent total DSH eligible hospital costs and revenues for the State plan rate year under audit.

Method 2

**A.** Cost Report #1 - Hospitals should follow the established 2552-96 cost reporting and apportionment process and the revenue identification process described in the General DSH Audit and Reporting Protocol for the full cost report year that includes a portion of costs and revenues applicable to the Medicaid State plan rate year under audit. DSH eligible hospital costs and revenues identified for the cost report year should be multiplied by the percentage of the cost report year applicable to the State plan rate year under audit. The product should represent DSH eligible hospital costs and revenues for a portion of the State plan rate year.

**B.** Cost Report #2 - Hospitals should follow the established 2552-96 cost reporting and apportionment process and the revenue identification process described in the General DSH Audit and Reporting Protocol for the full cost report year that includes a portion of costs and revenues applicable to the Medicaid State plan rate year under audit. DSH eligible hospital costs and revenues identified for the cost report year should be multiplied by the percentage of the cost report year applicable to the State plan rate year under audit. The product should represent DSH eligible hospital costs and revenues for a portion of the State plan rate year.

**C.** The sum of A and B should represent DSH eligible hospital costs and revenues for the State plan rate year under audit.

### Example Calculation

Cost Report #1 (January 1, 2010 – December 31, 2010)

Cost Report #2 (January 1, 2011 – December 31, 2011)

State Plan Rate Year (July 1, 2010 – June 30, 2011)

**A.** Total DSH Eligible Hospital State Plan Rate Year Costs and Revenues for July 1, 2010 through December 31, 2010 = Costs Report #1 Total DSH Eligible Hospital Costs and Revenues \* 50%

**B.** Total DSH Eligible Hospital State Plan Rate Year Costs and Revenues for January 1, 2011 through June 30, 2011 = Costs Report #2 Total DSH Eligible Hospital Costs and Revenues \* 50%

**C.** The sum of A and B should represent DSH eligible hospital costs and revenues for the State plan rate year under audit.

## **State-Developed DSH Audit Protocol**

### **22. Are states required to develop an audit protocol? If so, how can states ensure that it has satisfied audit protocol requirements?**

Yes, states are required to develop and to distribute to hospitals and the auditors an audit protocol for use by DSH hospitals to determine costs. Item #2 under States' Areas of Responsibility, from the CMS General DSH Audit and Reporting Protocol, specifies that states are responsible for developing an audit protocol for use by DSH hospitals to determine costs. In addition, CMS' Additional Information on the DSH Reporting and Audit Requirements emphasizes that the Audit and Reporting protocol should be used as a tool in collecting the necessary data and information.

States must develop this DSH audit protocol for use by DSH hospitals and cannot rely solely on their independent certified auditors to provide the instructions to hospitals, to provide training to the hospitals, and to collect required data. The state must ensure that the audit protocol complies with the federal requirements. In addition, the state should provide the auditor and the hospitals with applicable instructions of data elements required in accordance with the final rule.

### **23. What information should be included in the state-developed DSH audit protocol?**

The protocol should serve as a guide to hospitals in determining costs in accordance with federal requirements. It should include instructions identifying the relevant sections of the cost report that reflect costs eligible for inclusion in developing the hospital-specific DSH limit and must replace any current DSH survey information utilized by states. This protocol should include identification of all relevant hospital cost reports and financial statements and other auditable hospital accounting records associated with the audited Medicaid SPRY necessary for calculating hospital-specific DSH limits.

## **State Procedures and Internal Controls**

### **24. Are state internal control policies and procedures required for purposes of administering and overseeing the DSH program?**

In administering federal programs, states are required to have and maintain effective internal controls of those programs. With effective internal controls, states can provide reasonable assurance that they are administering the programs in compliance with applicable laws, regulations, and policies. States can also ensure that their financial reports are complete, accurate, and supported.

For the Medicaid program, states are responsible to have adequate internal controls in place to ensure that all Medicaid expenditures reported for FFP, including DSH expenditures, are complete, accurate, and supported.

- Per 45 CFR 92.20(b), the financial management systems of other grantees and subgrantees must meet the following standards:
  - (3) Internal control. Effective control and accountability must be maintained for all grant and subgrant cash, real and personal property, and other assets. Grantees and subgrantees must adequately safeguard all such property and must assure that it is used solely for authorized purposes.
- Per OMB Circular No. A-133, Subpart C – Auditees, § .300 Auditee responsibilities, the auditee shall:
  - (b) Maintain internal control over Federal programs that provides reasonable assurance that the auditee is managing Federal awards in compliance with laws, regulations, and the provisions of contracts or grant agreements that could have a material effect on each of its Federal programs.

### **25. Why are internal controls important?**

Without adequate internal controls, the estimated and actual hospital-specific DSH limits may significantly differ from the limits based on the audited actual data. This may impose financial hardships on hospitals whose excess DSH payments are subject to be recouped or redistributed.

States should implement appropriate internal control procedures to ensure the information used to estimate the hospital-specific DSH limit is accurate and supported. Additionally, they should implement appropriate internal control procedures by providing sufficient instructions to hospitals and auditors, providing and adequate oversight of the independent audit and related reported data. These internal controls will assist in ensuring that the information used to estimate and calculate the hospital-specific DSH limit and to compile the DSH data elements report is accurate, compliant with federal requirements, and sufficiently documented.

## **Non-Qualified Hospitals Receiving Payments**

### **26. What happens if SPRY 2011 and after DSH audits and reports show that some hospitals were not eligible to receive DSH payments during the state plan rate year under audit?**

All hospitals that receive DSH payments must meet minimum qualifying requirements under section 1923(d) of the Social Security Act and must meet all state plan DSH qualifying requirements in the approved state plan in effect for the state plan rate year under audit. This includes the requirement to have a provider agreement with the state. If an audit or associated report for SPRY 2011 or after identifies any hospitals that did not meet these requirements, CMS will regard this 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. However, if the approved state plan in effect for that fiscal year has a methodology to redistribute excess DSH that are identified by the audit, the state should rely on this approved methodology to redistribute these excess payment amounts.

## **Medicaid Inpatient Utilization Rate (MIUR) and Low-Income Utilization Rate (LIUR)**

### **27. 42 CFR 447.299(c)(3) requires that states report the Medicaid Inpatient Utilization Rate (MIUR), as defined in section 1923(b)(2) of the Act, for each hospital receiving a DSH payment. If states calculate the MIUR differently than as required in 1923(b) of the Act, what should the state report?**

If the approved state plan relies on the MIUR threshold as calculated in section 1923(b)(2) of the Act to qualify hospitals as eligible for DSH under the state plan, states must report the MIUR

in the 42 CFR 447.299(c)(3) cell of the data elements report. However, if the state instead relies on alternate qualifying criteria in the approved state plan methodology for qualifying DSH hospitals, including a state-defined version of MIUR, it should report the alternate statistic in the 42 CFR 447.299(c)(5) cell of the data element report in lieu reporting in the MIUR cell. Please note that if the state reports the alternate qualifying criteria, it must include a footnote on the data element spreadsheet specifying the methodology used to determine that statistic.

Though they are not required to report the MIUR as part of the data elements report, states that rely on state-defined alternate qualifying criteria must still follow requirements of sections 1923(b) and 1923(d) of the Act. States are responsible for ensuring that all hospitals meeting the requirements of section 1923(b) of the Act receive a DSH payment. Additionally, states must ensure that only hospitals that have an MIUR of at least one percent as defined in section 1923(d) of the Act qualify to receive a DSH payment under the state plan.

Regardless of whether states uses alternate qualifying criteria, it is important that states calculate the MIUR for purposes of 1923(b) and (d) correctly. The MIUR as defined in section 1923(b)(2) for a hospital is a fraction (expressed as a percentage), the numerator of which is the hospital's number of inpatient days attributable to patients who (for such days) were eligible for medical assistance under a State plan approved under Title XIX of the Act in a period (regardless of whether such patients receive medical assistance on a fee-for-service basis or through a managed care entity), and the denominator of which is the total number of the hospital's inpatient days in that period. The term "inpatient day" includes each day in which an individual (including a newborn) is an inpatient in the hospital, whether or not the individual is in a specialized ward and whether or not the individual remains in the hospital for lack of suitable placement elsewhere.

In determining inpatient days, days associated with patients that are dually eligible for Medicaid and Medicare, as well as days associated with patients that are dually eligible for Medicaid and private insurance, must be included in the numerator of the MIUR equation. States must calculate the MIUR for all hospitals receiving Medicaid payments in the state, not just hospitals receiving DSH payments, to determine whether or not a hospital is deemed a DSH hospital per 1923(b)(1)(A).

**28. 42 CFR 447.299(c)(4) requires that states report the Low-Income Utilization Rate (LIUR), as defined in section 1923(b)(3) of the Act, for each hospital receiving a DSH payment. If states calculate the LIUR differently than as required in 1923(b) of the Act, what should the state report?**

If the approved state plan relies on the LIUR threshold as calculated in section 1923(b)(2) of the Act to qualify hospitals as eligible for DSH under the state plan, states must report the LIUR in the 42 CFR 447.299(c)(4) cell of the data elements report. However, if the state instead relies on alternate qualifying criteria in the approved state plan methodology for qualifying DSH hospitals, including a state-defined version of LIUR, it should report the alternate statistic in the

42 CFR 447.299(c)(5) cell of the data element report in lieu reporting in the LIUR cell. Please note that if the state reports the alternate qualifying criteria, it must include a footnote on the data element spreadsheet specifying the methodology used to determine that statistic.

Though they are not required to report the LIUR as part of the data elements report, states that rely on state-defined alternate qualifying criteria must still follow requirements of sections 1923(b) and 1923(d) of the Act. States are responsible for ensuring that all hospitals meeting the requirements of section 1923(b) of the Act receive a DSH payment. Additionally, states must ensure that only hospitals that have an MIUR of at least one percent as defined in section 1923(d) of the Act qualify to receive a DSH payment under the state plan.

Regardless of whether states uses alternate qualifying criteria, it is important that states calculate the LIUR correctly for purposes of 1923(b). States should ensure that the numerator at section 1923(b)(3)(B) is the total amount of the hospital's charges for inpatient hospital services which are attributable to charity care in a period, less the portion of any cash subsidies in the period reasonably attributable to inpatient hospital services.

## **State Plan Issues**

### **29. How can a state ensure that it has a Medicaid state plan DSH methodology that meets federal DSH requirements, including DSH audit and reporting requirements?**

To ensure that DSH payments and the DSH audits and reports comport with section 1923(j) of the Act, implementing regulations at 42 CFR 447.299 and 42 CFR 447 Subpart D, and related guidance, there are certain criteria that states should including in their Medicaid State plan to ensure that DSH payments will be calculated in accordance with statutory and regulatory provisions:

- The State plan should specify that only hospitals that meet the minimum DSH provider qualification requirements at section 1923(d) of the Social Security Act qualify as DSH hospitals.
- The State plan should clearly define how hospital-specific DSH limits are calculated. The calculation method should meet all federal requirements, including the December 19, 2008 DSH Audit and Reporting Final Rule and associated guidance. The description of the calculation should include the definition of costs and revenues used to determine uncompensated care costs and the populations whose services are included in the calculation.



- The State plan should accurately describe the actual policies and procedures followed by the state in administering the DSH program. This requires that the state maintain clear and comprehensive written documentation of their DSH policies and procedures.
- 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. Regardless of this flexibility, the state plan should rely on DSH payment methodologies do not result in payments that significantly exceed hospital-specific limits.

**30. Can states modify their state plans to avoid having to repay the federal portion of DSH overpayments to CMS after the regulatory transition period?**

States have the opportunity to amend their Medicaid state plans requiring state recoupment and redistribution of overpayments as CMS advised in the 2008 DSH final rule and the CMS Information Bulletin released on June 21, 2011. Additionally, states can modify their prospective payment methodologies to ensure payment accuracy in advance of the calculation of the final hospital-specific DSH limit. The proposed SPA establishing a redistribution methodology must be submitted by the last day of the SPRY to preserve an effective for that SPRY.

**31. If there is a particular hospital service that is only covered under the state plan at particular hospitals or particular categories of hospitals, would the cost of such service be allowable as a hospital service cost for other hospitals? Or, for these other hospitals, would the service be treated as a service that falls outside of what the state plan defines as a covered hospital inpatient or hospital outpatient service?**

Regardless of whether a state plan defines a hospital service as a covered service only when furnished by limited facilities, any hospital that provides such a service can include allowable costs when calculating the hospital-specific DSH limit. For inclusion in calculating the limit, the service must be within the scope of the state plan's definition of inpatient or outpatient hospital services and must be provided to an individual eligible for Medicaid or with no source of third party coverage.

## **Section 1115 Demonstrations and Medicaid DSH**

**32. Are payments made under a section 1115 demonstration required to be offset against hospital costs when calculating the hospital-specific DSH limit?**

Any demonstration payments that are payments made to a hospital for inpatient and outpatient hospital services furnished to Medicaid or uninsured individuals should be counted as Medicaid or uninsured revenues for the calculation of the hospital-specific DSH limit. If the approved terms of the demonstration require treatment of the payments as DSH payments, the state must instead report the payments as DSH payments for Medicaid DSH audit and reporting purposes.

**33. How are states that have approved section 1115 demonstrations authorizing payments to hospitals for uncompensated care costs required to account for Medicaid DSH payments?**

States must ensure that section 1115 demonstration payments made to hospitals for uncompensated care costs are offset when calculating the hospital-specific DSH limit. States are only permitted to make DSH payments that do not exceed the hospital-specific DSH limit.

## **Certified Public Expenditures**

**34. There are states where the Medicaid State plan or a section 1115 demonstration authorizes the state to fund its Medicaid hospital or DSH payments by certified public expenditures (CPE). A cost protocol is approved for the CPE process which prescribes the cost reports used, the Medicaid and/or uninsured cost computation, and the cost reconciliation steps. Does the approved DSH CPE process override the DSH independent audit requirements?**

No, the DSH CPE process does not override the DSH independent audit requirements. Where the state and auditors look to or rely on elements of the CPE process as part of its DSH audit, there needs to be an audit determination that those elements from the CPE process, including the cost report used and the computation of Medicaid or uninsured uncompensated care costs, are in compliance and consistent with the final DSH rule. Furthermore, the timing of the CPE process may not match that of the independent audit process.

## **Obstetric Services Requirement**

- 35. Psychiatric and rehabilitation hospitals generally do not provide non-emergency obstetric services. If such a hospital was first opened after December 22, 1987 and did not offer non-emergency obstetric services, would it be considered exempt from the obstetric requirement?**

Section 1923(d) of the Social Security Act includes exceptions to obstetrical service requirements in that section of the statute. Hospitals that did not offer nonemergency obstetrical services to the general population as of December 22, 1987, are excepted from the two-physician rule. The law does not contemplate a grandfathering clause or otherwise make exception to the obstetrician requirement for hospitals that came into existence after December 22, 1987; therefore, such hospitals would not be considered exempt from the obstetrician requirement at section 1923(d) of the Act.

## **Medicaid Inpatient Utilization Rate (MIUR)/Low-Income Utilization Rate (LIUR)**

- 36. To determine estimated DSH payments and initial DSH eligibility statistics, many states use MIUR and LIUR data from a prior year to ensure timely payments to providers. Are states required to adjust qualification and payment when the MIUR and/or LIUR data is available from the actual SPRY?**

CMS clarified in the 2008 DSH final rule that states will continue to have the flexibility to use MIUR and LIUR data from time periods other than the Medicaid SPRY to estimate DSH qualification and DSH payments, but must provide for adjustments to ensure that final qualification and payments are based on MIUR and LIUR and LIUR data from the actual SPRY. If a hospital initially qualified using prior year data, but no longer meets the qualification criteria based on actual SPRY data, the state must recoup any DSH payment made to that hospital and return the federal share to CMS unless the state has a redistribution methodology in its approved state plan. Conversely, if a state determines that a hospital that did not preliminarily qualify using prior year data later meets the qualification criteria using actual SPRY MIUR or LIUR data, the state must make a DSH payment to those hospital in accordance with the approved state plan in effect during the SPRY for which the actual data is used.

- 37. Section 1923(b)(1)(a) of the Act requires that states determine the MIUR of all hospitals receiving DSH payments in the state for deeming hospitals as DSH. Are states required to use a prior year estimate for purposes of this calculation or are states required to use actual data?**

States must obtain the actual data for the relevant state plan rate year for the MIUR for all Medicaid hospitals. We are not, however, expecting that the MIURs for non-DSH, Medicaid hospitals be audited as part of the independent audit. However, the data for the MIURs for the Medicaid hospitals would be collected in the same manner that the state collects this data for the initial DSH qualification determination, except that the actual state plan rate year period is used.

## **Auditor Independence**

### **38. Can states hire an entity to conduct the independent certified DSH audit if the Medicaid Agency has or had a contract with the same entity to calculate Medicaid DSH payments or hospital-specific DSH limit?**

Medicaid regulations at 42 CFR 455.301 define an independent certified 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. The term “independent” means that the Single State Audit Agency or any other CPA firm that operates independently from the Medicaid agency or subject hospitals is eligible to perform the DSH audit. States may not rely on non-CPA firms, fiscal intermediaries acting as Agents for a State’s Medicaid program, or on certification programs currently in place to audit uncompensated care costs. Nor can states simply expand hospital financial statements to obtain audit certification of the hospital specific DSH limits.

CMS provided guidance on auditor independence to states in the Additional Information on the DSH Reporting and Audit Requirements document published subsequent to the 2008 DSH audit and reporting finale rule. This guidance reinforced the responsibility of states to ensure that no possible impairment exists between the auditing organization/auditors and the Medicaid agency and/or hospital and required that states and auditors follow the GAGAS standards in ensuring independence.

Specifically, the guidance provided a list of potential conflicts regarding independence, including an auditor performing work relating to State plan DSH payments aside from the independent certified audit. It is possible that the auditing entity could have appropriate firewalls in place to eliminate potential impairments to independence so that the audit entity meets the GAGAS independence standards. If the state and the auditor believe that the meets it these standards despite a potential impairment (including those listed in Chapter 3 of the GAO’s GAGAS standards, CMS guidance, or any other potential conflict not listed in those guidance documents), the state must submit the following along with its annual independent certified audit and associated report:

1. A written narrative justifying how the audit entity meets the GAGAS independence standards despite the appearance that the auditing entity is not independent.
2. A signed statement from the audit entity declaring independence of the respective Medicaid agency and hospitals (please note that this is a standard requirement for all states).

States are responsible for ensuring that auditors that they contract with meet the auditor independence requirements. CMS will not accept any DSH audits or reports from states that do not submit the two required items. Additionally, CMS will not accept audits or reports from states that utilize auditors that have impairments to independence.

**39. Are states permitted to use Medicare contractors to conduct the independent certified audit required by section 1923(j) of the Social Security Act?**

States may use a Medicare contractor to conduct the independent certified DSH audit only if the Medicare contractor meets the definition of an independent CPA firm and operates under a contract that ensures independence. States may also use Medicaid agency auditors to gather the data and perform initial data analysis for the DSH audit. However, the audit must be certified by an independent auditor.

CMS's Additional Information on the DSH Reporting and Audit Requirements provided additional guidance regarding the DSH auditor independence requirements. Specifically, this policy document requires state and auditor compliance with Chapter 3 of the General Accountability Office's (GAO) most recent revision to Government Auditing Standard, which identifies specific criteria for independence and outlines impairments to independence in government auditing practices ( <http://www.gao.gov/govaud/govaudhtml/index.html> ).

We recognize that there are Medicare contractors conducting DSH audits. At least two audit reports contained numerous disclaimers and qualifications about complying with Chapter 3 of generally accepted government audit standards (GAGAS) "yellow book" standards. The nature of the work of the Medicare contractors could lead to the potential impairments to independence. Further, we understand that many, if not most, Medicare contractors have common audit agreements in place with Medicaid agencies for which they are conducting the DSH work. We view contracting with Medicare contractors as a potential conflict to auditor independence. Accordingly, states that contract with Medicare contractors for DSH audit purposes must submit the signed independence statement and the explanation of independence described in the preceding response for each SPRY in which they utilize a Medicare contractor to conduct the DSH audit.

## Revenue Reporting

- 40. The General DSH Audit and Reporting Protocol is specific in that uninsured revenues are reported based on when the payments are received and that there is no attempt to allocate payments received during the state plan rate year to services provided in prior periods. Does this same policy apply to Medicaid revenues? Please clarify whether revenues pertaining to services furnished to Medicaid eligibles should be tied back to the service periods.**

The General DSH Audit and Reporting Protocol sets forth an exception to the general rule that revenues should be tied back to the service periods for uninsured revenues. Since this exception does not apply to Medicaid revenues, all revenues pertaining to services furnished to Medicaid eligibles should be tied back to the service periods. In other words, there is a matching of revenues to the costs of services incurred during the state plan rate year. This applies to all revenue sources for the Medicaid eligible services, including but not limited to payments from the state (home state or out of state), Medicare and third party payers, the Medicaid recipient, and Medicaid managed care plans. We provided an exception only for uninsured payments in the CMS guidance due to the feedback we received on the inconsistent nature and timing of uninsured payments.

- 41. Are grants considered to be uninsured revenues requiring offset in the computation of the hospital-specific DSH limit? Does it matter whether the grant is a federal grant, a private grant, or a state/local government grant? Does it matter whether the grant is earmarked for specific purposes or uses at the hospital?**

Any grant that can be attributed, in part or in whole, to Medicaid and/or uninsured hospital patient care, would be considered a revenue for Medicaid and uninsured services and, therefore, must be included as offset in the computation of the hospital-specific DSH limit. Any identifiable portion that is earmarked for purposes unrelated to Medicaid and/or uninsured hospital patient care can be excluded from the offset. Also, any grant that is determined to be an indigent program payment from a state-only or local-only governmental entity is not offset; this type of payment is not considered to be a source of third party payment in accordance with Section 1923(g)(1)(A) of the Social Security Act.

## Resources for States, Hospitals, and Auditors

- 42. What resources are available on the DSH audit and reporting requirements for states, hospitals, and auditors?**

The 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](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>

September 18, 2013 Additional DSH Reporting Requirements Rule

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

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>

DSH Report Format Template

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